

WORKING WITH RACE AND DIFFERENCE IN CROSS-RACIAL THERAPY  
DYADS: AN EXPLORATORY STUDY OF PSYCHODYNAMIC  
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## ABSTRACT

Changing US population demographics and the rise in racial minorities serves as a mandate for innovation within traditional Western forms of psychotherapy. The need for culturally competent clinical practice that addresses issues of race in treatment is paramount. The following study explored white psychodynamic psychotherapists' experiences of working with race and difference in cross-racial therapy dyads. Eight licensed clinical psychologists who identified as white, psychodynamically-oriented, and had worked with at least one African-American client in the past five years were interviewed about their experiences working cross-racially. Four research questions were addressed: 1) How do white therapists come to understand and think about race in treatment? 2) How do they use race in client conceptualization? 3) How do they address the topic of race and difference when working cross-racially? 4) How do they work with race and difference in the therapy process? A qualitative study design was used and data were analyzed via grounded theory methodology to reveal major themes. Themes identified included: the limitations of race-related trainings; the importance of early experiences, self-exploration, and interactions with people of color to understanding race; the anxiety, shame, and humility of cross-racial work; the significance of race to client conceptualization; the importance of discussing race in deepening the work; the impact of power and privilege on therapy process; the difficulty of working with racialized defenses; and the ability of white therapists to evolve over time. Additional themes included organizational barriers to cross-racial work, and psychodynamic therapy as a treatment for all. The findings of this study suggest important implications for practitioners, organizations, and the field including: the need for more advanced trainings

on racial competence and race in treatment; the need for white therapists to examine their own racism and be aware of dynamics of power and privilege in the therapy; the importance of examining systems-level barriers to racial competence; and the continued incorporation of racial and multicultural principles into traditional psychodynamic theory, research, and practice.

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## Chapter I

### Introduction and Overview

#### **Statement of the Problem**

US demographics are radically changing. As of the 2010 census, nearly 36% of residents in the US were of non-white minority status (U.S. Census Bureau, 2011). The rise in persons of color has significant implications for clinical practice and requires the re-examination and evolution of traditional Western approaches to psychotherapy.

Research has shown that cultural competence is an essential component of ethical and effective treatment (Fouad, 2006). Therapists' responsiveness to issues of culture and diversity have been found to positively impact the therapeutic alliance (Atkinson & Lowe, 1995; Knox et al., 2003; Sue & Sue, 2002), client satisfaction in therapy (Constantine, 2002) and client self-disclosure (Thomspon et al., 1994). While much work has been done to operationalize and better understand multicultural competence, there still exists a need to determine how these theories translate into therapy process and technique (Bukard et al., 1999; Fuertes & Gretchen, 2001). Additionally, while much focus in the field has centered on the over-arching construct of multiculturalism in treatment (including ethnicity, sexual orientation, SES, and other markers of identity), some argue that this focus has shifted attention away from a more specific emphasis on race and racial issues in treatment (Helms, 1995; Helms & Cook, 1999) which may ultimately serve to invalidate the race-based identities and experiences of persons of color (Carter, 1995; Helms, 1984).

In examining the racial competence of psychodynamic theory and practice, opinion is mixed. While some scholars assert that psychodynamic therapy is well

positioned to explore issues of race in general and the racial differences between therapist and patient through concepts that leverage the therapeutic relationship (Altman, 2010; Javier & Rendon, 1995; Perez Foster, 1993), others criticize its majority-based positioning (Greene, 2007), historical focus on the intrapsychic, and its virtual silence until recent years on the issue of race in treatment (Curtis Boles, 2002; Dimen, 2000; Leary, 2000). This study seeks to examine race in therapy from a psychodynamic perspective. Specifically, it seeks to understand how white psychodynamic therapists work with race and racial difference in cross-racial therapy dyads.

Within the current literature, few studies have focused specifically on the construct of therapist responsiveness to racial content and how it impacts the process of treatment (Thompson & Jenal, 1994; Thompson, Worthington & Atkinson 1994; Zhang & Burkard 2008). One study by Knox et al. (2003) examined the issue of racial competence from the perspective of white and black therapists in cross-racial treatment relationships. This study found that while white therapists reported greater discomfort in addressing race in treatment than did their African American counterparts, therapists of both races noted that addressing race in cross-racial dyads had a positive effect on the treatment and therapy relationship overall (Knox et al., 2003).

Given the lack of research in general in the area of racial difference and treatment process from the perspective of the therapist, it is not surprising that there is little research or writing on this topic from a psychodynamic perspective. Indeed, most of the work in the area of race and racial difference from a psychodynamic standpoint has relied on detailed case studies in which the primary author reflects on his or her own experience of the treatment relationship (for example see Altman, 2010). The purpose of this

exploratory study lies in extending the current, albeit limited, research in the area of working with race and racial difference in African American-white therapy dyads in treatment to include a qualitative examination of the experiences of white psychodynamic therapist's in the field. The study examined four major questions. 1) How do white psychodynamic therapists come to understand and think about race in treatment? 2) How do they use race in client conceptualization? 3) How do they address the topic of race and difference when working cross-racially? and 4) How do they work with race and difference in the therapy process? It was hypothesized that white psychodynamic therapists would vary in their familiarity with and understanding of working with race from a dynamic perspective and would consider it of varying levels of importance to client conceptualization. Additionally, it was expected that therapists interviewed would differ in their understanding and awareness of how race and racial difference would impact the treatment process from a dynamic perspective.

## Chapter II

### Review of the Literature

#### **The Case for Cultural Competence**

The reality of population growth in the United States today dictates the critical need for the continued development of clinical theory and practice that is sensitive to the experiences of diverse patients. Rapidly changing population demographics in the US and a rise in racial and ethnic minorities serve as a mandate for innovation and adaptation within traditional forms of psychotherapy as a means of better meeting the mental health needs of clients of color. As of the 2010 census, nearly 36% of residents in the US were of non-white minority status (U.S. Department of Commerce, 2011). Projections indicate the continued growth of populations of color within the US with the biggest increased anticipated amongst Latinos and Asians, and the movement of whites to minority status by 2042 (U.S. Census Bureau, 2008). More than ever there is and will continue to be an increasing need for the delivery of clinical services sensitive to not only culture, but also race and racial difference in a treatment setting.

Unfortunately, the foundations of modern day clinical theory and practice rest in a psychology that has traditionally been based on white, Western, and affluent perspectives of mental health and functioning. While clinical theory and practice have begun to extend itself beyond its mono-cultural and ethnocentric roots to adopt a broader view of culture and context (APA, 2003; Sue & Sue, 2008) mental health services in the US on the whole, still do not adequately address cultural and racial issues in treatment, leading to continued disparities in mental health services among racial and ethnic minorities (USDHHS, 2001).

Scholars and practitioners, however, assert that cultural competence is essential in delivering clinical interventions that are both ethical and effective (Fouad, 2006). For example, research has shown that therapist responsiveness to multicultural issues in therapy is important in treatment process and outcomes. Studies assessing therapist cultural competence have found a strong positive relationship between self- and client-rated therapist cultural competence and the therapy alliance (Atkinson & Lowe, 1995; Knox et al., 2003; Sue & Sue, 2002), client satisfaction with treatment (independent of clinical competence) (Constantine, 2002) and client self-disclosure (Thomson et al., 1994) – all important aspects of the treatment process.

Conversely, practice that is culturally and racially uninformed has been found to adversely effect treatment, diagnosis, and case conceptualization (Constantine, Warren & Miville, 2005; Gushue, 2004). Indeed, a lack of sensitivity to issues of race and culture in a clinical relationship may lead non-majority clients to feel abused, intimidated, or even harassed by helping professionals (Sue & Sue, 2008). Therapist microaggressions, microinvalidations, and implicit racial prejudice (Franklin, Boyd-Franklin & Kelly, 2006; Sue & Sue 2008), even at an unconscious level, can have devastating impacts on minority clients. At its worst a lack of sensitivity to race and culture within clinical practice is unethical and has the potential to be harmful to a client. At the very least, it serves as a barrier to help seeking among racial and ethnic minorities and may be associated with reduced treatment compliance, increased numbers of missed sessions, and pre-mature termination of therapy (USDHHS, 2001). Given its important implications for the mental health of minority clients, sensitivity to race and cultural issues within a clinical setting is vital in providing appropriate mental health care for non-majority, non-white clients.



## **Psychoanalytic Psychotherapy and Multicultural Competence**

With regard to psychoanalytic therapy's relationship to multicultural competence feelings are mixed both within and outside of the field. While some argue that dynamic treatments make room for the engagement of complex and nuanced racial issues between therapist and client (Altman, 2010; Aron, 2011), others criticize analytic theories' historical focus on the individual origins of pathology as contrary to the contextualism of multicultural theory and practice (Greene, 2007; Herron, 1995).

Those criticizing dynamic treatments, concentrate on its majority-based cultural positioning and its modern-day catering to clients from predominately white affluent backgrounds (Greene, 2007). With regard to its Westernized subjectivity, some cite analytic theory's emphasis on a one-person or intrapsychic model of pathology and treatment, and the exclusion of critical "extrapsychic" factors (e.g. racism, poverty, socio-political barriers, etc.) underlying patient distress, as evidence of the narrow (and culturally insensitive) focus of analytic work. According to Lillian Comas-Diaz (2007), therapists' failure to understand the embedded social and systemic realities of racial and ethnic minorities and the impact of these realities on both the intra- and interpsychic experience, represents a failure of psychoanalytic theory to understand clients of color and negligently places the onus for pathology back on the client. With regard to race, others cite a virtual "silence" in the analytic literature until recent years on this issue and a lack of appreciation for the impact of racism and discrimination in the conceptualization of a client's presenting problems, experience, and difficulties (Butts, 2002; Curtis Boles, 2002; Dimen, 2000; Leary, 2000). These scholars warn that the, "...rigid adherence to a theoretical orientation [particularly within psychoanalytic

psychotherapy] without taking into consideration a client's cultural context and real life experiences can result in 'missing' the big picture (Curtis Boles, 2002, p. 206)" and in the case of African American clients and other clients of color, the invalidation of their experiences.

Indeed, some theorists, such as Bucci (2002) believe that dynamic therapy's failure to move beyond a one or two-person psychology to a more embedded and multicultural conceptualization of functioning and treatment may be one of the reasons why some within and outside of the field have come to view dynamic work as archaic and insensitive to the needs of diverse individuals. Others including Christian and Jurist (1997, in Bucci, 2002) feel that this lack of sensitivity may also be contributing to the marginalization of analytic work within our larger society. Psychoanalyst Lew Aron (2011) asserts that adapting and expanding psychoanalytic theories and techniques to meet the needs of an ever-growing multicultural and multiracial US population may be the most critical issue facing dynamic therapy in the years to come; essential to its future and continued existence.

While some criticize psychoanalytic therapy for its historical and contemporary exclusion of clients of color, others do not see it and the treatment of minority clients as mutually exclusive particularly in its more modern manifestations. Contemporary scholars assert that analytic theory and practice are well-suited to explore issues of race and racial difference in treatment through relational concepts and a nuanced examination of relationship not found in other orientations (Altman, 2010; Javier & Rendon, 1995; Perez Foster, 1993). Contemporary and classical concepts in the literature that have been examined within the context of race and racial difference in treatment include

transference and countertransference relationships, enactments, defenses and the unconscious, and the presence of multiple racial selves and identities. These constructs while serving to structure the therapy relationship and process also create space for reflection and dialogue on the self, other, and society within the context of the therapy dyad. While analytic theory has yet to develop a more formal school of thought incorporating socio-political, historical, and cultural-contextual factors inclusive of race and difference, the concepts above represent areas in which dynamic theory and practice has already begun to engage the working with and through of difference within the treatment relationship. The following section, examines recent psychoanalytic literature exploring the relationship between these therapy constructs and processes and issues of race and racial difference in the therapy dyad.

**Transference and countertransference in cross-racial dyads.** Transference and countertransference are much used terms within the analytic world, whose definitions vary slightly based on the school of analytic thought within which one is defining them. At its broadest level, transference accounts for the patient's current "perceptions, thoughts, fantasies, feelings, attitudes, and behavior" towards the therapist as derived from the patient's early childhood relationships (Mishne, 2000, p. 76). Countertransference, in its simplest form, can similarly be viewed as "any and all feelings and reactions of the therapist in response to the patient" in addition to the therapist's displacements from their own early relationships (Mishne, 2000, p. 86). With regard to race and racial difference, many analysts have begun to write on how the exploration of racialized transference and countertransference in the therapy relationship can serve to

acknowledge, validate, and work with the race-based experiences (and projections) of both the client and therapist.

From an analytic standpoint, writings on client racialized transference in cross-racial therapy relationships have largely focused on hierarchical issues of power and authority. While most authors acknowledge the inherent power differential in the therapy relationship (Aron, 1996; Hoffman, 1996; Renik, 1996) those studying issues of race and culture, note that this differential is often exacerbated in therapy dyads consisting of a white therapist and a client of color (Shonfeld-Ringel, 2000). For example Chin (1994) cites a common racial transference that can arise in a cross-racial treatment in which the therapist is viewed as all knowing and all-powerful by the client, thus placing the client in a position of powerlessness and compliance. While some authors note that this hierarchical relationship may also be the result of cultural expectations in cross-cultural relationships (McGoldrick, Giordano & Garcia-Preto, 2005) others note that this hierarchical transference may recapitulate current and historical cross-racial relations in the U.S., particularly when the therapist is white and the client is of color. Even in matched racial dyads (i.e. with the therapist and client identifying as the same race), internalized racism introjected from societal objects may impact the transference, and clients may subsequently devalue or question the competence of their non-white clinician (Mishne, 2000).

With regard to countertransference, much analytic writing has focused on white therapists' experiences of working with clients of color. For example, Gorkin notes four common countertransference reactions that can be experienced by white therapists working cross-racially: extreme guilt, over-identification with the client, devaluation of

the client or their experience, or avoidance of the topic of race or difference in general (Gorkin 1996). For majority therapists, racial difference may cause anxiety and lead the clinician on the one hand to minimize or ignore this difference in the treatment relationship or on the other hand to rely on racial stereotypes in diagnosing, conceptualizing, and treating a client (Mishne, 2002). Therapist countertransference can also lead to a process of projective identification, in which the therapist evokes stereotypic reactions from the client based on the therapist's initial projection of his or her own stereotypes (Altman, 2010; Mishne, 2002). According to Perez-Foster (1999) cultural countertransference may manifest in a variety of ways in the treatment relationship both consciously and unconsciously, activating any number of "pre-existing cognitions and affects about cultural groups (p. 270)" of which the therapist should be aware and utilize in the treatment process.

In working with racial transference and countertransference analytic theorists suggest a number of strategies. First, they urge therapists to acknowledge and, when deemed appropriate, address their own and their clients' racial and cultural biases, particularly as they emerge in the transference and countertransference relationship. Second, they suggest that the therapist position herself in session in a "third" or transitional space in which she is both present in, and aware of, the client's and her own subjectivities, *and* the interplay between the two (Shonfeld & Ringel, 2000). It is in this third or transitional space that authors recommend client and therapist explore their relationship to race and difference, using a stance of curiosity, empathy and mentalization. Third, researchers suggest that white therapists rely on "associative identification" in treating clients of color, using, when appropriate, their own experiences

of exclusion and marginalization as an empathic bridge to attempt to understand the experiences of minority clients (Shonfeld & Ringel, 2000). Fourth, they recommend discussing the meaning of race and racialized projections in the therapy relationship thus opening up new conversations about race and difference that are not often broached in extra-therapy cross-racial relationships (Leary, 1995; Perez-Foster, 1999).

**Enactments.** While some aspects of the cross-racial transference/countertransference relationship may ultimately be articulated, others will be acted out between therapist and client before they can be clarified and explored. Shonfeld-Ringel (2000) posits three types of roles that the therapist or client can assume in cross-racial therapy relationships. These include: the marginalized other, the oppressor, and the altruist. With regard to these enactments, Shonfeld-Ringel (2000) notes that “both the client and the clinician can play alternating roles on the marginalization continuum and the role of the marginalized other can be alternately projected onto and experienced by each (p. 52).” In working in enactments, the clinician must acknowledge and periodically assess where he or she is located on this continuum in relation to the client. Racialized dynamics between therapist and client and the roles they enact may be further exacerbated by the “politics [i.e. hierarchy] of the therapeutic encounter” (Littlewood, 1998), further polarizing the therapy relationship along racial lines and entrenching therapist and client within an enactment.

In working through these enactments Perez-Foster (1999) suggests addressing them directly and articulating that which is being acted out. In articulating these enactments, Shonfeld-Ringel (2000) references Winnocott’s concept of “transitional space” the place between mother and child, therapist and patient, that allows for both play

and creativity, in addressing racial or cultural dynamics. This intersubjective space provides the therapist and client with a place to encounter and address personal experiences and internalized biases and fantasies that they bring to the analytic encounter (Shonfeld-Ringel, 2000). This “third” space or the “ethnic third” therefore allows the therapist and client to address issues of “mutuality and difference – exclusion and inclusion (Shonfeld-Ringel, 2000, p 54)” that are essential to acknowledging and the working through of racism, stereotype, and racial difference in a treatment setting.

**Defenses, the unconscious, and race.** Psychoanalytic thinking has long identified racism and prejudice as arising from the primitive defense of projection. In their book *Antisemitism and Emotional Disorders*, Ackerman and Jahoda (1950) conceptualized prejudice as a form of projection in which disavowed feelings of vulnerability, inadequacy, anger, deprivation, etc., were projected onto other groups, usually racial and ethnic minorities. Since that time, much writing has been done on the defensive processes inherent in racism and prejudice and specifically how these projections become introjected by the other (Altman, 2010).

