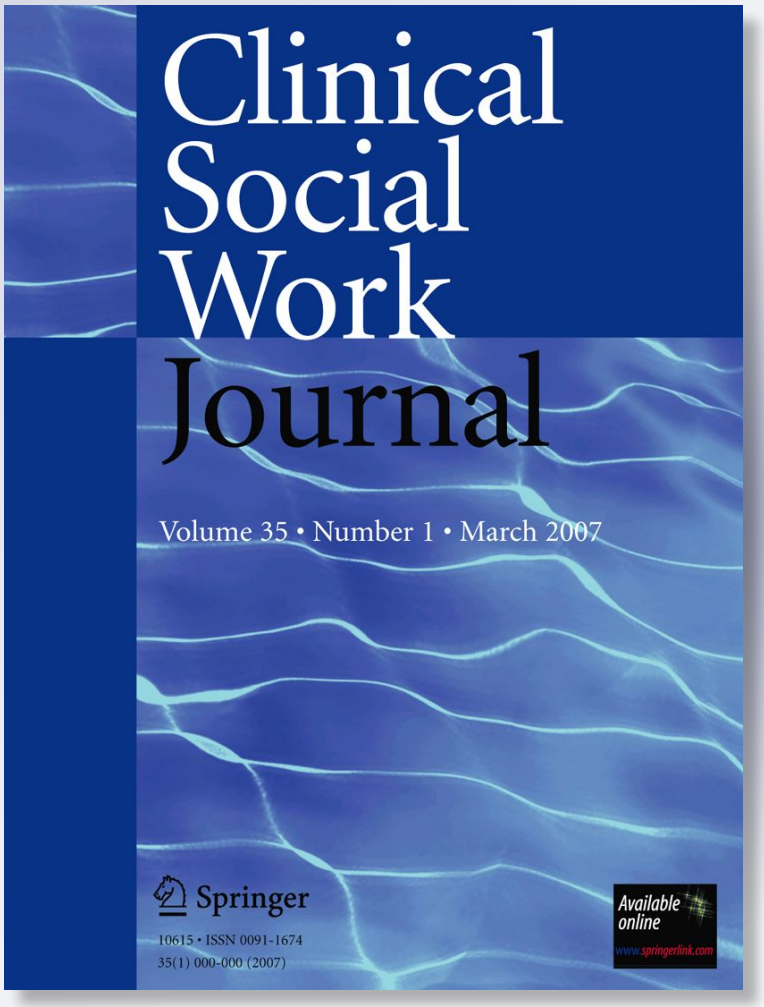
The Elephant Is Not Pink: Talking About White, Black, and Brown to Achieve Excellence in Clinical Practice

Mary Pender Greene & Lisa V. Blitz

Clinical Social Work Journal

ISSN 0091-1674

Clin Soc Work J
DOI 10.1007/s10615-011-0357-y



Springer

Clin Soc Work J
DOI 10.1007/s10615-011-0357-y

ORIGINAL PAPER

The Elephant Is Not Pink: Talking About White, Black, and Brown to Achieve Excellence in Clinical Practice

Mary Pender Greene · Lisa V. Blitz

Abstract Incorporating issues of race and racism can improve clinical engagement and the therapeutic alliance. Assessing, understanding, and responding to experiences related to racial identity and racism related stress can be an important factor in a clinician's ability to be culturally responsive. A vignette of client treatment presents common dilemmas in clinical treatment. Responses to questions about race from focus groups are presented to frame the experiences of women of color who struggle with poverty and social-emotional issues. A framework of multicultural antiracist practice highlights the skills necessary for clinicians, supervisors, and managers.

Keywords Racism · Racism related stress · Microaggression · Race · Therapy · Counseling · Cultural competency · Cultural responsiveness

Hazel[1] arrives for her therapy appointment 5 min late. She opens the session with a brief apology to her therapist, and then sits quietly for several moments, her head downcast, her hands fidgety. Her therapist's voice is gentle, a quality Hazel appreciates, and she responds, "No apology is necessary; this is your time. But I wonder if something is going on that led to you being late." Hazel begins to talk about her ailing father and the struggle with balancing caring for him with an increasing work load at her job. Then she pauses abruptly, looks directly at her therapist, then looks away, tears welling up in her eyes. "That's not why I'm late. It's bullshit, dealing with bullshit, that's why I'm late." She then explains that the security guard demanded that she produce identification before she be allowed upstairs. Hazel was carrying a heavy backpack and another bulky package, and did not want to put everything down to find her ID. "He knows me! That man knows me—I've been coming here for 2 months. That's just some racist bullshit. They don't like Black people in this building."

The therapist, a White woman, easily finds empathy for Hazel's frustration but struggles with the hurt and outrage that she is expressing. The therapist knows the security guard is under strict orders to check identification from everyone who comes into the building, regardless of whether he knows them. She does not agree that this is an example of racism, and wonders if Hazel is opening a door to her unconscious, showing vulnerability, suspicion, and anger she has not shown before. She wonders what this means in the context of Hazel's relationships and the dull, chronic depression that brought her into therapy. Deciding that an interpretation along these lines would not be appropriate given Hazel's emotional state, she considers her intervention options. The last part of Hazel's statement suddenly hits her, almost vibrating in the room. "Do you ever wonder how *I* feel about having Black people in this building, in my office?" she asks. Hazel's look is a powerful combination of rage and hope, with an engaging undertone of playfulness as she answers, "Absolutely."