In working with race and racism in a treatment setting, understanding the processes of projection and projective identification in the therapy relationship is critical to conceptualizing client dynamics, pathology, and resilience. Broadening the scope of what is projected and who does the projecting to the societal level is also essential to incorporate the reality of external factors (such as overt and institutional racism) that contribute to a client’s experience and distress. In working cross-racially, white clinicians are encouraged to both acknowledge their own defensive processes (which may be unconsciously manifest in the treatment of a minority client) and to not collude with a

client around explicitly racialized content, particularly when it may obscure a deeper examination of split off affect (Herron, 1995) or primary relational wounds (Javier & Redon, 1995).

With regard to unconscious experience, much of analytic writing and practice has been based on the uncovering and articulation of unconscious mental processes and drives be they sexual and/or aggressive (drive theory) or relational (relational theory). However, less work has been done on the racial or ethnic aspects of the unconscious (i.e. how race and culture impact the formation and expression of the unconscious). In writing on the “ethnic unconscious” Herron (1995) discusses the importance of examining repressed material that is shared by an ethnic group and passed from generation to generation. He encourages the therapist to be aware not only of repressed material derived from one’s ethnic identity in the moment, but also of the inter-generational or historical legacy of avowed or disavowed unconscious material. Further he suggests being attuned to the “expressions and repressions of ethnicity...the degree and type of ethnic identifications” in the analytic relationship (Herron, 1995, p. 530) and to mental representations of fantasy or folklore that are colored by culture. While Herron (1995) speaks predominately of an ethnic unconscious, one can easily extend his thinking to a racial unconscious, one that is formed in and by a client’s racial reference group (historically and in the present) and in the interaction of this reference group with racial others.

**Self and identity.** Finally, in examining analytic theory’s relationship to working with race and racial difference, it is important to examine the area of identity and self-integration. A central goal of dynamic therapy rests in an “integrated self” and the re-



integration of “split off” or disavowed parts of the self (Messer & Wolitzky, 2007). At the same time, work in multicultural therapy revolves around the understanding and validation of a client’s multiple selves and the cocktail of identity derived from race, ethnicity, sexual orientation, religion, ability, etc. Dynamic conceptualizations of the self examine these individual identifications (both conscious and unconscious) and in particular those parts of the self that have been disavowed, rejected or labeled dangerous as a result of a client’s earliest relationships. Here some analysts writing on race and culture, note that it is important to consider these earliest relationships, as not just the client’s family of origin, but also the culture and larger society (Herron, 1995). In its conceptualization of multiple selves, psychodynamic theory makes room for multicultural theories of race that seeks to understand and appreciate a client of color’s racial identity, particularly as it takes place within and in contrast to the majority culture (Thompson, 1995). Thus, a critical part of working with racial identity must include an examination of a client’s multiple conceptions of self; specifically where these selves eclipse one another, co-exist, or can be integrated into a more cohesive whole. Additionally, in exploring the self in clients of color, Thompson (1995) urges therapists to explore the impact of racism and stereotype. He notes that one of the primary goals of treating the racial self, should lie in helping clients to acknowledge, “the negative....[stereotypes] without being limited by [their] implied constrictions (p. 534).” In this way a therapist validates the reality and trauma of discrimination and prejudice for a client of color, while helping them to develop a separate self apart from them.

## **Working with Race and Racial Difference from a Multicultural Perspective**

In examining the ways in which analytic therapy has begun to engage issues of race and racial difference in cross-racial treatment dyads, it is important to look to the literature in multicultural psychology to better understand where these two disciplines compliment, stand in contrast to, or can begin to inform the other.

Multicultural Psychology has arisen in the past several decades to meet the ethical and pragmatic mandates of working with diverse clients and to address the lack of cultural competence in the field. In 2003, the APA devised a set of multicultural guidelines providing a framework for multicultural research, training, and practice in psychology. This document put forth six guidelines for cultural competence in psychology expanding the field beyond the level of the individual to include a consideration and understanding of an individual's socio-political and historical contexts and group memberships. These guidelines included a consideration of race, ethnicity, language, sexual orientation, gender, age, ability, class, education, and religion and spirituality as important aspects of multiculturalism (APA, 2003). Through this document, the APA suggested the use of a "cultural lens" in clinical research, work and education, and urged clinicians to acknowledge and understand the broader contexts that influence their own and others' perspectives and experiences.

While the APA guidelines provided a framework for what multicultural competence in psychology should look like, other researchers and scholars have attempted to operationalize the concept of cultural competence providing the field with a common foundation and definition upon which to work. Two of the most prominent models are Sue, Arrendondo and McDavis's (1992) tripartite model of multicultural

competence and Sue's re-conceptualization in 2001 of this theory into a multidimensional model of cultural competence (Sue, 2001). The tripartite model of multicultural competence focuses on clinician competencies based on cultural awareness, knowledge, and skills (Sue et al., 1992) and remains foundational within the field. In the *awareness* domain, the therapist is encouraged to become self-aware, acknowledging his or her personal assumptions, values and biases and cultural conditioning. To become culturally competent one must cognitively and affectively engage one's own values, biases, and prejudices. The second domain of cultural competence, *knowledge*, involves understanding, acknowledging, and accepting the varied world views of individual clients, and recognizing the broader socio-political and historical client contexts impacting clients including power, oppression, institutional and cultural racism, and white privilege. Sue et al.'s (1992) third domain, *skills*, emphasizes the application and use of culturally appropriate clinical intervention strategies and techniques in the therapy setting based upon a client's multicultural identities and experiences. In 2001, Sue expanded his three-part model of multicultural competence to include levels of intervention beyond the individual (i.e. individual psychotherapy) to include professional, organizational, and societal arenas in which cultural competence initiatives can take place (Sue, 2001).

Within the field, multicultural competence has become as much of a positioning and outlook as it has a series of techniques, which has led to some criticism. Indeed, one definition of multicultural competence has revolved around, "A therapist's ability to integrate into his or her theoretical and technical approach to assessment and intervention, relevant human diversity factors [relevant to the therapist, client and/or

therapy relationship] that are important to the process and successful outcome of therapy (Fuertes & Ponterotto, 2003, p. 52).” Within this definition, cultural competence becomes a matter of integrating multicultural theory into every day therapy practice regardless of orientation. While this is an optimal goal the, “weaving together (p. 223)” of multicultural theory with traditional forms of psychotherapy practice has been a difficult task (Green, 2002). And while much work in multicultural competence has been done in the theoretical arena, little empirical work has been done examining how these theories play out in therapy process and practice and how they translate into therapy technique (Bukard et al., 1999; Fuertes & Gretchen, 2001). Thus the present study examines how white psychodynamic therapists in the field incorporate multicultural psychology into their work with race and racial difference. At the same time, it also explores how they apply and adapt the processes underlying their own theoretical orientation to working with African American clients.

In addition to criticisms focused on the lack of articulated techniques within the field of multicultural psychology, there are those that criticize the field for focusing too much on *cultural* difference at the expense of race. Race in its most basic definition is a phenotypal socially constructed phenomenon applied to a, “category of persons who are related by a common heredity or ancestry and are perceived and responded to in terms of external features or traits (Wilkinson, 1993, p. 19).” Some scholars have suggested that this focus on the larger construct of multiculturalism has shifted critical attention away from a more specific emphasis on race and racial difference in the therapy relationship (Helms, 1995; Helms & Cook, 1999). Unfortunately, this emphasis on culture at the expense of race may lead to a lack of attunement and invalidations within the clinical

relationship. Specifically, from a patient perspective, the eclipse of race by culture in treatment may invalidate the racial identities and racialized experiences of clients of color (Carter, 1995; Helms, 1984). The current study seeks to shift the focus within the area of clinician cultural competence back towards racial competence by specifically inquiring about white clinician's experiences of race and racial difference in a cross-racial therapy relationship. Addressing race in cross-racial African American-white relationships is particularly important in that, race and racism are, "a part of the everyday present and past experiences of the African American (Curtis- Boles, 2002, p. 203)" and therefore, something that should not go unaddressed or unexplored in intimacy of a therapeutic relationship.

### **Working Cross-Racially in Treatment**

One final area for review includes a look at the current research findings in the field related to cross-racial therapy processes and outcomes. Within the literature most studies of race in the therapy dyad have focused on various definitions of therapist multicultural competence (including race) and its relationship to treatment outcome (Knox et al., 2003). Fewer studies, however, have focused specifically on the construct of racial competence or responsiveness to racial content and how it impacts the *process* and unfolding of treatment. One study, by Thompson, Worthington, and Atkinson (1994) examined self-disclosure among 100 African American "pseudo-clients" (undergraduates in a laboratory setting) with either white or black counselors. Findings revealed that pseudoclients engaged in greater self-disclosure when their counselors directly addressed the topic of race (i.e. their experiences of being a black woman in a predominately white university) independent of the race of their counselor. A follow up qualitative study by

Thompson and Jenal (1994) found that clients reported more frustration with those counselors who avoided discussing race or racial content *following* its introduction by the client. A third study by Zhang & Burkard (2008) found that white therapists in cross-racial dyads who discussed racial differences with clients of color were seen as more credible by these clients and were rated higher in their working alliance than those therapists who did not discuss racial differences. From the client perspective these studies, taken together, appear to suggest some degree of positive relationship between therapist responsiveness to racial content and/or difference and client self-disclosure, therapist credibility, and the therapeutic alliance.

One recent study; however, has examined the issue of racial responsiveness and competence from the perspective of the therapist. In their qualitative study of racial responsiveness, Knox et al., (2003) interviewed 12 licensed psychologists about their experiences with addressing (or not addressing) the topic of race in a cross-racial therapy dyad. Participants consisted of seven white therapists and five African American therapists of varied theoretical orientations. Researchers asked therapists to discuss their experiences with raising or not raising the topic of race, along with their experiences of and training in race and racial difference prior to, during, and after graduate school.

Findings revealed that white therapists reported greater discomfort in addressing race in treatment than did their African American counterparts. By extension, it appeared as if African American therapists addressed race more frequently with clients of color than did white therapists. However, therapists of both races both reported that their experience of addressing race in cross-racial therapy dyads often had a positive effect on the treatment and treatment relationship.

## **Limitations of the Literature and Implications for the Current Study**

Given the lack of research in the area of racial difference and treatment process from the perspective of the therapist, it is not surprising that there is little research or writing on this topic from an analytic perspective. Because most of the work in the area of race and racial difference from a psychodynamic standpoint has relied on detailed case studies in which the primary author reflects on his or her experience in cross-racial relationships (Altman, 2010; Davies, 2011), the purpose of this study lies in extending the limited research in this area to include a more in-depth qualitative examination of the experiences of white psychoanalytic therapists working with race and difference in African American-white therapy dyads.

Research questions examined in the current study included: 1) How do white therapists come to understand and think about race in treatment? 2) How do they use race in client conceptualization? 3) How do they address the topic of race and difference when working cross-racially? 4) How do they work with race and difference in the therapy process? It was hypothesized that participants would see race as an important aspect of the treatment relationship but would vary in degree to which they saw it as central to client conceptualization and presenting problems. Additionally it was believed that the majority of subjects would have had little formal training in racial competence and would therefore differ in how they addressed and worked with race and difference from a psychodynamic perspective.

## Chapter III

### Methodology

#### **Qualitative Research**

The current study relied on qualitative research methods to examine the experiences of white psychodynamic therapists working cross-racially with African American patients. A qualitative study design was used to provide a richer and more in-depth account of how white psychodynamic therapists conceptualize, discuss, and work with race and racial difference.

Qualitative research designs provide a researcher with a more thorough exploration of a specific problem or practice and serve to richly contextualize human phenomenon (Haverkamp & Young, 2007). According to Corbin and Strauss (2008), this approach allows a researcher to see experiences through the eyes of participants, and to understand how individuals ascribe meaning to those experiences. In this way, qualitative research deepens our understanding of a particular phenomenon, staying close to the experiences of its subjects. Broad understandings and themes that emerge from the data are then used to generate hypotheses for further study.

Psychologists within the field support the use of qualitative research methods and have called for an expansion of methodology beyond traditional quantitative techniques. In a 2007 article, Alan Kazdin argues that non-traditional research methods, including qualitative study designs, can provide the field with valuable information that transcends what can typically be obtained through experimental research design. Kazdin (2007) argued that diversifying methodology within psychology could serve to enhance our understanding within the field and to enrich the current body of research.



A qualitative design was chosen for the present study due to a lack of research in the area of race and difference from a psychoanalytic perspective. Currently, there exist few studies exploring the experiences of white psychoanalytic therapists working cross-racially. Those that exist have relied primarily on detailed case studies in which the primary author reflects on his or her experiences of cross-racial work in an unstructured way (Altman, 2010; Davies, 2011). Because of the dearth of current research in this area, the present study relied on qualitative methods to obtain a more in-depth picture of the experiences of white psychodynamic therapists working with African American patients through the use of open-ended questions. It was hoped that the use of qualitative methodology would shed light on the experiences of white therapists working with race and difference and generate additional hypotheses to inform future research.

### **Grounded Theory**

Grounded Theory, a form of qualitative research, was used in the current study. The goal of this type of research is to derive theory from the qualitative analysis of data (Corbin and Strauss, 2008). In “grounding” the theory in the data researchers are able to provide in-depth descriptions of problems or phenomenon, and to generate hypotheses for future research (Corbin and Strauss, 2008). Grounded theory provides researchers with a better understanding of participants’ experiences in a particular area of inquiry and of the meanings ascribed to these experiences based on participant context and culture. Additionally, this type of qualitative design often brings to light previously unknown or unidentified variables. The current study utilized a modified version of the grounded theory method in order to more accurately reflect the experiences of participants and to derive theory from the data obtained.

## **The Person of the Researcher**

Because researcher bias and perspective can impact all phases of the research process including data collection, analysis, and interpretation (Kvale, 1996) it is important to consider the positioning of the principal investigator (PI) when conducting qualitative research. In this study, the PI was a white hetero-identified female in her early-mid 30s with an interest in psychodynamic therapy and issues of race in treatment. The PI was responsible for creating all instruments used, administering all interviews, analyzing all data, and interpreting the results. She also received guidance from her dissertation committee and a dissertation working-group whose purpose was to provide peer feedback at all stages of the dissertation process from conceptualization and instrument creation through data analysis and interpretation. The PI's dissertation committee consisted of two members. The first member and Chairperson was an African American female clinical psychologist and professor at a university in the mid-Atlantic, who practiced from a family systems perspective and is an expert in multicultural psychology. The second committee member was a white female clinical psychologist and professor at a university in the mid-Atlantic with expertise in psychodynamic psychotherapy. The dissertation working-group consisted of doctoral students in clinical and school psychology from a variety of racial and ethnic backgrounds, identifying with diverse theoretical orientations including CBT, family systems, and psychodynamic therapy.

## **Participants**

Participants were recruited through advertisements posted on the list-serv of a mid-Atlantic psychoanalytic institute and membership organization (see Appendix A)

and through a networked sample of psychodynamic therapists who were known to provide services to clients of color.

Participants consisted of eight licensed doctoral-level psychologists who identified as white, practiced primarily from a psychodynamic framework, and had worked with at least one African American client within the past five years. In this study researchers used the term psychodynamic to encompass those who practiced from a psychoanalytic, relational, object relations, ego and self-psychology perspective. A small sample size was used due to the qualitative study design, and no control group was identified. Of the eight participants, 100% identified as white and psychodynamically oriented. Of those who were psychodynamically oriented, three subjects (37.5%) also identified as relational, one (12.5%) as systems-oriented, one (12.5%) as incorporating elements of classical theory and ego psychology, and one (12.5%) as psychodynamic with a focus on personality. The sample was equally divided by gender with 50% (n=4) of the sample identifying as male and 50% as female. The average age of participants was 60.4 years old with a range of 51-71 years old.

In terms of training and education, all eight subjects were doctoral level psychologists. Four (50%) possessed a Psy.D. in clinical psychology, two (25%) had received doctorates in Education, one (12.5%) held a Ph.D in clinical psychology, and one (12.5%) had received a Ph.D. in personality psychology. The average number of years in clinical practice was 21.6 (range: 7-35 years) and all subjects (100%) practiced in New Jersey. While subjects had worked in a variety of settings over the course of their careers, at the time of the interview four (50%) worked solely in private practice, one (12.5%) worked in a semi-correctional setting, and three subjects (37.5%) worked both

part time in private practice and part time in an additional setting which included a college counseling center, an employee assistance program, and as an organizational consultant. All subjects interviewed had worked with an African American client within the five years prior to the interview. While most subjects noted that their caseloads were predominately white, they reported that 32.5% of their typical caseloads (range 12%-75%) were comprised of persons of color and that the average length of treatment was 4.2 years (range 6 sessions to 9 years). The four most common diagnoses reported in their caseloads were: dysthymia, major depressive disorder, PTSD, and adjustment disorder.

### **Measures**

The current study utilized a demographic questionnaire and a semi-structured interview to collect data from participants. A demographic questionnaire (see Appendix C) was sent to each participant via email and was completed prior to the in-person interview with the researcher. This questionnaire requested information regarding subject demographics (including age, race and ethnicity) and their psychotherapy practice (e.g. number of years in practice, employment settings, the racial demographics of typical and current caseloads, theoretical orientation and specialty areas, and common diagnoses treated).

A semi-structured interview (see Appendix D) was used to gather data regarding participants' experiences of working with race and difference with African American clients. This protocol included a series of open-ended questions and prompts related to four primary areas: 1) The therapist's understanding of and training in multiculturalism and race, 2) The therapist's conceptualization of race and racism in treatment, 3) The therapist's experience of working with race and difference in the therapy process, and 4)

The therapist's reflections on working with racial difference over the course of their careers and the interview process itself.

## **Procedures**

Individuals interested in the study who contacted the principal investigator were provided with information about the study's purpose and procedures. The principal investigator confirmed each participant's eligibility. Once an individual was deemed eligible, the principal investigator arranged for an in-person interview at a location of the participant's choosing. Individuals not deemed eligible for the study were provided with an explanation regarding their ineligibility, debriefed, and thanked for their time and interest.

Subjects chosen for the study were emailed a demographic questionnaire to complete prior to the in-person interview. At the beginning of each in-person interview, participants signed an informed consent form (see Appendix B) and were given a copy for their records. Subjects were also asked for their consent to audio-tape the interview. The informed consent form outlined the purpose and procedures of participation, the risks and benefits of the study, the voluntary nature of the study, limits to confidentiality, and provided contact information for the principal investigator and all individuals and institutions affiliated with the study. Participants were informed that they could decline participation in the study at any point during the interview and could also request that their interview not be audio-taped. All participants were then interviewed by the principal investigator using the semi-structured interview (see Appendix D). Participants were assigned a case number prior to the interview to protect their identity. All interviews were recorded for later review and transcription. No identifying information was attached to

the study data or audiotapes obtained. Each interview lasted approximately one and one half hours.

### **Treatment of Data**

**Consent and demographic questionnaire.** All consent forms were kept in a locked file cabinet in the home of the researcher. Data obtained from the demographic questionnaire were used to categorize participants based on age, gender, ethnicity, and psychotherapy practice. Each participant was assigned a code number to protect their identity.

**Interview data.** Hard copies of the semi-structured interview were assigned a numerical code and stored in a locked file cabinet to which only the principal investigator had access. Audio recordings of each interview were stored on the researcher's password protected computer on a further password protected file. All transcriptions were completed by the principal investigator, assigned a numerical code, and stored in a password-protected file on the principal investigator's home computer. It was determined by the principal investigator that all study data would be destroyed three years following the completion of the research.

### **Data Analysis**

Data were analyzed using Strauss and Corbin's (1990) grounded theory methodology. Grounded theory accounts for and examines issues of "process and change over time (Morse & Richards, 2002, p. 54)." Underlying this type of analysis is the assumption that theory can be constructed from and *grounded* in the data (Morse & Richards, 2002). The primary goal of data analysis was to, "determine the categories,

relationships, and assumptions that inform [participants'] view[s] of the world in general and the topic in particular (McCracken, 1998).”

Data from the current study were analyzed using the three sequential phases of grounded theory analysis: open coding, axial coding, and selective coding (Strauss & Corbin, 1990). Open coding, the first phase of data analysis, involved scrutinizing the data for similarities and differences and for micro- and macro-level themes. Through open-coding, data across transcripts were collapsed into more general categories and coding labels taken directly from the language used by participants were extracted (Morse & Richards, 2002). Axial Coding, the next phase of data analysis (Strauss and Corbin, 1990) involved exploring and identifying the relationships between the categories and subcategories identified in the open-coding phase. Axial coding helps researchers to understand patterns and connections between concepts that present themselves in a given model (Strauss & Corbin, 1990). Selective Coding, the final step of data analysis (Strauss & Corbin, 1990) involved further collapsing categories identified into the primary or core categories of the theoretical model. These categories were then connected through a model that makes up the actual “grounded” theory (i.e. the theory that is grounded in the data itself). In the current study, subject responses were collapsed into specific concepts and categories at the level of open coding. These categories were then further refined at the level of axial coding and developed into overarching themes based on the data obtained in the selective coding phase.

## Chapter IV

### Results

The following section outlines participant responses to a semi-structured interview divided into three major sections. These sections included subjects' 1) understanding of and training experiences in multiculturalism and race in therapy; 2) conceptualization of race and working with race in treatment; and 3) reflections on working cross-racially in general. Each of the three major sections of the interview are further subdivided and articulated below.

#### **Understanding of and Training in Multicultural Competence and Race**

**Defining multiculturalism.** To begin the interview, participants were asked to define multiculturalism. In providing a definition in their own words, five of the eight participants (63%) focused on the recognition of and respect for the multitude of human experience in all of its forms. As one participant asserted, multiculturalism is, “just openness to the vast diversity of the ways in which someone can be human.” While two of these subjects (40%) focused primarily on cultural diversity in their definition, the remaining three subjects; spoke of a broader definition based on race, culture, sexual orientation, and a variety of other identifying factors.

Subjects also asserted important elements of psychotherapy practice in their definition. Two of the eight respondents (25%) noted that not making assumptions about a client's background or affiliations was central to their own multicultural practice. As one subject put it:

I try not to make an assumption that because someone walks in and looks a certain way, or that they tell me they're of a certain descent that I attach any



assumptions to that...I always try to be conscious of what it [race or another identification] mean[s] for this person.

Similarly, another participant noted that for her, a multicultural practice involved being aware of her own biases and assumptions, and how they intersected with a client's experiences, reporting that it was important:

To be aware of...as far as possible, what assumptions I bring - including assumptions about myself and my background, and how I'm seen, as well as what I am, what I think I'm seeing, and as much knowledge as one can bring to bear on what are the formative aspects of being individuals within a culture [are].

The remaining responses to this question involved defining multiculturalism as levels of membership (n=1), as an organizing principal (n=1), and as understanding the impact of the dominant culture on a patient and the treatment relationship (n=1).

**Influential experiences of race.** Participants were also asked what experiences had been most influential in their understanding of race in therapy. Five of the eight participants (62.5%) noted that personal experiences early in life with African American caregivers, students, and/or local communities, had had a profound effect on both their interest in and understanding of race and racial difference. One subject noted:

It would be my personal experiences with black people from when I was quite young. After my mother died, my sanity was more or less saved by a black woman who was a housekeeper for us...she was really important to my self-esteem.

Another subject pointed out that it was both the presence and abrupt absence of an African American caregiver early on that had been particularly significant to her:

I had a black caregiver until I was four and then she was suddenly dismissed from our household because she was a typhoid carrier, or so I was told...Part of my growing up experience was the sudden disappearance, with an explanation that I as a little kid couldn't understand...So it's a combination of associations with a lot of warmth but also a...kind of ambivalence.

Other subjects mentioned experiences and relationships with African American colleagues and students during high school and college as having the most impact. For example, one subject described a time in her life when as a college prep counselor for African American high school students, she witnessed discrimination against her students:

One night...we all went out for pizza...and they [my students] said, "oh no, that place isn't going to serve us...because we're black" and I said, "No they're going to serve us, come on." So I [took] them to this place. We sat, and sat, and sat, and they never served us...Experiences like that kind of shape and influence your sense of what race is like in the world.

Three subjects mentioned the sociopolitical culture of their times, including the civil rights movement, as having an important impact on their understanding and experience of race and fostering a personal interest in the subject. One subject; however, noted growing up in the 1940s and 1950s and being exposed to "a whole lot of racial stereotyping and...very negative images" as leading her to feel self-conscious about race during the early part of her career.

Other experiences that subjects found most helpful in understanding race in therapy included: using one's own experiences of marginalization as an empathic bridge

to the discrimination of others (12.5%), having African American supervisors and/or professors (25%), doing therapy with African Americans and persons of color (62.5%), being a part of a formal group dedicated to exploring one's own background within the context of diverse others (12.5%), and having supervision that made space for processing racial issues (12.5%).

**Training experiences in diversity and race: Graduate school, analytic training, and professional development.** Subjects also responded to a series of questions related to their training in race and racial difference in graduate school, analytic training, and post-graduate professional development.

*Graduate school training.* Five of the eight subjects (62.5%) reported having no formalized training or didactics addressing issues of diversity or race in graduate school. As one woman commented, "It was the 70s and people were talking about issues of diversity...there was a lot of general attention to race, but I don't remember much focus on it in graduate school." Three of the eight subjects (37.5%) received some formal training in school through a one- or two-semester diversity course; however, only one of these subjects (33.3%) found the course helpful. The other two found the coursework either too simplistic, or not sensitive enough to engage racial difference in general and within the classroom. As one subject noted:

I think it [the course] was a really unpleasant experience for everybody...there was something that felt kind of simplistic and that not only dismissed the individuality of people of color but also our individuality...it was kind of ironic because it sort of affirmed what the class was intended to challenge...that there can be no conversation, no individual experience about race and culture.

Those subjects that did not receive any formalized training in their graduate programs attended school in the 1970s or before. Those who received formal training but did not find it helpful, attended their programs in the 1980s, and the one subject who reported benefiting from her graduate diversity class attended school in the 1990s and 2000s, perhaps reflecting progress in diversity curricula across graduate programs over time.

One subject reflected that while he had been required to attend a diversity course in graduate school, that it would have been more helpful to have issues of diversity “integrated into all course curriculum” versus being limited to a one-semester class. Beyond formal coursework, respondents also mentioned the following as helping them to better understand race and difference in their graduate training: treating African American patients and/or patients of color through externship and internship placements (50%), paid work experiences during graduate school that involved work with African American students or clients (25%), having African American supervisors (25%), and the presence of African American faculty in their graduate department (12.5%).

Two subjects (25%) also mentioned that coursework in other fields, more experienced with integrating issues of diversity into training and practice, had helped augment their diversity training during psychology graduate school. One participant noted taking a community psychology course, which directly addressed issues of racial difference and division. Another participant found that the training he received during his masters of social work program stood in contrast to that which he received during his psychology doctorate noting, “In my doctoral program there was no coursework [on race

or diversity]. In my MSW program there wasn't a distinct course, it was woven into everything.”

**Analytic training.** In discussing their analytic training, most subjects noted a lack of attention to issues of race in particular and diversity in general. Of the subjects interviewed four (50%) completed training at an analytic institute for psychotherapy, one (12.5%) completed training at an analytic institute for organizational consulting, two (25%) began analytic training but did not complete it, and one (12.5%) did not attend a formal institute, but sought training through specialized analytic supervisions and continuing education credits (CEUs). Of the seven subjects who attended an analytic institute in some capacity, only one (14.3%) received formal coursework in diversity from an analytic perspective, the remaining six (85.7%) did not.

In speculating why diversity did not get addressed more in their analytic training several subjects commented that the racial composition of their programs, both students and faculty, tended to be overwhelmingly white. One subject traced the lack of attention to diversity to a largely white faculty, stating, “Our faculty at the time was all white, and I think most of them were pretty comfortable. I don't think the thought [of race or diversity] entered their mind...” Similarly, another participant noted that most of the professors in her analytic program were, “identified with a fairly mainstream group and...felt it was probably more important to talk about universal developmental stages and defenses than it was to train people in cultural difference.” Another participant commented on the lack of candidates of color both during his analytic training and in analytic programs today as having an impact on training content, “Almost all the candidates were white. Though [my program] has a scholarship for racial and ethnic

minorities, so there was always an effort made to recruit...[but] I think it's not enough effort."

Most subjects noted that any dialogue about race and diversity received during their analytic training tended to be piecemeal and informal consisting mostly of supervisors who made room for discussions of race and difference (37.5%), white professors for whom this was an area of expertise (12.5%), in-class readings by African American analysts (12.5%), and in class discussions where either, "the issue would come up in a kind of organic way" (12.5%) or the topic was intentionally raised by the participant (12.5%).

*Post-graduate training and professional development.* Finally, in the area of general professional development and training, subjects were asked about any experiences that they had had following graduate school and apart from their analytic training which might have addressed issues of race and difference (for example, CEUs, workshops, conferences, etc.). Five of the eight subjects (62.5%) stated that they had not sought out any formal training in this area since graduate school. Two of these five subjects stated that they had not pursued formal training in race or difference because they found didactics in this area too basic and not helpful. As one subject mentioned, "I haven't been attracted to workshops and CEUs because they all seem so basically consciousness-raising and I felt I was a little past the consciousness-raising stage."

Three subjects (37.5%) asserted that having African American supervisors or colleagues with whom they could consult on issues of race and diversity had been particularly helpful to their growth in this area. Two subjects (25%) noted that trainings and experiences in other fields, such as family therapy, had been helpful in expanding

their knowledge of diversity issues. Finally one subject (12.5%) noted the presence of a diversity committee at her workplace dedicated to exploring issues of race and other forms of diversity as they impact clients and staff, had been a helpful form of professional development.

**Self-exploration.** In addition, to training received in graduate school and beyond, subjects were also asked about any work they had done to explore their own racial identity. Three of the eight subjects (37.5%) mentioned their own therapy/analysis as essential to understanding their positioning and bias; two subjects (25%) spoke of being involved in formalized groups that included an exploration of race and identity within the context of diverse others; two subjects (25%) noted exploring their ethnicity and genealogy as a means of understanding their racial background; and two subjects (25%) mentioned personal and professional relationships with African Americans as putting their own race and privilege into perspective.

In talking about their own analysis, two individuals noted that therapy had been critical in helping them to process their own feelings of whiteness and to uncover race-related feelings of guilt and shame. For example one woman noted that analysis helped her to explore her race and, "...my share of liberal white guilt about what's been done to African Americans." Another therapist spoke deeply about how her own analysis had brought her face-to-face with uncomfortable and prejudiced aspects of herself in general. Though speaking of ethnicity she noted:

I had a phase in my own analysis that despite all of my passion about equality and respect and dignity I would have these anti-semitic dreams when my analyst offended me in some way. I would dream about these Jewish thugs extracting

money in some way from me and I remember the poor man [the analyst] trying to bring it up, “I wonder if this has anything to do with the fact that I’m Jewish” and I’d say, “No, no, no! I’m best friends with...” One of my friends calls it wincing, when you realize that you’re carrying this stuff, that it’s inevitable to carry this stuff, and to find it within myself was probably the best lesson that I had, and I got that originally from my analysis.

Another subject noted that while he had not done any formalized work around his own whiteness he had attempted to help his students do so while teaching a diversity module to a local internship class:

I made a decision...[to make] white people the object of study and it was so interesting, the reaction. I mean the African American students laughed like crazy. From the white people [it was like] “what, what do you mean, white studies?” Discomfort, but blown away because white is “regular”...we’re so quick to say I’m French or Irish or whatever, but you’re also white.

### **Conceptualizing and Working with Race in Treatment**

The next section of the interview involved understanding how white psychodynamic therapists prepare for, conceptualize, and work with race and racial difference in psychotherapy. Subjects were asked a variety of questions related to how they prepare for sessions with African American clients, how they think about race and difference in the treatment, if and how they address racial difference in session, and how race enters into the process of therapy.

**Preparing to work cross-racially.** Subjects were asked about any groundwork or planning they typically did before working with a client of a different race than their own.



Fifty percent of subjects (n=4) stated that they did not prepare in any way for working cross-racially, noting that this was consistent with their analytic training. One subject pointed out that she tried to maintain a stance of receptivity, “I just prepare to be open to what I’m going to learn.” Another subject stated that his analytic training emphasized being non-defensive with one’s patients and open to whatever experiences they may bring, “the training I’ve gotten is to be authentic and open, so I don’t want to build up in advance [my expectations].” Finally, one subject commented that he did not want to prepare in advance and thus bias his countertransference and what he might attend to in session, “I feel like I shouldn’t prepare. That’s basically what I’ve been taught as an analyst. Because if you start to prepare it’s countertransference a-go-go. You...then [are] starting to dissociate certain aspects of treatment.”

Of the remaining subjects who engaged in some form of preparation (n= 4, 50%), three of these noted that they sometimes read or did research on the background of their patient after they had gotten a sense of the nature of the difference between themselves and their client, one mentioned that she consulted with friends and colleagues from the racial backgrounds of her patients, and two mentioned that they brought general racial and cultural knowledge and schema to bear in preparing to treat someone of a different race than their own. As one respondent pointed out:

I have a certain set of cultural assumptions that click into place when I hear [someone] on the phone or when the person walks into the room, that is how I prepare...but on the other hand everyone is an individual.

Interestingly, one subject noted that while he did not prepare for sessions with patients of color, in the traditional sense, he acknowledged that sometimes his preparation involved readying himself for the possibility of encountering his own racism in session:

I kind of think ok, I might have to do a little bit of shame management... Am I going to make a mistake? I mean yes, of course I'm going to make a mistake as a therapist but if I make the mistake that is attached to race, I will feel ashamed. I think that's what we struggle with as white people it is shameful when your racism is exposed. But we can be big boys and girls and deal with it, own up to it, and not think that we're such terrible horrendous people, just because we have "do's" and "dads" of racism inside of us.

**Conceptualizing race I: The role of race in a client's life.** In attempting to gain an understanding of how therapists conceptualize race as a construct in treatment, subjects were first asked what role they thought race plays in a client's life and experiences in general. In answering this question, all eight subjects (100%) spoke about their understanding of minorities' experiences of race, while only three of the eight subjects (37.5%) commented on majority or white clients' experiences of race as well.

In speaking about their views on the role of race in minority clients' lives, subjects saw race as either: 1) an organizing principle (n=3, 37.5%), 2) a construct taking on meaning in relation to one's family, culture and society (n=4, 50%), and/or 3) an individualized factor that varies from person to person (n=2, 25%). Three of these subjects (37.5%) conceptualized race as a central organizing principle. As one therapist commented, "I think it's as much of an organizing principle as gender, class...education...it's up there." Another subject noted the inescapable and central

nature of race for her minority clients stating, “for most of my cross racial clients...they’re always aware of how they’re not similar, how you don’t know the rules, they don’t necessarily fit, I think it plays a major role...”

Other subjects spoke about how a client’s experience of race does not exist in isolation, but takes shape from a person’s family, culture, and/or society. As one subject noted:

If [patients are] immersed in a culture that’s the same as their racial culture, it may not play as large of a role. I think it’s only when you’re in a diverse culture or a culture that’s different from yours that it becomes an issue.

In discussing the experience of race for their African American clients, two subjects commented on the interplay of race and a hostile environment as impacting development and experience. One respondent asserted:

I think with minority clients they are forever aware of difference. But thinking from analytic developmental perspectives it goes back to the parents having to [endure]...a hostile environment, protect them [their children] and at the same time teach them how to live in that environment... I think minorities scan the world in the way that people from a majority culture don’t have to.