M. Pender Greene
Brooklyn, NY, USA
e-mail: mlpenderg@gmail.com

L. V. Blitz (✉)
Department of Social Work, Binghamton University,
P.O. Box 6000, Binghamton, NY 13902-6000, USA
e-mail: lblitz@binghamton.edu

[1] "Hazel" is a composite character developed for this vignette based on the clinical and research experiences of the authors.

Published online: 17 August 2011

Racism and Cultural Competency

Hazel's therapist takes cultural competency seriously and believes that talking about differences in the therapeutic relationship is an important part of building trust. She understands that differences in worldview, early socialization, and social norms have a strong impact on how people perceive and experience life problems and successes, and on how they use counseling. She listens carefully for opportunities to talk about gender, sexual orientation, race, and other factors of identity. Working from a strength-based perspective, she knows that culture supports and shapes individual capacity and can be an important source of social and personal strength. In the seven times that they have met, she and Hazel have begun to develop a trusting alliance. The therapist is about to learn, however, that real trust, and the deeper work of therapy, will not be achieved unless she is able to enter her client's racial world. In this world she, as therapist, is a healer. As a White person, she can also be an unintentional abuser with the potential to inflict harm through a lack of knowledge of, and thus responsiveness to, Hazel's daily experiences of racism related stress.

How Racism is Experienced

Racism's many forms: interpersonal, social, cultural, and institutional, impact all people in society. Interpersonal racism consists of direct acts of prejudice or bigotry between or among individuals. Social, cultural, and institutional racism can be more subtle and difficult to identify. These manifestations of racism, like other forms of oppression, primarily consist of norms, standards, and worldviews that are developed in a monocultural context. As a result, systems are created that disproportionally benefit White people and place People of Color at a disadvantage. People of Color bear the brunt of the injury, but White people are also injured even as they benefit from systemic inequities (Bowser and Hunt 1996). For instance, racism related injury experienced by People of Color can limit inter-racial relationships and deeper engagement with all people in a multicultural society. The resulting social segregation can potentially inhibit fuller potential in self-actualization for White people who may be denied opportunities for multicultural relationships. For People of Color, racism threatens life and personal integrity. The danger of racism comes in the form of immediate threat to life from violence, but also in less visible forms, such as long term health related risks. Disproportionate poverty and less access to health care contribute to high blood pressure, obesity, substance use, and other health and behavioral issues that shorten life and lead to poorer health outcomes in People of Color (U.S. Department of Health and Human Services [USDHHS] 2001).

The mental health needs of People of Color are also inadequately addressed. According to the Surgeon General's Report (USDHHS 2001), People of Color have less access to mental health services and are thus less likely to receive them. Once in treatment, they often receive poorer quality of care and suffer a high disability burden due to unmet mental health needs. People of Color are underrepresented in mental health research, so their unique needs are not adequately understood. Misdiagnosis is common (Kunen et al. 2005), which limits the effectiveness of the treatment they do receive. Furthermore, if issues of race and experiences of racism are not discussed in treatment, the client may not be fully understood nor will their issues be fully addressed.

Many People of Color have been able to organize their lives in such a way that they can minimize the trauma of the kind of racism that directly impacts their life direction, such as housing or employment discrimination. They lead successful and satisfying lives—but still live in the context of racism on all levels and must learn strategies to cope. Even those who achieve high levels of success are not immune. The subtleties of unconscious negative stereotyping may result in People of Color being subjected to more intense criticism and scrutiny than their White counterparts as they become more successful. Additionally, increased prestige or career responsibilities are likely to bring People of Color into more situations where they are the only Person of Color among groups of White people. As such, they may have fewer people in their social or professional network who share the complexity of their racial experience or understand the subtle nuances of how they experience racism.

People of Color, regardless of class or culture, are subjected to vicarious racism and the indignities of microaggressions that contribute to racism related stress (Harrell 2000). Vicarious racism (Tatum 1997) refers to witnessing or sharing the experiences of race prejudice and bigotry that happen to friends, family members, and neighbors. Vicarious racism also includes events that are reported by the media that create anxiety, anger, and a sense of vulnerability. In this context, the experience of racism related microaggressions is particularly poignant.

Microaggressions (Franklin et al. 2006) are the frequent, often daily, subtle and usually unconscious insults that happen to People of Color. Examples of the more obviously toxic microaggressions include jokes or stories that make fun of People of Color or perpetuate stereotyping. Microaggressions can also be manifested environmentally (Sue et al. 2009), where a White dominant culture is emphasized in subtleties of décor, educational materials, or interpersonal interactions between others that are witnessed by the Person of Color.