Similarly another subject commented:

I think that for people who are African American or...who feel like a stigmatized minority, they are in a terrible bind because they feel racism all the time, [but] they’re accused of playing the race card if they name it. And if they don’t name it they are colluding with their own stigmatization. I just think it [the role of race] can’t be underestimated.

Finally, three subjects (37.5%) expanded the conversation to include their thoughts on the impact of race for their white clients. These participants noted that their white clients often had difficulty fully understanding the world of a racial minority and were typically ignorant of the role of race in general. As one subject stated, “for those of us who are not racial minorities [we] have no full capacity to understand the magnitude of the implications of race.” And as another participant reported, “for majority clients, it [race] plays a role that they don’t even know it plays, because they don’t have to think about it.”

**Conceptualizing race II: Client conceptualization and presenting problems.**

Subjects were next asked how they use race in conceptualizing a client and their presenting problem(s). Eight subjects responded to this question; however, one response was discarded due to a lack of understanding of the question asked. All subjects’ answers focused on how they conceptualized race in the lives of their minority clients, without reference to how they conceptualize race for their majority clients. Of those subjects who responded two (28.6%) again asserted a conceptualization of race as an organizing principal in a patient’s life, stating that it could not be underestimated as a force impacting a client’s experiences. As one subject stated:

I think of it [race] as an organizing principal. I think it colors the person’s object world, colors the sense of self, and their expectations of the environment. It determines who are safe attachment figures and who aren’t. It affects everything - object relations, self-object experiences; all the hits in the psychodynamic hall of fame.

One participant (14.3%) viewed race as a construct impacting early attachment and thus affecting one's development and subsequent presenting problems, noting:

I think I want to know and explore what role it [race] played in development...did it have an impact, play a role in secure attachment? In terms of cognitive development?...what kind of family structure existed and how was that structure internalized.

Three respondents (42.9%) pointed out that they tended to look at race as it related to the trauma of racism, stigmatization, and marginalization for their clients and their presenting problems. One subject noted that in conceptualizing patients of color she often attempted to look for the "fault lines" of racial alienation in a client's life and pathology, noting the interplay of the two:

It [race, is] not a pathology...[but it is] trauma in a way to be alienated and not treated with [respect]...so then it becomes a fault line in...development.... So race becomes connected with these intrusive events that create psychopathology. It isn't [psychopathology] but...[a hostile environment] creates it.

Another subject reflected on her treatment of an African American patient in discussing the impact of racism and marginalization on a client's presenting problems:

With African American people in my experience...there's usually some connection [between race and the presenting problem] but sometimes it doesn't emerge right away. I remember an African American physician...I tried to get him to talk about how there might be things that he would notice in himself about my being white and his being black and we could reflect on that and he said, "no, no, no"... but two and a half years into the treatment he began talking about how

he'd been one of those chosen kids from one of the LBJ antipoverty programs who got plucked out of a really, really poor neighborhood and sent to one of the really prestigious neighborhood prep schools and then to one of the ivy league schools. When he actually got into the details of what it felt like, not to know how to use knives and forks the way the other kids did, or how to buy the right kinds of sneakers...when he got into all the details of the constant humiliations of being the token black person that the institution is so proud of itself for rescuing. It was pretty excruciating and it was hard to bear in the transference..."

One subject (14.3%) noted that she conceptualized race in terms of a client's identifications and identity integration:

I try to get a sense of where their racial identity stands...is it fully integrated? Something they are just coming to terms with? ...is it the sort of thing somebody leads with or is it something that emerges over time in the relationship? And also whether or not it [race] can be talked about.

One final subject (14.3%), working at a college-counseling center discussed attempting to conceptualize race and difference in treatment in a way that accounted for a patient's lived experience:

I try to think of...the "lived world." What can I understand of how this person and their families have looked at life, at their own future, their family's future, and what is it about the context here, the fact that they were plopped here in the middle of a university that is a continuation of the family's life, and what is radically different from their life and family? I try to understand what's been

traumatic. And so...[I try to be] aware of how their experiences have been affected by living as a person with a different color skin.

**Conceptualizing race III: The impact of racism.** In discussing their conceptualizations of race, subjects were also asked how they think about racism in their work and how it had come up in treatment. Seven subjects (87.5%) answered this question by discussing negative experiences with racism that their African American clients had encountered, and the subsequent impacts that it had had on their clients' lives and presenting problems. Two subjects (25%) described how early experiences of racism could be introjected, ultimately affecting a patient's sense of self, others, the world, and their future. One subject in particular spoke about his work in a semi-correctional setting and the connection he saw between his clients' incarceration and the way in which racism has truncated their sense of self and possibility:

I think racism plays a role in how some people get to me...I think it also plays a role in keeping these people in bad situations – limiting their view of their own futures...one of the things that's really important if these guys are going to get out of this facility is to have a view of a better life. And some of them are just so unable to even imagine it.

Two subjects (25%) spoke about current and historical racism as a trauma in their patients' lives. One participant noted, "We're still living with the post-traumatic effects of slavery. It's not all that long ago that we enslaved people." This same subject asserted that while in recent years, the manifestations of racism had shifted since the 1960s, from "dramatic" instances to "small microaggressions" that this phenomenon was, "...still as painful [but just]...underground." Another subject (12.5%) described a necessary

hypervigilance that he noted in his African American clients, which sometimes led them to become “pre-occupied” and “consumed” with scanning their environments, adversely affecting their daily lives.

Finally, two subjects (25%) noted how internalized racism could impact the self, leading clients to disavow the racialized parts of themselves or their communities. One therapist gave an example of his work with a biracial African American and Native American female in his private practice, who struggled with the African American parts of herself and history, and as a result distanced herself from romantic involvement with African American males, and experienced issues with intimacy in general:

My patient...doesn't like the attention she gets from black men. She will acknowledge she is racist and doesn't like the African American part of herself. And [as a result] she doesn't like African American men, she finds them to be intrusive to her.

Another therapist also pointed out the devastating additive effect of racism and other forms of stigmatization on her clients. In discussing an African American transgendered patient, this subject noted the prejudice that her patient had experienced within the healthcare system in attempting to receive hormone therapy as an African American transgendered individual:

I think the amount of racism she encountered in healthcare, part of it was...I do feel she was at an additional disadvantage because of her race...she'd been living as a woman for more than a year and had this legal name change and...[the nurses] wouldn't register her under her legal name...they said this was because they had a rule that your name had to match the body you possessed...I feel pretty



strongly that had this been a middle class white person that it would have been a different experience.

Finally, three subjects in answering the question of how they viewed racism in treatment, discussed how they managed their own and their clients' racism in session (25%) and how they worked to help clients disentangle projections of racism from actual instances of overt racism or microaggression (12.5%). One last subject noted that she did not often work with racism in treatment because of organizational constraints, which necessitated shorter-term therapies. This subject maintained that the more problem-focused nature of her work often tended to obscure conversations of race and racism:

At least in my interactions it has been rare for [racism] to come up, partly because we tend to be dealing with things in a much more short-term, problem-focused way...that I think can keep it out of sight...Because we tend to be CBT-ishly focused [at the counseling center] we just don't bring it up. So I don't doubt that there are areas that it needed to have been aired but it wasn't, because [it] didn't seem to be appropriate [to the treatment focus].

**Addressing racial difference in therapy.** The next set of questions focused on if and how white therapists addressed racial difference with their African American clients. Subjects were first asked if racial difference came up in their sessions, and if so, who brought it up, and at what point in the therapy it tended to be discussed. All eight participants (100%) stated that they addressed racial difference in their treatment of African American clients. Three of the eight subjects (37.5%) stated that they themselves generally brought up the topic within the first few sessions, in order to create space in the relationship for this discussion early on. The remaining five subjects (62.5%) could not

give a specific timeline of when they addressed racial difference as they felt that it varied based on such factors as a patient's readiness and receptivity, level of psychopathology, and/or systemic or organizational constraints.

Two subjects (25%) asserted that it was important to pay particular attention to the client's pacing, in bridging the topic of racial difference and to avoid bringing it up simply to appear racially sensitive. One subject stated:

[In] the first session, I try not to impose any agenda of my own...I just listen, I try to feel my way into their experience...I'll ask them if they want to try therapy with me and is it ok, if in the next session I take a full history. So in the second session, I'll take a full history and by the end of that session I will ask them, if they haven't brought up race, tell me what it's like for you to be talking about your history with a person of a different race? I'll usually say to them, I'm sure you've thought about what kind of therapist you wanted before you came to me. Did you consider trying to find an African American therapist and if not, what's the story with that. But again I could imagine a person radiating not wanting to go there in enough of a way that I wouldn't want to, out of my wish to show that I'm sensitive to it, I wouldn't want to override whatever their sense of pace was.

Another subject pointed out that it was important to follow the patient's lead in this discussion in an effort not to objectify a patient's race:

I think I wait and see for a while, because...it's maybe annoying and objectifying if the white therapist immediately in the first session brings up race. You know...I get annoyed when somebody knows I'm gay and then the first conversation they talk about is, I've been to a gay disco or I have a gay friend...I mean I have mixed

feelings about that, because on the one hand I'm appreciative they're trying to say to me, I'm on your side...but I forget sometimes I'm gay...I don't know if African American people have the same experience, if they ever go through a period of time where they forget they're African American...but if too much time goes by and they haven't talked about it, when I feel like there's a lead in...I'll say so what's it like to work with a white therapist?

One subject who worked in corrections and primarily used a group therapy modality, also noted that organizational factors, not simply client or therapist pacing, impacted the way in which racial differences were addressed:

I think it's a mix of both [who brings up race first in the treatment]...What's complicated is that we [the therapists] generally enter existing groups so you're coming in and having to make your own place in general. I've only once had the opportunity to start a group and even when [race] comes up, I don't think it's as direct as what role does race play...it's more like just always listening [for it]...I want to see if they credit race [in their discussions]

Finally, one subject noted an interesting pattern in her own work at a college counseling center, stating that she tended to bring up racial difference more with her African American and Afro-Caribbean clients than with other clients of color:

I'll almost invariably bring it up early on. What's it like to be talking with me, selected out of the blue? Because they [the clients] didn't choose us. They get assigned randomly as to who's available at the time their schedule matches...But in terms of someone, a black woman or a black man comes in, I will say what is it like, what do you anticipate are some of the misunderstandings or the ways in

which I might, or might not understand what's going on...as a white female...And I do that exclusively with African American and Afro-Caribbean [clients], sometimes with Latino and Latina [clients], but much more rarely. [I'm] much more likely with a pretty strong difference of skin color.

***Making the decision to discuss racial difference.*** Therapists were next asked how they make the decision to bring up racial difference with their clients. Five out of eight subjects (62.5%) noted that it was often something that they just “feel in the air” and that to not address it would in some way hinder the therapy:

It feels intrusive in the room. There it is. And to not [address it] would be some countertransference issue of mine. I don't want to do this uncomfortable thing that would be stupid not to do, so it would be the natural progression of things.

Another participant called it, “the elephant in the room, that people are skimming around.” Others noted that patients' body language, facial affect, and comments all contributed to a “feeling in the air.” Describing these nonverbal cues, one participant noted that it was important for not only her clients to feel comfortable in bringing up the difference but for her as the therapist to feel safe to bring it up:

What I'm really paying attention to when I'm working with somebody, it has something to do with the kind of quality of the relational atmosphere between us. So I don't want to be bringing it up if somebody is at the edge of their chair and stiff and giving me one-word answers. I like to see people relax a little bit. I like to feel in myself some sense that I am relaxed in asking it. I don't want there to be too much weight, I want this to be a question that doesn't stand in a world of its own.

Three of the eight subjects (37.5%), stated that they made the decision to bring up racial difference after their patients alluded to it, or spoke about race more generally in their sessions. One respondent observed that her African American patients sometimes spoke more generally about race or an important African American figure in their lives and that this then became an entrée into discussing the racial difference between them. Similarly, another subject discussed listening to a patient's meta-narratives and what this might be saying about the relationship between the therapist and client with regards to race:

As an analyst, I also am thinking about when someone is telling a narrative, I'm wondering how much is a transference narrative. So when [a patient is] talking about the clueless goofy white woman at her job, I think, is there also an unconscious derivative that's going on between us?

Additionally, three of the eight subjects (37.5%) noted that they sometimes brought up racial difference, not because they felt it in the air or because of a client alluding to it, but simply because they felt obligated to do so. As one subject pointed out:

Sometimes I bring it up out of obligation, I think I should be bringing it up because it may be here, even though I don't feel it...one of the reasons for doing it out of obligation is to convey very clearly it's a topic we can talk about. So even though I may say I don't see this is happening [now], I want to put it out there...that this is something I am open about.

***Deciding not to discuss racial difference.*** Subjects were next asked if they had ever purposely *not* brought up racial difference in working with their African American

clients, and if so why they had made this decision. Seven of the eight subjects (87.5%) stated that they could not recall a time in which they had not addressed the racial difference in their treatments with African American clients. One subject stated that if she didn't address it, it would be at the patient's request and only for a period of time until the patient would be ready to discuss it:

The only time I haven't addressed race was when the patient told me they weren't ready to go there yet and that it was clearly not an issue. And then it wasn't a matter of deciding not ever to bring it up. It was a matter of deciding to wait.

One subject (12.5%) noted that there may have been one patient in her 20 years of practice, who was not African American, with whom she had not addressed or explored the impact of their racial difference, but that this had been due to the short term nature of the treatment coupled with the fact that this particular patient was in crisis for most of the treatment:

I have a sense that that may have happened [that I did not bring up race] but I'm not putting together a real clear picture of the circumstances... I had a client an Asian Indian male undergrad come in suicidal and announcing he had a date for his suicide and he had been rebuffed by a girl he had been in love with from afar...it was interesting because the supervision was a lot about his ethnic background and what caste he was in and what the expectations for Indian males were, but I don't think I ever talked directly with him about it...The sense was that he was in such a crisis that that for him to...fill me in about his racial background...it felt like it was more of a crisis where I did not [address the racial difference].

*Benefits and challenges of discussing racial difference.* Subjects were also asked to describe a time when they had brought up the racial difference between themselves and their client and it had had either a beneficial or detrimental impact on the client or therapy. Five of the eight subjects (62.5%) described anecdotes in which addressing racial difference had had a positive influence on the treatment relationship or work. One subject (12.5%) stated that because the short-term nature of her work at a college counseling center necessitated that she address the topic directly with the patient in the first session, it was difficult to determine the result that bringing up the subject had had on a patient due to not being able to see a turning point in the work. Finally, two subjects (25%) discussed a time when they had brought up race and it had been detrimental to the treatment.

Of the five participants who felt that bringing up racial difference with a patient was beneficial, one (20%) asserted that this discussion often created greater trust between patient and therapist. Two subjects felt that this discussion could provide the client with a sense of relief and serve to deepen the work (40%). A fourth participant (20%) noted that it could help to heal race-related pain. In talking about the profound relief that her patients felt when race and difference were brought up in the treatment, one respondent provided an anecdote from her treatment of an African American teacher who encountered racism at work:

[A patient] ran into some problems with the possibility of cutbacks and even though she had tenure...she's had a major depression, and she's suicidal...so I can imagine that her teaching hasn't been quite the level that it was once. But she began to get these veiled messages from the administration that she was

expendable and I remember saying to her something like does your administration have any sensitivity to the fact that even on a political basis it might not be the smartest thing to go after the African American faculty member? And she breathed a huge sigh of relief, and said I don't know if that figures into why they're targeting me or it's other stuff, but it's sure going to look like that and let me tell you how I feel [about], what it's going to look like. And then she talked in depth about that kind of bind. Should she name what it felt like was coming at her? Should she ignore it? Should she fight for her job in other ways? The relief [the patient felt] was palpable. And took it to a deeper level, her own feelings about it.

Another subject spoke about how challenging a patient on race and difference expanded the work of therapy and lead the patient to new insights and ways of thinking about his presenting problems:

...[A] male [African American] patient...never talked about...whiteness and blackness...we talked about the racial difference between he and his [white] partner and he was kind of destabilized by it, "well what do you mean? It's not a problem"...So I challenged some of that. The last 3 years of the treatment have all been about race, about his disowning his identification with the black community....Both of his parents were African American, but both [were] biracial, they were southern in origin and mixed race from slavery...He talked about his particular lack of faith and trust [in] and contempt for African Americans. He had a father who was seriously mentally ill and in and out of psych hospitals [and] a brother who had been in and out of psych hospitals...So



he developed this sort of long standing sense that African American men aren't sturdy, reliable, not as valuable.

Interestingly, another subject noted that sometimes working with racial difference involved knowing when a patient might be better served by a therapist of color, which might require removing oneself from the case. In discussing a patient he saw in a semi-correctional setting he stated:

I had a guy, he was very violent guy and he had this long history. At the age of 4 he was by himself and observed a lynching and his parents had to send him away, up north to live with family. He became selectively mute for the next three and half years. When he started to speak again, life wasn't a lot better up here for him. He still lived with a lot of prejudice and at about the age of 9 he and his cousin were attacked by five white guys, older adolescents, who pinned him down and then raped his cousin and he observed it and felt responsible for not protecting her even though he was a young kid and couldn't have. And he's been trying to tell this story and nobody was listening. So I let him tell the story and saw that it was very important. And I pushed for him to have an African American therapist and...they gave him an African American therapist and he has in a very short period of time advanced a great deal. So I think by acknowledging... race...and giving him a chance to talk about it, he was very satisfied.

Of the two subjects (25%) who had addressed racial difference with their African American patients and found the experience detrimental, one stated that he could not remember the specific instance but simply remembered a feeling of "trauma" on both

sides of the interaction. The second subject mentioned how her own anxieties and discomfort had gotten in the way of an open exploration of race early on in her career:

I think at times I may well have alienated people without knowing...and my guess is that at least sometimes that would have had to do with their picking up my anxiety about not saying the wrong thing, so of course that they felt they could say the wrong thing to me. I think I needed to evolve I needed to learn something about my experience of difference in general... getting more comfortable with the idea of asking something that might be difficult or awkward for someone to talk about.