Microaggressions also include events that may not appear to be directly related to racial bias. Examples include such things as being overlooked or ignored in social or professional situations, followed or scrutinized in retail stores or other public spaces, or being mistaken for someone in a service position. This type of microaggression may sometimes be explained away as an act of rudeness, thoughtlessness, or bad manners that does not reflect racial bias. Microaggressions never happen in social or cultural isolation, however. When an individual is regularly exposed to vicarious racism, lives in the context of social inequities based on race, and has had personal experiences of clear racial insults, the affronts are experienced as racism, regardless of any other explanations that may apply. For example, a colleague, a Black woman, was invited to be the keynote speaker at a prestigious conference. Upon arriving to the venue, she approached the registration booth to ask for directions. Before she could make her inquiry, the person behind the desk assumed that she was the caterer and gave her directions to the kitchen. Regardless of whether the desk staff would have made this same mistake had she been White, because of the context of cultural and systemic racism, our colleague experienced this as a racist act. She had only a few minutes to recover, regain her dignity, and give her speech in front of the 250 guests.

The injuries of microaggressions are often invisible to White people, who do not experience or understand the events and their relationship to racism (Sue et al. 2009). Thus, the pain of the experience is heightened by the isolation of not being able to share the experiences with White people, including friends and colleagues, for fear that they will dismiss, rationalize, or minimize the experience. In therapy, these missteps in empathy can undermine or destroy the therapeutic alliance, or impinge on the depth and value of the treatment.

Back to Hazel

Hazel's therapist is correct: the security guard routinely asks all visitors to show their identification, regardless of how long they have been coming to the clinic. What the therapist cannot know, however, is the tone of voice used by the security guard or the look in his eyes when he questioned Hazel. Nor does the therapist know what else had gone on in Hazel's day that heightened her sensitivity to racism's insults. More importantly, the therapist and Hazel have never talked about race in detail. Without having had rich conversations about race, the therapist does not know about Hazel's racial experiences over her lifetime and has not assessed her level of racism related stress.

Early on, the therapist asked Hazel about the racial difference between them, and Hazel responded by indicating that race did not matter. The therapist accepted Hazel's statement that she sees people as individuals and does not consider race. This seemed evident in what she knew about Hazel's life, and it was congruent with her own value system. In seven sessions of intimate talk, about family, childhood, sex, failures, regrets, and dreams, her therapist never had any hint that Hazel was being emotionally abused by racism every day. The incident with the security guard is the first invitation into Hazel's racial world.

Hazel did not enter therapy because she wanted help dealing with racism. In fact, she never considered that a White therapist could be a partner in this part of her life. In Hazel's world, dealing with racism and the stress that comes with it is something People of Color must contend with on their own. While she regularly has conversations with other People of Color about racism, Hazel learned early on not to share these thoughts with White people. White people have their place as colleagues, friends, even as confidants. But they do not share the same racial experiences and, for Hazel, White people have never been trusted intimately. She never says it out loud, but with her White friends, and now her therapist, Hazel protects herself with a quiet reminder: I love you as a person, but your people hurt me every day—and eventually you will, too.

The support Hazel is seeking is only as effective as her therapist's ability to understand her issues. Without knowing the full context of racial experience for Hazel, her therapist does not know her whole client. The challenge now faced by Hazel's therapist is to suspend her psychodynamic interpretation of Hazel's reaction to the security guard, recognize his actions as having been experienced as an unintentional microaggression, and get to know her client more intimately.

Barriers for Clients in Talking About Race and Racism

It is important to acknowledge that while this paper focuses on race, understanding the impact of all forms of oppression, marginalization, and privilege is important in all areas of mental health. All people live within the dynamic intersections of multiple aspects of identity, where we experience privilege and pain in various combinations. An individual's cultural identification is informed, in part, by how they experience marginalization and privilege. Understanding and responding to an individual's social and cultural world is fundamental to engagement and assessment.

Culture influences the meaning therapists give to the information they gather, and impacts the client's expression of somatic symptoms and views of helping and treatment. The therapists' challenge is to negotiate the

boundary between their own culture and that of their clients. True cultural responsiveness, however, requires that therapists understand how their clients are treated and responded to based on how others perceive them. Culture also influences how people communicate, how they interpret their own experience, and how they feel about what has happened to them. Cultural responsiveness, therefore, cannot be achieved through intellectual understanding alone. It is helpful for therapists to understand what it is like to be that other person, to understand the world through their experience of it, and to respond accordingly. Immersion in the experience of racism is best accomplished through intimate contact with People of Color, but any form of experiential learning that engages emotions is beneficial (Wang 2008).

Much of what is discussed here could be applied to explorations of sexual orientation and homophobia, gender and misogyny, or any other form of oppression. Focus on race is not meant to detract from other aspects of identity and experience. The intent is to highlight one facet of experience to add depth to understanding. For many people, there are few opportunities to learn how to talk about racism, often because there may be limited opportunities for people to develop meaningful cross racial personal relationships where these conversations can take place. As a result, genuine and nuanced empathy is particularly difficult in discussions of race, especially when the therapist is White and the client is a Person of Color, but barriers exist regardless of the race of the therapist.

Many social workers and therapists have been taught two things that directly impact their ability to bridge issues around race and racism. First, many have been taught that, beyond asking certain specific questions during the initial assessment, they should either follow the client's lead in determining issues for clinical attention or rely on manualized evidence based methods to inform the course of treatment. Uncovering the pain of racism is unlikely in either approach. Fear of being misunderstood, judged, or dismissed contributes to clients' hesitancy in bringing up race, and evidence based treatment protocols have not been developed with an appreciation of the impact of racism related stress.

Second, many White people have been taught that racial equity means being color-blind in their approach to people. They may view racism only as overt, blatant prejudice and individual acts of cruelty and intolerance. They may not understand institutional or systemic functioning that disproportionately benefits White people and places People of Color at a disadvantage, thus they may not see how they personally benefit from racism. Through a color-blind lens, the insults and stress of microaggressions or vicarious racism remain invisible. By viewing everyone as equal, they may believe that they have transcended racism, not realizing that People of Color cannot avoid racism's injury. Furthermore, since a person's race is usually visually obvious, when White people claim color-blindness they not only annihilate the racial experience of People of Color, they risk coming across as fundamentally dishonest.

Cultural competency literature and research in mental health supports the fact that we cannot be, nor should we be, color-blind. Failure to acknowledge race results in denial, minimization, or rationalization of social injustice and individual experiences of discrimination (Bonilla-Silva 2003; Monnat 2010). If racial experiences are not recognized, it is possible that the therapist will not develop a complete assessment of the client's strengths, resources, or stressors. Therapists who maintain a color-blind racial ideology have lower multicultural counseling competencies, lower abilities in integrating race and ethno-cultural issues in conceptualizing etiology and treatment, and lower multicultural counseling awareness and knowledge (Neville et al. 2006). Therefore, therapists who do not fully acknowledge the complexity of their client's racial experiences are less able to understand other key aspects of their clients' cultural experience, or approach the depth of their clients' pain and frustration. As a result, they are less likely to understand their clients, and thus less likely to intervene in optimally effective ways.

Most concerning, the therapist may never understand that the rift has occurred. Lack of cultural competency is associated with client dissatisfaction with treatment (Chang and Berk 2009). Chang and Berk's study found that clients of color are particularly sensitive to acts of cultural incompetence, and may leave therapy without telling the therapist why. Clients may drop out unexpectedly, may attend a few sessions and state that they have achieved their goals, or may give some other reason for being unable to continue. It would be a rare client, indeed, who stated outright that she or he is not satisfied with the therapist's cultural competency. Additionally, when racism is not discussed and treatment drop-out rates are high, People of Color may be passively blamed as being treatment resistant or seen as poor candidates for psychotherapy.

White people, including therapists, can be seen as perpetrators of racism. Even when the person does not actively engage in racists acts, she or he may be perceived as supporting and benefiting from a socio-cultural system in which racism is allowed. Clinicians who are People of Color can be subjected to the same suspicion, since they are working within an institutional context that may be experienced as racist by the client and they have institutionally sanctioned contextual power over the client. Clients of color may fear that talking about racism with their therapists might sound like an indictment against the therapist personally, a confrontation they are unlikely to risk when they are feeling vulnerable and need the therapist's help. People of Color may be cautious when talking

about experiences of racism with White people out of fear that they will be discounted, or that the White person will attempt to argue or disagree, compounding the injury (Sue et al. 2009). People of Color may also fear being perceived as racist, or seen as the stereotypical 'angry Black woman/man', if talking about racism unveils their hurt and anger in a way that is not understood by White people.

American culture does not encourage intimate and complex talk about privilege and oppression. When it comes to race, White people and People of Color may not have the language to articulate and understand the multifaceted experience of race privilege and discrimination. As noted by Harrell (2000), "the stress—and potential damage—of racism lies not only in the specific incident, but also in the resistance of others to believing and validating the reality or significance of one's personal experience" (p. 45). The inherent mistrust that exists within unjust power hierarchies makes the discussion more difficult. It also makes it more necessary. In therapy, it is the role of the clinician, not the client, to learn the skills to talk about race with their clients. Therapists may need to actively reach for racism related content, as the client may not be willing to initiate the conversation.

Benefits for Clients in Talking About Racism

Talking about racism will improve engagement and help build a more trusting relationship (Burkard et al. 2006). Knowing the client's racial world allows the therapist to work with clients actively to help improve internal mediating factors that can help improve their ability to manage and cope with racism (Harrell 2000). By talking about race and racism, the therapy can support racial identity development and help the client develop effective racism-related coping styles and skills. Clients also benefit from enhanced cultural identification and improved skills in negotiating between their culture and the dominant culture. All of these factors support enhanced self-esteem and self-efficacy. Furthermore, if the client is not talking about racism in therapy, the therapist may be missing an important part of the client's experience. Talking about race opens up the whole person and allows the client to bring their whole self to treatment.