Finally it is interesting to note that a number of respondents (n=3, 37.5%) also stated that even if bringing up race or difference initially felt uncomfortable or lead to conflict with a patient that this in and of itself could be beneficial and healing. As one subject recalled:

I've certainly brought it up and felt that my timing was bad and that it didn't do anything good for the relationship, but it's not something bad. People usually, even if they're not ready to go there, are glad to get the message that this can at least be named like anything else.

Another subject pointed out that discussing difficult topics could also be an important part of the therapy process:

It's hard to imagine...that anything I bring up is detrimental. It's not like it's hurtful. It's always good to put something out...You want to model that you can be spontaneous and say what's on your mind, and if it doesn't go over well that's ok, and conflict is ok...that this relationship can tolerate conflict. We can have differences and continue to work even if we don't agree on everything. I would

hope that people would be able to have those kinds of relationships in their lives and that they're not always worried about what they say or have to walk on egg shells.

*Addressing white privilege.* Subjects were also asked whether or not the topic of white privilege had ever come up in treatment and if so what the circumstances surrounding it had been. Three of the eight subjects (37.5%) mentioned that white privilege had come up in treating African American clients. Three subjects (37.5%) reported that the topic had not come up in therapy or that they had a hard time identifying it in past treatments, and three subjects (37.5%) stated that privilege in general was a topic often brought by their white patients.

Of the three subjects who reported that white privilege came up in treating African American clients, they noted that the conversation often focused on issues of financial privilege or entitlement or the therapist's lack of understanding due to racial privilege. As one subject stated:

...With several patients where I'm trying to help them find whatever options they have or level of agency they have, one of the ways they'll respond is they'll say, "Ya it's easy for you to say. You're white and comfortable and you don't have any sense of what it's like to be dealing with what I'm dealing with day in and day out." And I will usually say, "tell me more about that" or "Ya, I see what you mean, so tell me more what it is like."

Another subject, while cautious in using the word resistance, mentioned how a patient's beliefs in the therapist's privilege and subsequent lack of understanding, could be used to reject the therapy:

Well they [my clients] wouldn't use those words [white privilege], but I'd say they bring it up a fair amount. Often it's in the service of resistance...I'm a little cautious to say that because I don't want to sound like I'm discounting it but I think...it's just to say, "oh you don't understand because you're white" to try and to discount whatever I have to offer.

Interestingly, one of the participants who noted white privilege had come up with his African American clients, stated that in one case, an African American psychotherapist chose him to be her therapist because of his privilege:

One the reasons [my client] came to see me is she has a lot of issues around her financial management of her [psychotherapy] practice. A tremendous amount of guilt about fees, [and] charging what she's worth. This is a woman [a therapist] who has had so much post-grad training and was charging like 50 cents for her work. It was even worse when she would work with other African Americans...[she] gets hit with that all the time about her fees...how could she charge another sister that much money and can't she give another sister a break? She knows how hard it is in the world and so it works on her and she feels tremendously guilty. So she said, "I'm hoping as a white man you'll help me to feel more entitled to my work and to be affluent"...So it was a whole question about self interest...She said, "I want to learn how to be that way."

Three subjects (37.5%) mentioned that either the topic of white privilege had not come up at all with their clients (n=2) or that they had a hard time identifying themes of white privilege in general (n=1). One of the clients noted; however, that just because it

didn't come up in her practice did not mean it did not somehow exist in the work, "I'm sure it [white privilege is] all over the place...it just is part of the sea we swim in."

Finally, three subjects mentioned that some form of privilege (usually socioeconomic) tended to come up more with their white clients in treatment than with their clients of color. One participant stated, "I remember it more with white patients, than with my racially different patients. My white patients just start assuming wealth and privilege based on my profession and their own projections of whatever inadequacies they feel."

**Race and the therapy process.** Next, subjects were asked about if and how race enters into the therapy process and relationship. Participants were asked a number of questions involving psychodynamic concepts and techniques related to transference and countertransference, enactments, defenses, the unconscious, and identity as they played out in their work with African American clients.

***Transference/countertransference reactions.*** Subjects were first asked to discuss transferences and countertransference reactions that they had encountered in treating African American patients. Five participants (62.5%) noted that they had encountered race-related transferences. Transferences described by the subjects included patients seeing the therapist as: privileged and incapable of understanding their racial experience (60%), a white oppressor (20%), and racist (20%). With regard to privilege, one subject noted:

Certainly [I've seen] the one about privilege, that I can't expect you to get what I'm experiencing because after all you had a charmed life and can't know what it's like to be the object of racism because you were in the mainstream.

Another participant; noted that this projection of privilege was sometimes hard to disentangle from the reality of the therapist's privileged position and majority cultural expectations:

There have been times they've felt that some expectations are out of the culture...I worked with a lot of caregivers of ill aged parents. So I would work with some African American women who were caregivers...I was working with one in terrible caregiver burnout and I was really pushing her about her inattention to her own needs and I kind of also presented Nancy [Boyd-Franklin's] idea of the African American superwoman and she said, "that's all well and good but in my community individual identity and 'me' and 'my own' are not as important as what 'we' need. And you're pushing me about the 'me and my own' and that's white." And those moments are really hard because how much of that [is] defensive and how much of that is my cultural misattunement and a mixture of both. How much is transference, which is get off my back with your expectations?

A third participant stated that her African American patients sometimes tended to assume that she would be racist. This therapist noted that in some cases these projections were simply transference and in others could be accurate and something as of yet unknown to the therapist:

Sometimes they only find out that they assumed that I would have subtle racist attitudes towards them when they feel the absence of those. And sometimes they do pick up on subtle racist things that I'm not in touch with that I may have conveyed to them.

Two subjects noted an interesting phenomenon whereby African American clients had sought them out because as white therapists, they represented an object assumed to be very different from parental objects or collective community objects. In explaining this occurrence, one subject stated:

There have been a couple of black patients that...have had very bad relationships with their mothers and deliberately sought out a white therapist either consciously or unconsciously because their images of black maternal people were horrible and they thought a white person has to be better than that.

Participants also discussed their countertransference reactions in working with African American clients. All eight subjects (100%) were able to recall and reflect upon a variety of countertransferences that they had experienced in conducting cross-racial therapy. Two subjects (25%) discussed feeling white liberal guilt when working with African Americans and subsequently overcompensating for this in the treatment:

I do feel the liberal guilt, knowing that my road is easier and I think the bending over backwards phenomenon [is the result]. [I'm] more careful, more attentive, more present [with my African American clients]...I'll compensate and sometimes overcompensate.

Similarly another subject discussed wanting to be a good white object for both his client and his own self-concept:

I have the countertransference of wanting to be the nice white guy. I was glad, so glad that [a specific African American patient] found me to be nonjudgmental and my pleasure in that was both for his sake...but also it was personal, you know pat myself on the back that I'm not racist.

Three subjects (37.5%) described a feeling of seeing their African American clients as more disadvantaged or non-agentic than they truly were and wanting to rescue them. One of these subjects found herself associating more hardships (such as socioeconomic difficulties, vocational issues, etc.) to her African American clients than was merited. Another subject who worked in semi-correctional facility noted that this tendency to see his African American clients as marginalized often led him to give them more of a “break” in treatment and not hold these patients as accountable as his white clients:

Sometimes with same race clients, I’m sort of like how’d you get yourself into this...maybe I find more sympathy for people that have a history of exclusion and prejudice than for somebody that’s kind of like, well my mom used to yell at me all the time...and it’s not fair, I have to catch myself with my clients of other races that I’m not closing my eyes to [the fact] that they did bad things.

One participant summed up her rescue countertransference reaction as having the unfortunate result of infantilizing her African American clients:

[I have] this feeling of wanting to rescue people, as grounded in my liberal white guilt. My sense that people of color are at a disadvantage and my desire to somehow compensate for that. So there can be an infantilizing quality to my work with black people...I perceive black people as being particularly oppressed.

Other countertransference reactions described included feeling both anger at and skepticism of clients’ experiences with racism (n=1, 12.5%), fear of not understanding a patient’s experience and sounding, “like a stupid white person,” (n=2, 25%) and positive



associations to African American attachment figures from the therapist's childhood (n=2, 25%).

*Enactments.* Subjects were also asked whether or not they had encountered race related enactments in working with African American clients. Three of the eight subjects (37.5%) could not recall a race-related enactment taking place in their cross-racial therapies. Five subjects (62.5%); however, related vivid stories of enactments from their work.

One of these five subjects related an experience in which she and a client had acted out an early mother-child relationship and U.S. racial power dynamics in treatment, which lead the therapist to feel aggrandized and superior, and the patient to feel worthless apart from her association with her white therapist:

A black client...went to hear me speak...She had a very narcissistic mother and always felt that she was a value to her mother only as a narcissistic extension. Someone at the conference who knew that she was in treatment with me, said to a table of people as she was there, "guess who her therapist is, Dr. X" and it made her [the patient] feel like once again she was valuable only via her connection to the powerful, maternal object... I think there was a little piece of race in that for her...there was some implication that she was acceptable because she was connected to this white person...I suppose that the part of it that's an enactment is that she and I were both sort of enjoying being at the conference and I did feel to some degree pleased to be the big shot...and I played the part and she sort of faded into the wood-work and felt wounded, when the only way that she seemed to matter was her connection [to me], so we did a lot of processing of that.

Another participant described an enactment, which objectified racial difference, putting the therapist in the role of the objectifying white person and his African American client in the role of the exotic, black patient. A third type of enactment noted by two subjects (20%) involved that of the white protector/rescuer and the African American victim. This dynamic was poignantly recalled by one subject who related a story from early in her training, which involved an enactment around infantilization that ultimately may have led to early termination:

I was working in the community mental health center and I was assigned a woman in her 50s....she...couldn't afford a car and the nearest grocery store was a mile away. And she was very low weight, very depressed, and not eating... so all of my rescue fantasies became stirred up and... with my supervisor's approval, I took her to the grocery store, and went shopping with her with food stamps, which was an incredibly powerful experience in my training because I got to see how humiliating that experience is... Then I drove my client home and got to see her apartment and helped her unpack and she was incredibly grateful. And then she showed up again next week...with her grocery list she was ready to be taken again. And when I conveyed to her that....I saw myself as wanting to be helpful to her...in helping her to figure out how she can get what she needs in the world. She looked at me with a kind of a tired dismissal...she knew much better than I did how to navigate the world that she was living in. There was nothing I was going to do to help her with that...whatever transference she had had to me up till that point...became this is somebody who can chauffeur me but who really does not understand me. And I went along with that...looking back now, I think if I

had been able to hold my ground there were things that she was doing that were not helpful to herself including alienating a daughter in law who...had been driving her to the grocery store, I could have worked with her on making that relationship less conflictual so that she didn't lose out on her access to food.

Other enactments described by subjects included angry African American aggressor and white victim (12.5%), and the acting out of internalized racism, with the client enacting the white racist and the therapist colluding with that racism (12.5%).

***Race-related ruptures.*** Subjects were also asked if they had ever experienced a rupture in the therapeutic alliance based on race or racial difference. Five of the eight subjects (37.5%) could not recall a race-related rupture in their treatment of African American clients. Two subjects (25%), however, discussed instances in which a therapy had ended abruptly possibly due to racial difference, discomfort on the part of the therapist or patient, or a lack of attunement. Another subject (12.5%) asserted that his therapy relationships started off ruptured due to the fact that his place of work was a semi-correctional setting.

Of the five subjects who had difficulty remembering an instance of race-related rupture, each of them offered reasons as to why they thought this was the case. Three of these five subjects (60%) observed that it was possibly their own overcompensation or hypervigilance around race and difference that prevented a rupture from happening in the first place. One subject laughed and noted that she could sometimes be too sensitive to preventing race-related ruptures, "I can't think [of any ruptures] around race. Probably cause I'm too busy overcompensating. Making sure that my awareness and consciousness of the way this issue can be present...I'm just going to be right on top of it." Another

therapist mentioned that he tried to prevent race-related ruptures before they happened or to be sensitive to addressing them as soon as they arose, so that they could be processed between himself and his client:

I think it goes back to what I was saying before about saying something and trying to be attentive to how the person reacts and if I get a sense that something rubbed them the wrong way, to ask them about it.

One of the five (20%) subjects who did not recall having a rupture around race, pointed out that over the years his private practice had become less diverse, reducing the chances for such ruptures to take place. Finally, two participants commented that just because they could not remember a rupture, did not mean that it had not taken place:

I don't trust that that means it [a race-related rupture] hasn't been there. It's possible that someone I was working with decided to terminate and presented it as, "I think I'm ready" when they were picking up something in me that they couldn't go further...I think if you're a minority, you get very good at not necessarily always mentioning your complete motivation even to somebody who's saying you got to tell me everything.

Three of the eight subjects (37.5%) offered examples of when racial difference had caused a rupture in the therapeutic relationship. One of these subjects recalled a case that had resulted in the frequent and abrupt disappearance of her patient from therapy and associated to the fact that this may have been related to the patient's discomfort in discussing racial difference openly in the treatment:

You always wonder after this many years, sometimes there are people who just stop coming or said they're sick or they're going to be out of town for a few

weeks and they'll [never] call...one African American client I've seen on and off for 15 years the last time I heard from her was probably six or seven years ago where she just came in for one visit and then vanished again...I worked with her for about a year the first time, for about six months the second time...But her sort of vanishing has been such a haunting experience to me because I've never been able to get feedback about it from her...we talked about race [in the therapy], this is actually interesting that she's just coming to mind now, because I felt like she was kind of placating me about race...she really didn't think it was going to have an impact. [I asked her] did she feel like she could let me know? "Absolutely" she would let me know. But clearly there was plenty going on for her that she wasn't claiming.

Another therapist, working in a college-counseling center, owned that her own oversensitivity and discomfort around racial difference coupled with cultural misattunement that may have led to the early termination of a black Latino client:

[The patient] was in the music school here...My supervisor told me, "you seem to think that you're radically different from this person, and maybe pay attention to that." But the thing that I was not knowing how to handle [was], he really wanted me to come hear him play. I think I waffled about it, and I believe he was disappointed [when I said no] and didn't come back after that...Had I been Latina I might have understood how to either go or not go...The combination of my oversensitivity about his race, and...not knowing how to handle the cultural expectations...lead to [a rupture and termination]...We were never able to process it.

***Race and the unconscious.*** Subjects also responded to a question about how they had observed race or racial issues playing out in their own or their clients' unconscious. Three of the eight subjects (37.5%) spoke of their patients in answering this question, two subjects (25%) discussed their own unconscious reactions, and three subjects (37.5%) spoke of a broader more racialized collective unconscious. Finally, two subjects (25%) could not recall instances of this coming up in their treatments.

Of the three participants who spoke about their clients' unconscious processes, two discussed patient dreams involving race. Two subjects mentioned dreams in which African American clients had dreamt that they were white:

One of my African American candidates...was a psychologist at [a] university counseling center...she works with a lot of African American students and she said that they all have the experience of dreaming that they're white and they get so freaked out about it. They feel like it's internalized racism.

Another subject reported having clients who used whiteness in their dreams to mask conflicts with a black object in their current life:

Sometimes [my African American clients]...mention race in a kind of negation way, for example [a] patient...with [a] somewhat difficult husband, one of the dreams she had when she was first in therapy had to do with getting in an elevator and the elevator operator was a white man...I...noticed that she made a racial attribution to it, so when I asked her later to associate to this white man she described him, and then she realizes that she's basically just described her husband. And she said, "huh very clever of me to disguise him as white."

One of the participants also discussed how white and black figures in patients' dreams could represent various aspects of a client's internalized conflict around race:

[One of my patients] had a series of dreams about her church. She moved from a black Baptist church to a more multi-racial evangelical church and some of her conflicts in the church, in terms of herself, were represented by the black members of the congregation and the other members of the congregation. She brought in pictures of her sister who for all intents and purposes is a white person and the brother who for all intents and purposes is a white person. [My patient was the darkest skinned] and the bottom of the barrel [because of it] and the mother...was often the most physically abusive to her.

Two subjects (25%) talked about their own unconscious processes related to race in working with African American patients. Both of these subjects mentioned associations to either early black figures or images when working cross-racially. One subject noted a positive association to an African American childhood friend:

One of my best friend[s] in college was African American so I was in her house a lot...what's in my head, the smells, the look, it's a very powerful kind of image, [when I have an African American patient my mind goes to that friend]...it does...absolutely.

Another subject noted that his associations with African American males went to a more difficult place and evoked early associations of a childhood fear of black men:

What role does race play in my unconscious....unfortunately what's hard-wired into me and what I need to do work on is fear of African American men...I was a little kid during the riots in the 60s...so the cover of Life [Magazine] were

pictures of African American men just enraged with fires burning. I didn't grow up with a lot of stereotypic racism in my family. I was never taught that black people were inferior to me. We lived in a kind of segregated world, but what I was taught [was] to be fearful of black people. I remember we were watching the news covering the riots and my father said, "I don't blame them. If I lived in Harlem, I'd set fire too to the place." But the coda to that was, so that's why you have to be really careful because they hate us. With very good cause, but they hate us. So even though my father was trying to give me a culturally sensitive message, it was a scary message.