Focus Groups: Talking About Racism

Thus far we have been concerned with Hazel, a composite character created for illustration in this paper. Let's move away from Hazel for a moment and consider the ideas and opinions of real Women of Color who participated in focus groups in 2005 (Blitz 2006). Three focus groups were held with clients of a social service program in a large metropolitan area. The groups consisted of 12 women who were struggling with the impact of domestic violence, depression, anxiety, and difficulties in parenting. All the respondents were Women of Color. One identified her culture as American, six as African American, and the others identified with other cultures, even though most were United States citizens. Nine of the 12 spoke English at home all or most of the time, and half spoke Spanish at least some of the time. They ranged in age from 22 to 45, with a mean age of 28. Half had not completed high school, and the other half had some college, though none had completed a degree. All had struggled with poverty and ongoing financial insecurity for most of their lives and lived in racially segregated neighborhoods.

The groups were co-facilitated by the agency's supervisor and the social worker, both of whom received training in focus group facilitation. Both were Women of Color; the supervisor was African American, and the social worker was a Latina of Dominican descent. The principal investigator was White, and met with the group members to obtain informed consent and discuss the purpose of the study, but did not remain in the room during the discussions. Each focus group was approximately 90 min long and was audio taped and transcribed. The focus groups were part of a larger evaluation of program effectiveness. Questions about race were included to assess the impact of race and racism on the clients' experience in the agency and to understand how this impacted their experience of seeking help.

Many of the women's responses indicated that they believed that their experiences and those of White women are significantly different. The women saw themselves as strong, and felt they had family and community sanction for taking charge of their family. They agreed on a common belief that White women are not as strong:

> Our mothers, Latina, Black women, raised us up to be, you know, the women in my family is dangerous, you can't mess with a sista or a Latina, you know, you gotta do what you gotta do.
> You know what I think? You know what I know for a fact? White woman, let's say she is in her life right now if she had to live in the projects, if she had to live in our neighborhoods, she would break down, she would not be able to do it, she would break down, she would think her life was coming to pieces. Us, we're out there every day, we make it work every day.

Resentment of White privilege and an awareness of the systemic and institutional nature of racism were evident in many of the comments. The women clearly felt stigmatized and believed that they would have to work significantly harder than White women to get ahead:

> Basically, they put us in a situation we got to try so much harder to do things, what for them is easy, it just makes us stronger, because white women put in our situation they wouldn't make it. In their situation, because of their color, being white, they have all the advantage, they can easily get it done, they can easily do that, whereas us, … we have to struggle twice as hard just to do the things they do so easy.
> They can be whatever, like I can be gothic for now, and when I feel like going back to being white, well, I'll go to college, I can do whatever I got to do and I can get a job and be whatever I want to be. Us, we might have been through our days of smoking weed or whatever, but that's with us forever, you can't get a job, they be checkin' everything you do just because you black. Black people you come there in a suit they automatically assume that you're the bottom of the pit.

The women were asked how racial bigotry, cultural bias, and poverty impacted them. Some related directly to the personal impact of racial bigotry, indicating that dealing with race prejudice increases their burden as they struggle to make improvements in their lives. It seems clear that race prejudice is very painful and increases their experience of separation or isolation from White people:

> I see how people look at you … They look at you not so much with empathy or caring, they think of you as less, they surprised when you intelligent, or that you can get a job or you can express yourself in a way, like they so surprised.
> My son, he's 7, he was playing with this white kid and the kid's mother comes over and takes her son, and says, don't you play with that boy, you don't know him. And that day, I held my children, I was very emotional, I didn't know how to explain it, and he's asking me mommy what happened, and at night I can hear his pain, crying, crying, crying.

The women were asked about how talking to a White social worker is different than talking to a social worker who is a Person of Color. Some women indicated that they felt a barrier in talking to White people about their struggles, feeling that White people are less likely to be able to relate to the full context of their problems or concerns. The women expressed concern that White social workers may not be able to experience authentic empathy or be helpful:

> I just feel like, hey, you can't relate to my problems. That might be messed up, but that's how I feel in my heart. I've got my problems and you're going back to your white life. I just don't think they could understand what it's like to be black or to have the struggles that I was born with.
>
> I just feel like white people can't relate to me, they can hear my story and maybe have empathy, but they can't feel it the way I feel it.

Many, however, thought that the racial barrier could be negotiated as long as they sensed sincerity from the White person and felt that person was honest, non-judgmental, and down to earth:

> Black or white it don't matter as long as they got heart, as long as they're down to earth.
> [It's] most important that we're treated with respect
> I don't have a problem talking with a white person, as long as you're honest with me.

How to Talk About Race and Racism

Taking about racism in therapy is different than reaching for or supporting other types of client disclosure where the client may be embarrassed or self-protective out of fear of being judged. In those cases, therapists need to convey empathy and non-judgment, and encourage the client to tell the story at their own pace. In talking about racism, therapists must convey empathy and non-judgment, and also actively communicate their understanding of the complex nature of racism while maintaining awareness that they may represent the group inflicting injury. Anger and hurt are cumulative. In cross racial therapeutic relationships were the therapist is White, the client may have never had the opportunity to genuinely express feelings about racism to a White person. Early conversations may be highly charged. As the process develops, however, the anger is likely to subside, the therapeutic relationship will be enhanced, and the benefits may be invaluable.

Knowledge of the client's culture is also important. Chang and Berk (2009) found that, "clients praised therapists who demonstrated culture-specific knowledge, skills in navigating racial/cultural dynamics inside and outside of therapy, and awareness of the importance of race and culture in shaping individual experience and identity, and criticized those who displayed cultural ignorance or insensitivity" (p. 532). It is helpful for therapists to adopt a unique perspective with each client, understanding and responding to multiple intersecting cultural identities and oppressions, including gender, sexual orientation, religion, ethnicity, and socio-economic status. Clients can be invited to discuss important cultural reference groups, the therapist following the client's lead in talking about racism.

Therapists' self disclosure of their own struggles with racism helps to equalize the power balance in the therapeutic relationship by sharing the vulnerability and risk the client is expected to take in talking about race. Burkard et al. (2006) found that the therapeutic relationship directly

benefits from the therapist's ability to self disclose around race and racism. Findings from their study indicate that treatment is enhanced when therapists disclose their own struggles with benefiting from a racist system, or acknowledge unintentional complicity. By doing so, therapists can help mitigate the client's fear that the therapist is ignorant of the nuances of racism, or dishonest in their claims of color-blindness. Addressing power dynamics is vital. White therapists represent the racial power structure that supports racism, and therapists who are People of Color may be perceived as supporting institutional racial hierarchy. There are potentially multiple times during the course of treatment when issues of power need to be addressed. Racism, understood as an unequal distribution of social and economic power, can be part of the therapeutic conversation from the beginning, ensuring that any discussion about power is rich and complete.

Findings from the study by Burkard et al. (2006) also showed that therapists' self disclosure about their emotional reactions to clients' experiences of racism was an important element in bridging cross racially. While it is important not to convey shock at the existence of racism, since the client needs to know that the therapist is aware of racism as a reality, sharing feelings of anger or shock about the brazenness of a specific event when a client discloses an experience is valuable. They also found that disclosures about racism enhance client engagement and trust, thereby improving the therapeutic relationship, allowing clients to address other important issues in counseling.

Examples of White therapist self disclosure regarding racism include admitting to an awareness of benefiting from White privilege (i.e., a statement such as, "When I was in college the professors really encouraged me to apply to graduate school, while the Black and Latina students were being counseled about what jobs they could get with a bachelor's degree. I thought it was awful, but I didn't know what to do about it—and I wanted to go to graduate school and needed their recommendations.") or confessing an awkwardness about talking about race ("I was raised to think that racism is a thing of the past. I now know how wrong I was, but I still struggle with how to talk about racism—I feel like I'm breaking the rules or something. Can we make new rules here?"). Therapists of Color can disclose their own struggles with negotiating racism and discuss how they have learned to cope.

Therapists can also disclose their own past struggles with racist feelings, and share their own cultural values. For example, the therapist might admit to having been raised in a family where stereotyping was accepted, or having once believed that success or failure was determined by an individual's work and merit alone without an appreciation of social and economic factors. Self disclosures of this nature should be placed in past tense, with an additional statement revealing personal growth or change in attitude.

Clients should be encouraged to explore how they are exposed to racism (Harrell 2000) with therapists helping them to process feelings, reactions, and thoughts. These conversations can include examinations of family and social influences and an assessment of protective factors, such as cultural identity and community ties. Therapists can also assess for internal mediators such as racial identity development (Helms 1995) and coping skills for racism related stress, helping clients to build these skills when necessary. Helping clients talk about the accumulation of indignities in their daily lives is crucial in helping them to develop a strong ability to locate the problem of racism as external (Harrell 2000).

As in any area of treatment, it is important for therapists to know what they are *not* exploring with clients, along with fully understanding what is being discussed. Therapists need to be highly self aware, and be especially attuned to their own biases and preconceptions. To help build effective partnerships and address power issues in the relationship, it is helpful if the treatment is holistic, collaborative, and congruent with the client's values, needs, and preferences. Attending to 'pre-treatment work' may be necessary for clients of color who are not familiar with the therapeutic process and who may be struggling with the stigma of asking for help. The long history of abuses by the mental health field has sensitized many in communities of color to the potential harm or danger of seeking help from formal systems. People who are not educated about therapy may fear that seeking help indicates weakness, or that their troubles are a precursor to mental illness. Their friends and family members may have strong negative feelings about their decision to seek formal help, and they may be keeping their therapy a secret from loved ones. Therapy may be perceived as something that is only for White people, or that existing support systems, such as clergy or friendship networks, should be enough. A Person of Color seeking therapeutic help may be breaking important cultural norms and need help to talk about these issues.

Pre-treatment work involves education about what is involved in therapy, assessment, diagnosis, and potential collaborative referrals for medication or specialized services. Cultural awareness and responsiveness are necessary to reach for the client's expectations and anxieties about therapy. The more the client is able to talk about the nature and quality of other relationships that have been helpful in the past, the better prepared the therapist will be to meet the client's relational expectations. During the pre-treatment phase, the client is not fully engaged or committed, and may be struggling with a significant amount of fear about the process. Missteps in engagement can be interpreted as

racism, and the client may abort therapy without telling the therapist the real or full reasons behind the decision.

Where We Left Hazel

We left Hazel and her therapist at a pivotal point. Hazel declared that "they don't like Black people in this building" and her therapist wisely queried whether Hazel wondered how she, the therapist, felt about having Black people in the building and in her office. Hazel stated that she is "absolutely" interested in this. So what is the therapist's next best move?