Finally three subjects (37.5%) also touched upon the presence of more global racial archetypes, frameworks, and assumptions as pervading society and subsequently treatment, in an unconscious way. As one participant pointed out, "Everything we've been saying stems from deeply held beliefs [about race], and that deepness would be the unconscious that is at play even when we're not thinking about it." Similarly, another subject commented on racial archetypes associated with time, culture, and history, of which those in the majority are often unaware:

And even the way people use the terms black and white, can have a racial overtone...Even within African American communities...lighter is better and darker is more problematic...I don't know to what extent that's kind of a universal thing...whether there are archetypes of this, but it's certainly affects our language, our mythology, how dark is bad and light is good...I think there's something to the old Freudian idea that we associate dark with shit. And you occasionally hear those kinds of even dark/dirty associations. This is one of those



questions where it seems to me so much a fact of life, so much something that it is hard to get your head above and actually see because we're all in it. And there are many other aspects of that that are so dense that we're not paying attention to...I noticed it with my kids. They just didn't seem to talk about skin color because they had friends of different colors. It's just like they thought human beings come in a lot of colors but for somebody of my generation, it would have been so rare to have been raised... in a community where you wouldn't have developed an unconscious racism because the sense of us and them...would be inevitable.

***Race and defenses.*** Participants were also asked whether or not they had seen racial issues play out in their client's defenses and if so, what they were and how they emerged. Five of the eight subjects (62.5%) cited various psychodynamic defenses used to mitigate race-related fears and pain. Three participants (37.5%) recalled experiences in which their patients had used race itself as a defense against a disavowed emotion or experience unrelated to race, and one subject (12.5%) could not recall working with a race-related defenses. Of the five therapists that spoke of clients' use of defenses to minimize conflict, discomfort, or pain related to race, the most common defenses cited were denial (40%), introjection (20%), projection (40%) and intellectualization or isolation of affect (20%). One therapist recalled an African American patient in a biracial relationship with a white male, for whom race was a central issue, but who denied it playing out in any of her conflicts:

[she was in]...denial that race has anything to do with anything. It's not an issue [she'd say] but meanwhile they're raising this biracial kid so a lot of racial stuff came up around that. He goes to school where hardly anybody is black and he

wants to be around more “homeboys” and they’re hoping he doesn’t choose that because they’re afraid of that for him

One therapist noted a tendency for her African American patients to internalize or introject negative race-related objects, ultimately serving to protect the client from the painful and sometimes uncontrollable realities of race in society:

One thing I’ve seen is that we all have a wish to understand our world in ways that gives us the hope that we can influence it. And I’ve seen occasionally an African American person suffer something that they had really no control over and they go to the defense that they must be bad or at least they must not have been good enough, because that’s less painful, that’s something you can change...[versus] I’m in a racist environment here and there’s nothing I can do. In fact, the better I am the more they’re going to have to make trouble for me. Because they don’t want their stereotypes challenged. So I see that kind of defensiveness, that’s really introjection as a defense, taking on the idea of any badness, rather than facing the pain of seeing [a] painful surround.

Two therapists also observed that they had often experienced their African American clients projecting onto the therapist a non-acceptance of racial difference or expectations of a larger white collective. One clinician pointed out that this defense could be thought of more as a “racial protectiveness” which kept the patient and therapist separate and the relationship less intimate for fear that the client or therapist might be hurt:

I tend not to think any longer in that sort of ego psychology defenses framework mind, more the kind of protectiveness across racial boundaries...I think there are

times when my patients may be projecting that I might not accept something that they experience as particularly cultural to them or particularly racial... That I might not be able to take it or that it would be rude or some combination of that... like if I raise this, this is just going to be dynamite and I'm not going to bring that up.

Of the eight subjects, three (37.5%) also discussed instances in which their patients had used race as a defense against pain emanating from another area of their life. One therapist, a clinician who works with a number of gay clients, noted that he tended to see patients use racial and ethnic cultural norms and identities to defend against and marginalize their identity as a gay individual:

I often get referrals of non-traditional gay people... so I get an Asian, Korean, African American, born-again Christians, and Orthodox Jews who are struggling with coming out. And sometimes I get really frustrated in the treatment because I understand that culture plays a very important part in coming out, it's much dicier for a minority person to come out to their family but I sometimes wonder... I think that sometimes the gay identity gets marginalized and that there's a protection in that... the use of culture... to defend against the person's struggle against homophobia, internalized homophobia, and the homophobia of their family... I go along with it for a while, but then I oppose it and say do you think it's possible, I mean I've also known a lot of Christian, born again African American men, I did a lot of HIV work and I met with some born-again mothers who in the crisis of AIDS came to really accept their child's homosexuality to really connect and get

past their religious precepts. [But my patient will say] “it would never happen in my family.”

Similarly, another therapist noted that in working with two African American women struggling with issues of relationship and sexuality that he believed race and racial difference had been used as a defense against basic fears associated with relatedness and assertiveness:

[These two patients were] using race as a defense against a more fundamental thing about men in general, about how difficult it is for them to be assertive, how they feel about their own body, their attractiveness and it all gets sort of dumped into the racial pail and it gets hard to untangle, and say to someone else that’s not really a racial issue. Because saying that it’s not...it’s not really accurate to say it’s not a racial issue, it’s just that it’s more than a racial issue, is more accurate. If it was just a racial issue and these women had a comfort level with being assertive, they would just be assertive and it would be over...the racial thing...can be a screen for just difficulty for being...I think sometimes it’s easy to use race as an excuse to not deal with a more general issue that’s probably around anger, aggression, assertiveness, and sexuality.

***Working with multiple racial selves and identities.*** Subjects were also interviewed about how they work with multiple racial identities in treatment. Four of the eight participants (50%) observed that they attempted to both acknowledge the presence of multiple identities within a patient and invite discussion about them in the therapy. One subject (12.5%) noted that he attempted to not only acknowledge but integrate these multiple selves when possible. Three subjects (37.5%) stated that they did not work with

multiple identifications in treatment either because they could not recall a time in which they did or because they did not have the time for this issue to emerge in treatment due to organizational constraints.

Of the four therapists who mentioned that they attempted to acknowledge and invite discussion about a patient's multiple identities, each had their own way of doing so. Some noted that they did so both directly and playfully, stating, "So I'll ask...is that the...white Mary talking or is that the black Mary talking right now? And they've turned around and said so am I getting the white [Dr. X], or the gay [Dr. X]?"

Others pointed out that knowing what parts of a person felt accepted and rejected and when was also critical in understanding a patient's experience of the racial self:

I think I most want to understand how someone identifies themselves, how do they experience? Some people I've worked with have been bi-racial. What's the community where they feel included? If there is a community they feel included in. Is there a sense of some aspects of them feeling accepted in some places and having to be denied in others? So I think I much more look at what the individual's experience. I see people as a multitude of identities.

Finally, one therapist in hoping to acknowledge and work with a patient's multiple identities and identifications, also wanted to make sure that her patients felt they could bring all parts of themselves into therapy, not just certain ones saying:

Well I guess by just trying to invite all selves of the patient into treatment. If I hear them describing something where they were in a different self-state or they were among friends in which they could kick back and be different, I ask them to

talk about that. I really don't want my patients to feel like they have to be in only one self-state when they are seeing me.

***Racial and cultural needs and psychodynamic goals.*** Subjects were also asked if and when they had encountered a time in which the goals of psychodynamic treatment conflicted with a client's racial or cultural needs. Six of the eight subjects (75%) stated that they had noted times in which the goals of psychodynamic therapy clashed with their client's cultural frame. Of these six subjects, four (66%) cited conflicts between a client of color's need for connection (particularly for those clients from collectivistic or family-oriented cultures), and traditional psychodynamic therapy's emphasis on autonomy, individuality, and the internal world. As one therapist put it, understanding and honoring his patients' need for relatedness is essential to being culturally sensitive within a dynamic framework, particularly for clients of color who are not a part of the dominant culture:

The whole thing about the focusing on individuality and autonomy and [the] individual internal world as opposed to a family or group identity. Loyalty conflicts...I think that a lot of times analysts don't understand what's at stake with somebody...in some cases I don't think it's the case for relational [psychotherapy], but I think that old guard Margaret Malherian, the centerpiece of their orientation is separation individuation and because of the prizing of that, sometimes [therapists] don't recognize the isolation that they're going to leave their patients within a hostile dominant culture. You know if they [the patients] get too separate from their mother they're not safe in the world even if they're 58 and their mother is 88.

Another therapist commented on helping clients navigate both a more Western psychoanalytic focus on individuality and a collectivistic focus on group membership and identity:

The goal of psychoanalytic therapy is to help people be autonomous independent individuals and certainly for many cultures that flies in the face of what the cultural norm and expectations are. But I think that it's a false dichotomy... I can see the possibility that you could have a culture or a family where the cultural norm of being more tied in is balanced by also an allowance of them having their own life... So I think sometimes they may seem like they clash but I do think it's possible to find a way to get that individuation without necessarily clashing with cultural values.

Subjects also noted a clash between the approach and techniques of dynamic therapy and some patients' racial and cultural needs. Here one subject noted that some of her clients brought different expectations into session on what the work of psychotherapy involved and that she tried to be mindful of this while keeping a dynamic lens:

I think I take a more of a developmental approach at the beginning, a developmental relational kind of a thing...I'm much more likely to be engaged and interactive so I think it plays out more in...my awareness of there being...different expectations about the degree to which we need to be strategic and [put] problem solving in the foreground and put other kind of more dynamic issues in the background because of the expectations the person brings. But my own dynamic view is that for all of us, our home culture and expectations and the specific ways that our parents and families have impinged or neglected or

whatever...the learning about those things is helpful to the person to begin to see what they're trying to deal with as an emerging adult.

Two of the eight subjects, in answering this question, stated that they had not encountered a time when psychodynamic therapy clashed with a patient's cultural or racial needs and expectations. In clarifying their answer, each of these participants noted a possible prejudicial undertone in the idea of certain therapies only being helpful to certain clients. One of these subjects asserted:

I do want to comment on something that I think is a symptom of racism, and that's the idea that a psychotherapy that is very helpful for white people with needs would not be the right therapy for black people with needs. I think there's racism in the idea that this talk therapy, that might not be their [a black person's] mode [of therapy]...I've never seen any evidence that African American patients can't use talk therapy or psychodynamic therapy. I mean there are some people who are concrete or don't like that kind of therapy, but I don't think they divide by race. So the whole idea that psychoanalysis was a treatment for the privileged and that there was no applicability to black people who should be given something more useful to them, I think contained huge amounts of racism and it protected people from having to exert the discipline to find a way to cross whatever boundaries there were and make what they had to offer relevant to people from different backgrounds.

As another subject echoed:

And when I was first being trained and there used to be a kind of ghastly system of racism within psychoanalysis that African American people were wanting



change and not wanting to reflect, but I don't think anybody currently, I hope nobody, continues to foster that idea. And in fact I think [the] one hope that we have for psychoanalysis's future is the cultural diversity of the candidates and those interested in it.

### **Reflection Questions**

In closing the interview, subjects were asked to reflect upon their experiences of working with African American clients in particular and clients of color in general. In addition, they were asked to comment on their experience of the interview itself.

**Benefits and challenges of cross-racial work.** Subjects were first asked to reflect on what they enjoyed about working cross-racially and what they found challenging. All eight subjects (100%) offered that they very much enjoyed working with clients from racial backgrounds different than their own. Two subjects (25%) stated that they enjoyed expanding their world view and dispelling assumptions, and three subjects (37.5%) mentioned that they saw their work as facilitating racial healing. As one subject stated:

This is hokey but I feel like if I can be a decent white person...if I can be a decent, trustworthy, attuned white person and open to my shit in myself, there is something reparative...One of the precepts in Judaism is this Hebrew phrase, "tikkum olam" which means "heal the world" so I feel like for me to be a "good white," not good as in "goody goody," but if I can provide a reparative [experience] with a member of the white world, there's some element of tikkun olam in that.

Four subjects (50%) stated that they loved working with people from other racial backgrounds because of the opportunity to live and witness the lives of others who are

different from themselves. Speaking to this voyeuristic side of cross-racial work, one therapist noted:

I love having a diverse practice...I feel like being a therapist is a voyeur's dream - you learn what it's like to be from all different kinds of backgrounds and life worlds. It's like the chance to live more than one life, by bearing witness to other people's lives.

Another subject echoed this sentiment stating:

I tell people my doing this work has never been altruistic; it's about reading novels. It's like so many Tolstoy's and Dostoevsky's walking into the office, so each one is a new book...It's mind expanding, it's exotic, it's a little voyeuristic, and it's lovely to be trusted.

Subjects next discussed what they found challenging about cross-racial work.

Three participants (37.5%) stated that they found the anxiety and hesitation that they experienced as a result of cross-racial work to be difficult. One subject noted that her apprehension sometimes got in the way of being opened and fully attuned to her patients, "I bring [my] prejudices [into treatment] in a much more conscious way, in a kind of a negative way. It's not a helpful...It's more like an anxiety." Another subject noted a fear of inadvertently offending or hurting her patients, particularly because of the, "things that I don't automatically know. Ways that you might be stepping on someone's toes and doing something disrespectful." Other things that subjects found challenging in cross-racial work included the potential for the therapist to experience shame in encountering his or her own prejudice or lack of understanding (n=1, 12.5%); not taking cross-racial rejection in treatment personally (n=1, 12.5%); remaining attentive to one's own

prejudices, racism, and ethnocentrism (n=1, 12.5%); not idealizing racial difference and acknowledging the negatives *and* positives of racial group membership (n=1, 12.5%); and making sure a discussion of or focus on race in the treatment was driven by the patient and not the therapist's need to appear culturally sensitive (n=1, 12.5%).

**Working with minority vs. majority clients.** In reflecting on the interview subjects were also asked whether there were ways in which they worked differently with clients from majority versus minority backgrounds. Seven of the eight therapists (87.5%) endorsed differences in their approach to treatment with minority clients. Three of these subjects (42.9%) reported that they found themselves being more careful and attentive in working with clients of color. One participant noted self-censoring with his African American patients, "I have this extra filter up just to be [more] aware. With white patients, my comments flow more easily, because I kind of assume we're from the same world, and with black patients, I'm a little more tentative."

Another subject stated that he felt he worked harder for his minority patients:

Sometimes I think minority patients get my best self. I think I'm more attuned and aware and a lot less lazy because I feel like I want to do a good job and am much more aware of my own biases...I think sometimes I'm not conscious enough with my white patients. So I guess my minority patients do get my best therapeutic self.

Three subjects explained that in working with minority clients they often are more aware of their own biases and assumptions. As one subject reflected:

I think it's a matter of being aware of my own territory, my own assumptions...even if you have perfect vision, perfect insight and you can see

everything around you, the one thing you can't see is what's under your feet, you can't see where you're standing. So...just be aware...I think the main difference is that I just am aware that there are blind spots.

Other responses included, subjects finding themselves more willing to make monetary concessions or blur boundaries for clients of color (n=1, 14.3%); being more formal with clients from certain cultural backgrounds (n=1, 14.3%); and taking a more explicit or psychoeducational approach to treatment with clients of color (n=1, 14.3%):

This has more to do with their [the patients'] sophistication with therapy [than] about race, although sometimes those correlate. I might spell out more why I'm doing what I'm doing or asking a question that I'm asking, or what they can expect from therapy, what the rationale behind it is, and ask for their explicit questions. I may be more conversational. You don't want to take somebody with no prototype for this mirrored way of being with another person and just start doing it so...I do much more work trying to account for why I think this is going to be helpful and what the patient's part is and what my part is. Some people have never been told that this really works better if you say anything and they want to know why, and you have to be able to explain why.

Finally, one subject (14.3%) pointed out that she tended to make more normative majority assumptions with her white clients than with her clients of color, leading her to minimize the differences between her and her white clients based on ethnic identity, immigration, and a number of others factors more than she would with her clients of color.

**Personal growth.** Subjects were subsequently asked if and how their approach to working with race in treatment had changed over the course of their careers. Seven of the eight subjects (87.5%) unequivocally stated that they matured in this area and had become more adept at engaging racial difference. Of these seven subjects, two (28.6%) mentioned that they felt they had become more racially and culturally aware over the course of their careers. Two additional participants (28.6%) asserted that they now felt less self-conscious about discussing race in therapy and felt less white guilt in cross-racial treatments. Specifically, one subject noted that becoming less tentative and self-conscious with clients of color had had a positive impact on her work and therapeutic relationships:

I'd like to think I'm less overcompensating and less self-conscious. I think my early experiences with African Americans made me feel so guilty, not because of anything I did, but just because I wasn't aware...I think that's better [to be less self-conscious] it kind of dilutes my countertransference, makes it [the treatment relationship] healthier.

Another subject stated that he was much more capable of seeing and admitting his own racism today than he was when he first began his career, "I'm much more willing to say that I'm a racist. I'm more aware of that." Finally, three subjects (42.9%) stated that they were much more willing and able to directly address the racial difference and racism in treatment. One participant mentioned, "I feel more confident as I've gotten more experience...In the past I was probably less explicit about racial issues, I wouldn't bring it up as regularly as I do now." Another noted that in the past, an inordinate fear of hurting her patients, particularly her patients of color, had made her more hesitant to

address race in therapy, but noted that it was something that she did not currently struggle with as much:

I think I have [a] much more humble sense of the impact for good and evil that I have on my clients...when I first became a psychotherapist it felt like I...was like holding a fire hose on full force that I could knock people over and destroy them if didn't know how to control it. Now I very much have a sense...that what I have to offer is just a chance for people to be honest with themselves, and that if people are in a position where they want to have that happen, I can help make that happen. And if they're not then I can't. So I much more see myself in the role of a kind of guide or facilitator than the power of my own, that I can assert on someone else. So I can ask a question...and someone's response to that is someone's response to that. It's not something I made happen...I certainly contribute to it, but that I won't knock somebody over with a fire hose.