Our therapist in this scenario has a playful sense of humor and communicates warmth naturally. This gives her some latitude and helps support engagement. Warmth and caring also help bridge cross racially (Chang and Berk 2009). She answers honestly, "Me, too. When I was in school I thought I would be a social worker working in poor Black and Latino neighborhoods doing good work, helping needy people, and that someday I would have a private practice doing psychotherapy with wealthy White people. It wasn't until about a year into my training that I realized how racist those assumptions were and I needed to start figuring out what that was all about for me. It's been a few years, and I think I figured out most of it, but racism is such a big deal in our culture I worry sometimes that I'll never figure it all out. But I love having you here, in my office, and I really want to hear more about how you experience racist bullshit. What do you think is the best way for us to talk about it?"

Hazel sits back, relaxes a bit, and smiles to herself. She has just decided that she'll come back next week after all. To hell with that security guard.

As Hazel and her therapist move into the conversations around race and racism, they can anticipate the potential for uncomfortable cross-roads, possible reification of unintentional microaggressions, and missteps in empathy. By asking Hazel what she thinks may be the best way to talk about racism, the therapist has appropriately offered Hazel some choice and control. At the same time, the therapist must resist any temptation to defer to her client as an expert on race and racism. Hazel is an expert on her own experiences and her own multifaceted identity. She many not, however, know how to have intimate conversations about racism. Since Hazel has previously dismissed the impact of racism when her therapist brought it up, it can be assumed that she may be uncomfortable with the topic, and perhaps fears being injured by a therapist she needs. She may retreat again, may even dismiss her reaction to the security guard as evidence of a bad day, and deny the importance of racism in her life.

If Hazel should retreat from the topic, the therapist is called upon to handle this in much the same way she would handle any denial or avoidance of painful experience or memory. She may decide not to push in the moment, but to hold the concept for future work. The client may not return to it, just as clients often choose to use therapy to work on selected issues and avoid others. The therapist, however, retains an awareness and readiness to respond to the full range of potential issues, and looks for openings to reengage around the subject.

Once the topic has been opened up, regardless of the depth and complexity of the initial conversation, the therapist begins to weave racial identity and impact of racism into her assessment of the client's strengths and vulnerabilities. The assessment should also include a similar consideration of the client's sex, gender identity, sexual orientation, age, ability/disability status, and other aspects of identity that contribute to privilege or oppression. This assessment should be overt and shared with the client as appropriate.

Quite possibly, as conversations about race continue, Hazel may say something that triggers the therapist's defensiveness, hurt, or anger. Just as there were multiple explanations for the security guard's actions that Hazel experienced as racist, Hazel may identify other situations or ideas as racist that the therapist may find confusing or offensive. It is possible that Hazel may be dismissive of the struggles of financially poor White people, not understand the challenges faced by members of the LGBTQ community, or express her own discriminatory ideas about White people or other cultural groups, including other communities of color. The therapist may feel actively engaged in initial conversations about White privilege, but begin to feel resentful that she is only being seen as privileged without acknowledgement of her own struggles, hard work, and negotiations with systemic bias.

The therapist's reactions can be understood as complex interactions of countertransference, internalized privilege, and learning needs in areas unfamiliar to her. Lack of social discourse leads to limitations in knowledge and understanding about privilege and oppression, and can inhibit clinical and professional development in this area. Agencies and supervisors have a responsibility to support and guide therapists' ability to mature and grow in their cultural competency and ability to respond to a wide range of human experience.

Agency Responsibilities and Response

Studies have shown that counselors demonstrate increased multicultural counseling competency when provided with training, especially when training is combined with hands-on experience with clients of color (Smith et al. 2006). White counselors may not show significant progress in

racial identity development, but multicultural counseling skills can be taught and learned. Furthermore, multicultural counseling skills not only improve following training, the improvements are maintained over time (Vinson and Neimeyer 2003) indicating that there is a long term benefit for agencies to invest in this training.

Supervision

While there has been considerable attention to cultural competency in the therapy arena, cultural competence in supervision is addressed far less frequently. There is often a lack of discussion of race and ethnicity in cross-cultural supervision or in supervision of White staff whose clients are People of Color. When working with racially and culturally diverse clients, an essential feature of supervision is the supervisor's ability to raise and guide analyses of race, ethnicity, and culture (Estrada et al. 2003). These analyses are part of the critical process of honing the supervisee's ability to understand, raise, and discuss issues of culture, race, and racism in treatment. Supervisors may find it beneficial to be prepared to discuss issues, or even perceived issues, involving race and racism and to bring the subject up if the supervisee fails to do so.

Due to the power differential between staff and supervisor, many staff members may be unable to initiate discussions about race and racism without explicit permission. Supervisors wishing to integrate discussions of race and racism must be clear with supervisees that these issues will be a regular part of supervision. Staff members who are People of Color are likely to be relieved by this mandate if they perceive the supervisor as knowledgeable about the subject and able to connect empathically with them. White staff may feel more challenged by this, but supportive education about race and racism will help them to realize that their development as clinicians can be enhanced by their ability to incorporate issues of race and racism in the treatment.

Administration

The social culture of an organization can unintentionally reinforce dynamics that continue to privilege people with white skin. It is in this manner that American institutions remain dominated by practices which produce racial inequalities (Better 2002). Structural racism inhibits the participation and success of People of Color who join the organization as staff. Having staff of color, however, is an important way to have team members who can articulate the depth, intensity, and perspective of diverse groups of clients. Knowledge based on life experience in a given culture, coupled with objectivity, tools of analysis, and skills developed through good supervision, create the potential for bringing a unique perspective to the treatment. A more diverse and inclusive staff can also widen the circle of power and opportunity within the organization, which in turn can enhance all staff members' abilities to practice in culturally responsive ways. Agency leadership must learn how to help White staff as well as staff of color to better understand how systemic racism impacts all staff and clients, and be prepared to offer strategies and support for systemic change (Pender Greene 2007).

With this in mind, it is important for the top leadership to ask the hard questions: Are People of Color thriving in our institution? Are there People of Color in decision-making positions? Is there congruence between those in decision-making positions with those being served? When there is a change in client demographics, are the decision makers actively seeking to be more closely aligned with and responsive to the new group? If clinicians are to claim clinical excellence, the culture of the organization needs to support talking about race. Administrators need to take up the cause and lead by example, or honest and rich discussions about racism will not happen within the organization.

References

Better, S. (2002). *Institutional racism: A primer on theory and strategies for social change*. Chicago: Burnham.

Blitz, L. V. (2006). *Using a culturally competent multicultural framework for trauma recovery milieu therapy with Black and Latina women in a domestic violence shelter: An evaluation of services* (Doctoral dissertation). http://gradworks.umi.com/32/15/3215530.html (publication number: 3215530) Columbia University, New York, NY.

Bonilla-Silva, E. (2003). *Racism without racists: Color-blind racism and the persistence of racial inequity in the United States*. Lanham, MD: Rowman and Littlefield.

Bowser, B. P., & Hunt, R. G. (1996). *Impacts of racism on White Americans*. Thousand Oaks, CA: Sage Publications.

Burkard, A. W., Knox, S., Groen, M., Perez, M., & Hess, S. A. (2006). European American therapist self-disclosure in cross-cultural counseling. *Journal of Counseling Psychology, 53*, 15–25. doi:10.1037/0022-0167.53.1.15.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*, 521–536. doi: 10.1037/a0016905.

Estrada, D., Wiggins Frame, M., & Braun Williams, C. (2003). Cross-cultural supervision: Guiding the conversations toward race and ethnicity. *Journal of Multicultural Counseling and Development, 32 Extra*, 307–319.

Franklin, A. J., Boyd-Franklin, N., & Kelly, S. (2006). Racism and invisibility: Race-related stress, emotional abuse, and psychological trauma for people of color. In L. V. Blitz & M. Pender Greene (Eds.). *Racism and racial identity: Reflections on urban practice in mental health and social services* (pp. 9–30). New York: The Haworth Maltreatment and Trauma Press. doi: 10.1300/J135v06n02_02.

Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of People of Color. *American Journal of Orthopsychiatry, 70*, 42–57.

Helms, J. E. (1995). An update of Helms' White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–198). Thousand Oaks, CA: Sage Publications.

Kunen, S., Niederhauser, R., Smith, P. O., Morris, J. A., & Marx, B. D. (2005). Race disparities in psychiatric rates in emergency departments. *Journal of Consulting and Clinical Psychology, 73*, 116–126. doi:10.1037/0022-006X.73.1.116.

Monnat, S. M. (2010). Toward a critical understanding of gendered color-blind racism within the U.S. welfare institution. *Journal of Black Studies, 40*, 637–652. doi:10.1177/0021934708317739.

Neville, H., Spanierman, L., & Doan, B. T. (2006). Exploring the association between color-blind racial ideology and multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology, 12*, 275–290. doi:10.1037/1099-9809.12.2.275.

Pender Greene, M. (2007). Beyond diversity and multiculturalism: Towards the development of anti-racist institutions and leaders. *Journal of Non-Profit Management*, *11*, 1–9.

Smith, T. B., Constantine, M. G., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology, 53*, 132–145. doi:10.1037/0022-0167.531.132.

Sue, D. W., Lin, A. I., Torino, G. C., Capodilupo, C. M., & Rivera, D. P. (2009). Racial microaggressions and difficult dialogues on race in the classroom. *Cultural Diversity and Ethnic Minority Psychology, 15*, 183–190. doi:10.1037/a0014191.

Tatum, B. D. (1997). *Why are all the Black kids sitting together in the cafeteria? And other conversations about race*. New York: Basic Books.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Vinson, T. S., & Neimeyer, G. J. (2003). The relationship between racial identity development and multicultural counseling competency: A second look. *Journal of Multicultural Counseling and Development, 31*, 262–277.

Wang, H. (2008). Red eyes: Engaging emotions in multicultural education. *Multicultural Perspectives, 10*(1), 10–16. doi:10.1080/15210960701869330.