Of the eight subjects, only one noted that her approach to cross-racial work had not changed significantly over the course of her career, because race and difference had always been something she was aware of and passionate about. This subject; however, stated that while she felt she had always "been ahead of the curve" on issues of race and racism that she found herself having to be careful, lest she miss something in herself or the treatment:

I just I feel I've always been interested in, and I always wanted to learn about it [race and racial difference]. I guess, this is just part of aging, [but] it's a whole new process learning that there's more and more you didn't know. It was one of my conceits, that I was way ahead of the curve on issues of race, and I think in

some ways, I have been... but I'm just so oblivious to certain features of what it's like to be African American as a lot of white people are, so I have to not get my narcissism wrapped around, "I'm really good on race and I have nothing to learn." It's a life long struggle to be open to finding out that there is so much you don't know.

**Additional areas of consideration.** A final question asked participants if there was anything not asked by the interviewer that might have been helpful to consider in reflecting on their experience with race in psychodynamic therapy. Five subjects (62.5%) offered other areas that may have been interesting to explore. One of these five subjects (20%) mused how personal life experiences had be integral to informing her clinical work with patients of color and offered that it would have been interesting to consider these in the interview:

There's a lot in my life that has been focused on race, not relevant to my clinical work [directly], except that I think all of it I some ways did inform who I am...I don't think you can learn enough about this.

Two participants (40%) noted that they would have liked the opportunity to discuss the intersection of race and sexuality including a patient's race-related fantasies and projections in their own intimate relationships, and the sexual transference/countertransferences emerging in cross-racial therapy dyads. One subject (20%) also discussed a desire to have reflected on how his own race-based fears and projections may have gotten in the way of a past treatment. A final subject (20%) discussed a desire to explore how institutions and systems facilitate or inhibit the exploration of race in therapy.

**Experience of the interview.** Finally, subjects were asked to reflect on their experience of participating in the interview. Four of the eight subjects (50%) noted that it had been a positive experience that they found interesting and thought provoking. One subject noted that the interview had made her want to pursue further training in this area:

It left me with...things that I don't know and I'm not aware of and that it would be terrific to be immersed in a workshop or class where that's all I'm thinking about, because so many other aspects of my work I was very immersed in studying and understanding. It was a little presumptuous of me to kind of ride on my own life experiences...it isn't the same as being immersed.

Another subject noted that it had been interesting to reflect on her cross-racial work in such a systematic way and to generalize from her therapies with African American clients. An additional participant stated that reflecting on her cross-racial treatments had helped to clarify racial issues with particular patients that she may not have identified previously during a particular treatment.

Four remaining subjects (50%) stated that while they enjoyed the interview, that they had also found it challenging for a variety of reasons. Three subjects stated that it had been difficult to realize their own biases throughout the course of the interview. As one subject pointed out, "It's hard to confront your own racism and admit your own prejudices." Similarly, another subject stated that she had found that she had been worried about the potential for shame or embarrassment in the dialogue and had fantasized that African American mentors she respected would somehow learn of her answers. Finally, a fourth subject stated that he found the interview challenging because it forced him to encounter what he still does not know or is unaware of:



I've had to think about things in a way I hadn't thought about them as directly. I had to fight the urge to censor myself. I'm not as perfect. I will say to my patients...the parts of me that you see is that I'm a white man and so I've benefited from that and it may in fact come out in the things that I say and do and if you feel like I'm not understanding, I want you to tell me, or I want you to raise it because...I can't address what I'm not seeing, so if you see something you need to tell me about it. I don't want to make it the patient's responsibility but at the same time I can only see what I am. We can only see what our eyes see and sometimes our eyes need to be trained by others.

## CHAPTER V

### Discussion

#### **Themes**

This study explored the experiences of white psychodynamic therapists working with race and difference in cross-racial treatment dyads. Subjects were asked questions related to their understanding of and training in multiculturalism and race in therapy; their experiences with race and difference in conceptualizing and working with African American clients from a psychodynamic perspective; and their reflections on cross-racial work in general. The present chapter explores themes which emerged in the data and included: 1) the limitations of race-related trainings; 2) the importance of early experiences, self-exploration, and interactions with people of color to understanding race in therapy; and 3) the anxiety, shame, and humility of cross-racial work; 4) the significance of race to client conceptualization; 5) the importance of discussing race to deepen the work; 6) the impact of power and privilege on therapy process; 7) the difficulty of working with racialized defenses; 8) the ability of white therapists to evolve over time; 9) organizational barriers to cross-racial work; and 10) psychodynamic therapy as a treatment for all. Limitations of the present study and directions for future research are also discussed. Implications of current findings for practitioners, organizations, policy, and the field of psychodynamic therapy are addressed.

**Training on race in therapy is limited.** In discussing their training experiences in race and culture, subjects noted a lack of formal or advanced training in this area, a dearth of supervisors and professors of color, and a lack of integration of race and culture with general theory and practice. While most subjects noted having some course-work

related to diversity or multiculturalism in graduate school, several reported that they either did not find the classes helpful or found it to be a “one-off” class, citing the absence or lack of race in more general psychotherapy courses. It is important to note that in the current study the average age of participants was 60.4 years old with a range of 51-71 years old, and that the majority of participants completed their graduate training in the 1970s, 1980s, or 1990s. Thus, results obtained with regard to training experiences may have been different if the sample had skewed younger or completed their training within the last 10 years. Contemporary researchers, however, echo the sentiments of the current study’s participants and note that comprehensive training in multicultural competence is still lacking in the present day. Despite recent efforts to integrate multiculturalism and identity into graduate education and formal training, many believe that the field still has a long way to go, citing that most training experiences are limited to a single multicultural issues course (Goode-Cross, 2011) versus an integrated training experience.

Amongst current participants those who had a course in diversity often found it either too basic or an unhelpful exploration of the “other.” This is reminiscent of the criticisms of many in the field who disparage the traditional pen and paper intellectual approach to multicultural training that often takes place (Nolte, 2007; Sue et al., 1991). They note that textbook trainings seen in most graduate programs often lack the mixed race experiential and affective immersion experiences that are essential to confronting one’s own racism, and to internalizing and integrating theoretical concepts of race.

Those subjects in the current study who attended or took courses at an analytic institute noted a similar limited or piecemeal approach to discussing race in therapy and a lack of integration of psychoanalytic theory with race-related concepts. Many subjects

attributed this lack of attention to race, to institutes being predominately white and lacking faculty, supervisors, and students of color. Subjects spoke of the lack of integration of cultural and racial constructs into psychoanalytic theory and practice at the level of training, scholarship, and research. One subject asserted, “In the family therapy world...there was really a commitment and dedication to looking at difference” that this subject as a candidate at an institute, and later a faculty member, had not found.

As Leary in her 2012 article on race in psychoanalytic practice comments, “Psychoanalysis remains a profession that is overwhelmingly white and the socioeconomic diversity among those who teach, train, or who are treated, psychoanalytically is limited (p. 283).” This whiteness within the analytic world has implications for the advancement of and training in multiculturalism within psychodynamic practice. While some scholars relate the propagation of whiteness in psychodynamic therapy to its historical and traditional majority-based positioning and focus on the individual (Butts, 2002; Comas-Diaz, 2007; Curtis Boles, 2002; Dimen, 2000; Greene, 2007; Leary, 2000), others see it as an orientation that naturally accommodates issues of race and have called for the field to “renegotiate old loyalties...[to include]...large group identities...[and] the role of public environments in shaping individual subjectivity...(Leary, 2012 p. 286).”

As Green (2002) has asserted true multiculturalism involves a, “weaving together of multicultural theory with traditional forms of psychotherapy (p. 223).” By extension, racial competence involves the on-going consideration and integration of racial theory with psychological theory and practice. With regard to training, subjects in the current study noted that significant room for improvement exists within the field and that the

seamless integration of racial competence with psychodynamic theory, process, and technique remains a critical goal yet to be realized.

**White therapists' understanding of race is shaped by early experiences, self-exploration, and interactions with people of color.** Throughout the interview subjects noted the importance of experiences with persons of color in helping them to better understand and work with race in treatment. Subjects offered that for white individuals, race cannot be understood in isolation and must involve interaction, dialogue, and meaningful experiences with persons of color. Subjects noted that reflecting on and exploring their own white racial identity within the context of these interactions was also helpful.

For some participants, early experiences with a caregiver or friend of color first alerted them to issues of race and their own white identity, fostering in them positive associations with racial difference and in many cases a subsequent interest in civil rights and social justice. These formative relationships seemed to facilitate an emotional and affect-laden experience of race which researchers have asserted is crucial to multicultural learning and development (Tummala-Narra, 2009) As one subject noted:

It would be my personal experiences with black people from when I was quite young [that have had the most impact on my understanding race]. After my mother died, my sanity was more or less saved by a black woman...she was really important to my self-esteem.

Other subjects noted that having supervisors, colleagues, and professors of color helped to shape their thinking on race in therapy. Unfortunately, these same subjects also commented on the lack persons of color in psychoanalytic training institutes at the

candidate and supervisory levels and the subsequent limited consideration of race in the application of psychodynamic principles to their clients of color. With regard to supervision and training, studies have found that supervisors of color devote more time devoted to addressing multicultural issues in supervision and are associated with an increased capacity for supervisee multicultural case conceptualization (Gainor & Constantine, 2002; Hird, Tao & Gloria, 2004; Ladany, Inman, Constantine & Hofheinz, 1997). For white therapists, interactions and consultations with colleagues and supervisors of color, as noted by participants, may serve as an important means of increasing awareness and understanding of race in therapy.

At the same time, researchers also warn against placing colleagues of color in the role of “diversity expert” with a mandate to educate majority groups (Smith & Redington, 2010). Instead, they also place the onus on white individuals to enhance their own racial awareness and to foster an awareness of racial issues for their white colleagues as well (Ayvazian, 2004; Lawrence, 1997). Along these lines, participants cited taking responsibility for their own racial competence and exploring their white racial identity, prejudices, and racial shame as critical to their understanding of race in treatment. While subjects noted doing some of this work in mixed race contexts, others reported using their own analysis to explore their prejudices and positioning. In each case, subjects referred to not just the cognitive recognition of race but the affective felt experience of doing the work. One subject warned; however, that understanding race for a white therapist is not a static moment, but involves on-going self-exploration and interaction with persons of color that if not exercised, can be diminished or lost:

I think having people of color as teachers and supervisors...really helped me to kind of naturally have that lens. But it's so easy to lose it, it's so easy, especially working in private practice, in ...two very white [communities]...it's easy to kind of lapse into a white way of listening to things. [I'm] not being confronted all the time with my biases and frameworks

The need for on-going examination of one's on race and racial issues for white therapists is echoed in the literature. In a qualitative study of white anti-racists with well-developed white racial identities, subjects noted a tendency to slip back into a white way of seeing the world when they or their environment were not challenging them on this issue (Smith & Reddington, 2010). As one subject noted, "a thousand times a day...I still forget I'm white (Smith & Reddington, 2010 p. 546)." For subjects in the current study then, early experiences, interactions with persons of color, self-exploration, and continuously pushing themselves on issues of race, power and privilege were essential to developing their understanding of race in therapy.

**Cross-racial work involves anxiety, shame, and humility.** For all of subjects interviewed, cross-racial work involved feelings of anxiety, discomfort, and shame. Subjects reflected that working with African American clients involved exercising humility and keeping one's own narcissism and the need to appear racially sensitive and aware, in check.

Many of the therapists interviewed reported feeling anxious that they would say or do something to offend their patient or expose their own prejudice. White therapists interviewed often worried that they would unwittingly hurt their clients. As one subject remarked the, "things I don't automatically know [or] ways that you might be stepping on

someone's toes or doing something disrespectful" were the things that worried her the most. A fear of hurting black patients' feelings also entered into the cross-racial equation. As one participant stated, "I think people [my clients] are afraid of hurting my feelings and I get afraid of hurting their feelings...there's a fear that I'll say something that's hurtful or inappropriate." For some subjects, these anxieties lead them to be more tentative or hypervigilant in their cross-racial work and to have an extra filter up. For other subjects, their anxiety stemmed from the potential loss of ego and a fear that their clients would perceive them as a "stupid white person."

The anxiety of white therapists in cross-racial dyads is well-documented in the literature (Knox, et al., 2003; Qureshi 2007; Utsey, Gernat & Hammar, 2005). Richeson & Shelton (2007) point out that cross-racial interactions can be anxiety provoking because white individuals are often worried about appearing prejudiced to their patients of color. Similarly, other authors have written about white therapists' fears of asking the wrong questions, or not knowing how to ask the right ones, which lead them to worry that they will hurt their clients or expose their own ignorance (Cardemil & Battle, 2003; La Roche & Maxie, 2003).

Participants noted that working with African American patients often involved feelings of shame in encountering their own racism, power and privilege, and in discovering their own lack of knowledge regarding race-related issues. As one participant noted, working cross-racially for him, involved what he described as "shame management:"



Am I going to make a mistake? I mean yes, of course I'm going to make a mistake as a therapist, but if I make the mistake that is attached to race, I will feel ashamed. I think that's what we struggle with as white people.

Therapists interviewed felt embarrassed and self-conscious about what they didn't know about their client's racial experiences and sometimes found themselves overcompensating for this lack of knowledge:

I felt embarrassed by what I didn't know and I was trying to make up for not feeling like I was qualified to do psychotherapy [with someone] who was so different from me and was facing so many day to day challenges that I didn't know how to deal with.

Experiences of shame appear to be a common and inevitable phenomenon in therapy in general and cross-racial work in particular (Davies, 2004; Knight, 2013; Nolte, 2007, Suchet, 2004). As Suchet (2004) notes, "We all carry the haunting presence of shame and guilt as the heritage of our history, soaked as it is in the trauma of oppression, whether that is slavery, apartheid or anti-semitism (p. 430)." In writing about her treatment of a black South African patient, white therapist Zelda Knight (2013) noted a wish to retreat from discussing racial difference for fear of exposing her own prejudice and negative thoughts about her client's race. Indeed, she notes a common wish of white therapists to dissociate from their racialized biases, particularly if they see themselves as liberal or anti-racist. However, as Knight asserts, shame is an important part of cross-racial work as it is often evoked in "examin[ing] unprocessed unconscious racial issues" (p. 25), which if left unexamined can significantly impact cross-racial treatment.

In encountering one's shame and working with anxiety in cross-racial work, therapists also noted a need to practice humility and leave their ego at the door. This humility in session included everything from not taking comments and interactions arising in cross-racial work personally, to knowing one's limits and motivations in working with a black client. Participants expressed the importance of taking a stance of curiosity and acceptance towards oneself and one's lack of knowledge in cross-racial work and of acknowledging one's shame and prejudices rather than being paralyzed by them. As one subject noted:

It is shameful when your racism is exposed. But we can be big boys and girls and deal with it. Own up to it and not think that we're such terrible horrendous people, just because we have does and dads of racism inside of us.

**Race is essential to client conceptualization and presenting problems.** All subjects saw race as critical to conceptualizing their African American clients and understanding their presenting problems. Participants asserted its role as a central organizing principal and often relied on psychodynamic theory to inform their answers. Therapists interviewed discussed clients' race in terms of patients' views of the self and others, attachment, and identity formation and integration. One subject asserted:

I think [race] colors the person's object world, colors the sense of self, their expectations of the environment. It determines who are safe attachment figures and who aren't, it affects everything, object relations, self-object experiences. All the hits in the psychodynamic hall of fame.

This centrality of race in individual and collective experience, and in working with African American patients is well documented in the literature (Allen-Meares &

Burman, 1999; Carter, 1995; Comas-Diaz & Jacobsen, 1991; Paris-Anez, Bedregal, Andres-Hyman & Davidson, 2005). In speaking of this fundamental role of race for African American patients, Thompson (1996) notes blackness is, “A grid upon which every aspect of psychic development is constructed (p. 124).” Many scholars note that for African American individuals, race is something that permeates their daily lives and therefore should be expected to enter into the therapy in many forms throughout treatment (Franklin, Boyd-Franklin & Kelly 2006; Kelly & Boyd-Franklin, 2005; Smith, Allen, & Danley, 2007). In this way, participants interviewed tended to see race as underlying and impacting clients’ lived experiences, and therefore, influencing subjects’ psychodynamic conceptualization of the patient and their presentation in therapy.

At the same time, subjects also included the socially constructed nature of race in their conceptualizations and discussed how family, culture, society, and politics could shape a client’s experience of race and their presenting problems. One participant offered:

[I try to think about the] culture that they live in currently. The culture they grew up in, and their experiences in this society dealing with race...I had one patient...she had an African American father and a white mother.... she had one foot in each world. She had made it in the white world, but she felt some kind of draw back to her [African American] roots...and she was living out those conflicts [in her life and relationships]

While, many researchers have criticized the lack of the sociopolitical within psychodynamic theory and therapy (Moodley & Palmer, 2006; Sue & Sue, 2002), subjects interviewed appeared to incorporate context into their thinking about African

American clients and to examine how power and privilege associated with whiteness impacted client presentation. Many subjects in the current study appeared to follow Leary's (2012) advice to examine the, "critical role that public environments play in shaping individual subjectivities, implicit attitudes, and especially our psychic experience of race (p. 287)" and did so within a psychodynamic framework.

For all subjects, understanding their African American patients' experiences and presenting problems, also involved appreciating the impacts of racism. Here, subjects reflected on African American patients' conscious or unconscious sense of alienation, marginalization, and humiliation as a result of race-related injury. Participants acknowledged thinking about their client's internalized or introjected racism and how this impacted a patient's sense of self, others, and the future. Others subjects noted conceptualizing their clients within the context of a society that carries the legacy of slavery and inflicts the traumas of overt racism and pervasive microaggressions.

Kimberlyn Leary (2012) asserts, "in the everyday life of communities, racial stereotypes, prejudice, and discrimination affect real persons and leave real pain in their wake....they distort developmental trajectories and bankrupt narcissistic investments in the self (p. 283)." Understanding the role of modern day racism particularly as it manifests in racial microaggressions and microinvalidations has been seen as essential in understanding the experiences of African Americans (Sue, Capodilupo, & Holder, 2008). Of note; however, subjects in the current study stated that while they typically attempted to incorporate racism into their conceptualization of a client and their presenting problems, it was often not until well into the therapy that a patient would feel safe enough to discuss the full trauma of racism with their white therapists. As one subject related:

With African American people in my experience there's usually some connection [to the presenting problem but] sometimes it doesn't emerge right away. I remember an African American physician that I treated...I tried to get him to talk about how there might be things that he would notice in himself about my being white and his being black and we could reflect on and he said no...But two and a half years into the treatment he began talking about...the constant humiliations of being the token black person...that was a big part of his therapy, but it didn't emerge until the third year.

Thus, contrary to the literature which often criticizes psychodynamic therapy for not attending to issues of race and socio-political factors in treatment, current participants freely spoke of the centrality of race to their conceptualization of their African American patients and repeatedly spoke of how extrapsychic factors (such as racism) could impact the treatment.

**Talking about race and difference deepens the work.** All eight therapists interviewed unequivocally noted that they discussed the racial difference between themselves and their African American patients at some point in the therapy process. Participants varied stylistically as to when they brought up racial difference. Some preferred to introduce the topic as a part of their intake process, while others noted that their decision to bring up race was often based on client readiness and receptivity. While, some subjects reported that organizational demands or patients with more severe psychopathology or in crisis could serve to delay or limit the discussion of racial difference in treatment, all agreed on the importance of doing so. Participants related a desire to signal to their patients a willingness to discuss race and to convey that no topic

would be off limits. As one therapist noted, “I want to put it [race] out there...that this is something I’m open about.” As another commented, “Even if they’re not ready to go there, [people] are glad to get the message that this [racial difference] can at least be named like anything else.”

Therapists interviewed also noted that if they did not bring up racial difference in the intake, the decision to discuss it in subsequent sessions often involved a feeling in the room. Subjects noted that talking about race in session often was prompted by a “feeling in the air”, a sense of something “intrusive in the room” or a feeling that there was an “elephant in the room, that people are skimming around.” Subjects alluded to qualities of patients’ body language, affect, and non-verbals, as well as their own countertransference, as contributing to the overall gut feeling that the timing would be right to bring up racial difference. Other subjects noted that client’s meta-statements and transference narratives about race in general often signaled to the therapist that race and difference were being activated between them.

While some theorists place the onus on the therapist to bring up racial difference in a treatment relationship (Qureshi, 2007), others note the importance of the therapist following the client’s lead. In a study of 16 cross-racial treatment dyads consisting of a white therapist and a patient of color, those patients who attached higher value to their own race, ethnicity and culture, were found to appreciate when racial difference was discussed in the treatment. Those patients, however, who viewed their own racial, ethnic and cultural identities as less important, were less likely to see these factors as being important to the therapy (Chang, & Berk, 2009). Thus, while researchers recommend discussing racial difference in the treatment process (Knox et al., 2003; Thompson,

Worthington & Atkinson, 1994; Zhang & Burkard, 2008) the timing of this intervention, as subjects in the current study asserted may best follow the client's lead.

In reflecting on the impact of addressing race and racial difference with their African American clients, a majority of subjects noted that it had been helpful to the treatment process. Participants spoke of how discussing race led to a greater sense of trust in the therapy relationship, deepened the work by leading to new insights and new ways of thinking about patient's issues and presenting problems, and provided the client a sense of relief that they did not have to hold racial content alone in the therapy dyad. Of those therapists who discussed a time in which bringing up race had been detrimental to the therapy relationship, all participants seemed to focus on their own anxiety about the topic and lack of readiness as getting in the way of the process. As one participant stated, "I don't think it was helpful for me to bring it up the way I did the first time...I [was] so careful to be inoffensive that I think at times I may well have alienated people without knowing."

In most cases participants noted that even if bringing up racial difference was at times difficult, anxiety provoking, or ill-timed, that it was rarely if ever a mistake:

I don't think I've ever felt it's been detrimental... It's not like it's hurtful it's always good to put something out [there]... You want to model that you can be spontaneous and say what's on your mind and if it doesn't go over well that's ok, and conflict is ok... I would hope that people would be able to have those kind of relationships in their lives.

Studies of cross-racial therapy with white therapists and clients of color have found similar positive impacts, and have noted that discussing racial difference is

associated with increased patient disclosures, higher treatment satisfaction, and a better therapeutic alliance (Knox et al., 2003; Thompson, Worthington & Atkinson, 1994; Zhang & Burkard, 2008). In the current study, subjects across the board broached the topic of race and difference with their African American clients and tended to follow their clients' lead. As a result, subjects often described discussing race as a turning point in the therapy that increased the sense of trust in the relationship and took the work to a new, deeper level.

**Power and privilege impact therapy process.** In discussing psychoanalytic therapy process, subjects noted dynamics of racial power and privilege permeating the therapeutic relationship. Specifically, many participants spoke of the overt or subtle influence of US African American-white racial dynamics on the transference/countertransference relationship and in enactments in the therapy.

With regard to transference and countertransference several therapists described manifestations of a dynamic, which included an empowered and privileged white clinician and a disempowered and/or marginalized African American client. Transference reactions included the client seeing the therapist as a white oppressor, as holding social and/or economic privilege, as being racist, and/or as being clueless to race-related issues due to their majority positioning.

In discussing countertransference reactions, therapists noted several felt power differentials between themselves and their African American clients and a desire to repair current and past racial wrongs. Therapist countertransferences included feelings of guilt, overcompensating for racial inequality, and a tendency to see their African American clients as more disadvantaged, marginalized, or less agentic than they actually were.



These countertransferences sometimes resulted in participants exhibiting a hypervigilance or greater level of attention with their African American clients, infantilizing them, or to projecting greater hardship onto their lives. These reactions also played out in several polarized enactment patterns that included: the empowered superior white therapist and the disempowered inferior African American client; the white protector and African American victim, the white objectifier and African American objectified; the African American racist and white collaborator; and the African American aggressor and white victim.

Several authors speak of the inevitability of the entry of racial power dynamics into the treatment relationship. Some posit that the inequality of the therapy relationship, which casts the therapist as expert and the client as the recipient of services (Aron, 1996; Hoffman, 1996; Renik, 1996; Shonfeld-Ringel, 2000) may activate racial dynamics of exclusion and marginalization, particularly when the therapist is of a majority background and the client is of a minority background (Shonfeld-Ringel, 2000). Others have noted that because both patient and therapist bring their own unique racialized subjectivities into the consulting room, that cross-racial therapy with a white therapist will inevitably contain themes of power and privilege and expose the therapist's racism. These scholars state that it is impossible to separate the therapy relationship from the socio-political and historical context of racial atrocity and inequality in the US (Curtis-Boles, 2002) and assert that inevitably in therapy, "our positions...mirror the historical positions of those with and those without (Knight, 2013 p. 27)."

The transference/countertransference reactions and enactments encountered by participants in the current research, have been documented in the literature. They include:

white guilt, the oppressor and the oppressed, the devalued client, the black or white victim and/or aggressor, and the white savior or altruist, (Chin, 1994; Gorkin, 1996; Knight, 2013; Shonfeld-Ringel, 2000). While some authors note that white therapists and clients of color often play multiple roles along the “marginalization continuum” (Shonfeld-Ringel, 2000), others state that unconscious prejudices often coalesce around historical racial lines (Perez-Foster, 1999) similar to the experiences of subjects in the current study. Thus in the present research, participants frequently encountered dynamics of power and privilege in their treatment of African American patients and spoke of how these dynamics pervaded critical aspects of the therapy relationship from an analytic point of view.

**Difficulty working with racialized defenses.** In terms of therapy process, working with racialized defenses presented a dilemma for some of the participants interviewed. Subjects appeared to wrestle with seeing client’s self-reported experiences of racism in the world as either a reality, a defense against something else more painful or difficult, or both. Subjects noted that for many of their African American patients, traditional psychoanalytic defenses (in particular denial, introjection, projection, and intellectualization or isolation of affect) could be used to protect a client from the pain of living in a racialized and racist society. Other subjects; however, noted their African American patients could sometimes use race as a defense against another disavowed emotion (e.g. intimacy or assertiveness) or aspect of identity (such as sexual orientation). It was this latter use of race as a defense against something else that was the most difficult for white participants to disentangle.

While subjects interviewed appeared to have less difficulty acknowledging and working with client defenses that were turned on the self or involved the self, such as internalized racism or denial of racial issues in general; subjects seemed to have more difficulty with projected racism onto an “other”, ultimately questioning either the validity of the expressed racism, its severity, or its defensive nature. In speaking of the therapy relationship, some subjects noted feeling at times that race became an issue in the dyad as a way of maintaining distance between the therapist and client. One subject spoke of the challenge he faced in discerning what were a client’s real and accurate fears of not being understood in treatment due to the racial difference, and what were projections based on the client’s fears of intimacy and connection with the therapist:

Well they [my clients] wouldn’t use those words, but I’d say they bring it up [racial difference] a fair amount. Often it’s in the service of resistance...I’m a little cautious to say that because I don’t want to sound like I’m discounting it but I think...it’s just to say, “oh you don’t understand because you’re white” to try and... discount whatever I have to offer.

Other subjects noted holding a dialectic when working with racism in session:

Sometimes they [my clients] only find out that they assumed that I would have subtle racist attitudes towards them when they feel the absence of those. And sometimes they do pick up on subtle racist things that I’m not in touch with that I may have conveyed to them.

This particular subject went on to discuss that holding multiple realities with a patient (i.e. that they were experiencing racism and that they were possibly projecting racism) was important.

The literature around working with racism and racialized defenses mirrors the experiences of the subjects in the current study, on the one hand looking at racism as a form of projection or a defense against disavowed parts of the self (Akerman & Jahoda, 1950; Herron, 1995; Javier & Redon, 1995) and on the other hand a phenomenon rooted in a race-based reality particularly for persons of color (Altman, 2010; Curtis Boles, 2002; Leary, 2012; Sue et al. 2002). In writing of black-white cross-racial treatments, Kimberlyn Leary (2012) a psychoanalyst notes a tendency of white therapists to question the validity or veracity of a minority client's reported experiences of racism. In discussing the work of a white colleague, Leary notes:

When her patient began to tell a story of rudeness and inconsiderateness at work by her white superior, which the patient ascribed to racism, the therapist candidly reported that there was only one problem. She wasn't sure she believed her patient...she wondered if maybe her patient was hypersensitive. How could...(the therapist) know if the problem was 'really about race' (p. 282)

In her article, Leary attributes this questioning of racism to the therapist's hope that problems are not just about race (Leary, 2012). Wachtel (2007) on the other hand asserts that with racism, it is always difficult to ascertain what is real versus what is perspective and dynamics stating, "People are all – always – in the position of trying to sort out what is real from what is their personal take, and they all do this imperfectly (p. 135)."

Authors from a multicultural standpoint; however, caution against not recognizing expressions of racial content or racism as fully real, and warn of the possibility for therapist microaggression or microinvalidation in so doing (Sue et al., 2007). As Curtis-

Boles (2002) asserts, “It is essential in understanding and clinically intervening with African Americans that the impact of racism, discrimination, and color prejudice be addressed. A theoretical or clinical orientation that does not take these factors into account, risks distortion and misinterpretation by minimizing the ways in which social, political, and economic factors impinge upon mental health, psychological well-being and coping styles of black people (p. 206).”

In this way, the responsibility of the therapist working cross-racially lies in not only processing client’s reactions to and defenses against racial content, but also helping them to acknowledge and adjust to living and working within a world that contains very real racist dynamics. The challenge of the subjects in the current study in working with racialized defenses is further articulated by Leary (2012), highlighting the socially constructed nature of race itself, “on the one hand, race is never ‘really real’; on the other, the effects of racism have material impacts that exist beyond trope (pp. 284).” Thus, while some psychoanalysts assert the importance of looking at race and racism using the lens of defense and the intra-psychic, the incorporation of the socio-political reality of persons of color cannot be ignored. In the experiences of the participants in this study, it appeared that they often held both realities for their African American patients – seeing instances of racism as reality but also listening for ways in which it might or could be used in the service of denying other painful aspects of their reality.

**Systems can inhibit cross-racial work.** While most subjects in the current study worked in private practice at the time of the interview, two subjects worked in organizational settings either separate from or in addition to private practice. These two subjects throughout the interview repeatedly returned to the ways in which systems could

serve as a barrier to discussing and working with race and difference in therapy. Both of these subjects discussed how limits on the number of sessions, preferred organizational theoretical orientations, and systems influences on treatment goals could obscure a focus on race.

For one subject working in a college counseling center, time-limited and problem-focused therapy necessitated by a large student body and a lack of counselors, appeared to reduce the scope of what could be addressed in treatment. This subject noted that unless race was directly connected to the presenting problem, and overtly stated or seen by herself or the patient, that it would not be addressed beyond the intake process. In answering a question about working with racial identity integration in treatment this subject laughed and responded:

You're assuming we have the time to do that kind of thing...Those are the kinds of things that start emerging when there's a lot of trust...and also a lot of time. Where you can kind of sit back and explore the meanings of these things. For some people it's right on the surface and what they present with. "In my school I had this experience, I was bullied for this and this reason, I was the only person in my class who was x and we got along but I was very well aware of it," so there are times when it's very explicit. But if...it's more of a subtle [thing] then it's not going to come up here because we don't have the time. We don't take the time, and we don't have the time.

Similarly this subject noted that racism very rarely came up in the treatment due to the problem-focused nature of the treatment which often kept it "out of sight" even though

this participant believed that there were times that it needed to enter into the conversation between herself and her clients.

A second subject who discussed organizational barriers to racial competence noted how exploring race and racial difference was not always in line with the treatment goals of the semi-correctional setting in which he worked and the modality (group therapy) used. Because of this, race tended to not be as directly addressed as in other settings, like private practice, in which he had previously worked:

When I did have a private practice...I'd be much more direct [about racial difference]. I'd bring it up much sooner... sometimes I'm stifled by doing co-therapy [in my current setting] and so I don't bring it up as quickly just because I know I'm going to have to defend myself for it.

The ability of organizations to impact if and how diversity, including race is discussed and addressed in the workplace is well-documented. From an organizational psychology or systems perspective various aspects of an organization can impact how issues of culture and difference are acknowledged and addressed both amongst staff and between staff and consumers (Kelly, Azelton, Burzette & Mock, 1994). From a treatment standpoint, APA guidelines on multiculturalism (APA, 2003) encourage clinical service organizations to examine the ways in which they facilitate or obstruct multiculturally competent practice. From a psychoanalytic perspective, Neil Altman (2010) has asserted that, "context is an inextricable part of the psychoanalytic field (p. 189)," and has called upon practitioners to consider how systems and clinical/organizational contexts impact the treatment dyad. While the current study focused on the experience of white therapists with their African American patients within the context of psychoanalytic treatment,

themes emerging from practitioners working in clinical organizations, highlighted the ways in which systems can have a profound impact on whether or not and *how* race and difference is addressed in treatment.

**White therapists evolve over time.** Another theme that emerged in the current study involved the ability of white therapists to become more sophisticated in their approach towards cross-racial work. Nearly all subjects reported an evolution in their work with clients of color and African American clients in particular. In reflecting on their careers, participants noted a significant change in their feelings and attitudes towards race and cross-racial treatment over time that in turn impacted their work and behaviors in session. Subjects found themselves becoming more racially and culturally aware with time and experience, feeling less self-conscious and anxious about working with race in therapy, and experiencing decreased feelings of white guilt when working with African American patients. As one therapist reflected:

I'd like to think I'm less overcompensating and less self-conscious. I think my early experiences with African Americans made me feel so guilty, not because of anything I did, but just because I wasn't aware.

As participants reported an increased confidence in their cross-racial work they also described feeling less defended and subject to shame in discussing race, more able to encounter and accept the inevitability of their own racism, and less self-conscious about their lack of knowledge or awareness about certain racial or cultural issues.

Changes in attitudes and feelings towards cross-racial work also seemed to impact subjects' behaviors in session. Many subjects reported that they were more willing and able to directly and explicitly discuss race and racial difference with their African



American clients as they progressed in their careers. Participants found themselves being less tentative and cautious around issues of race in the treatment and less prone to overcompensate or overextend themselves as a way of undoing their own unprocessed white guilt or discomfort. Most subjects indicated that with time and exposure to cross-racial work, they were able to integrate race and racial issues more seamlessly into their everyday practice. As one subject indicated, cross-racial work seemed to come more easily to him over time:

Well I mean [my attitudes and approaches to cross-racial work] have matured.

I'm more open today probably. Probably less self-conscious today than I was. It just comes naturally.

Interestingly, while participants highlighted the experience of increased racial competence over the course of their careers, they also warned of a tendency to plateau or regress in this area without continued professional development in or exposure to working with clients of color. As one subject painfully acknowledged:

If we're looking at the curve of time and my racial sensitivity, it's sort of gone like this. [subject makes a bell curve where the right hand side ends higher than the left, but is lower than at the peak]. I think when I started I wasn't as aware, and [I] got more aware and maybe [had] some peak of awareness. Then as I've had to worry more about financial stuff and raising a family and send[ing] the kids to college, I'm probably a bit more willing to go for the white people who can pay. So it's like a bell curve...It ends higher than it started, but lower than its peak...It's something I regret, but it's a reality I have to deal with.

While some white authors have reflected on their own evolution in racial competence over time (Altman, 2010), few authors have directly explored the mechanisms underlying this evolution. One factor possibly contributing to the growth of participants in the current study may be related to the development of therapists' white racial identity.

Racial identity theory explores psychological processes within a cultural or sociopolitical context in which power is unequally distributed according to race (Helms, 1984; Helms, 1995). According to racial identity theory, individuals progress through stages that involve varying cognitive, behavioral, and affective responses to race within the context of one's own environment (Helms, 1995). Within racial identity development there is understood adaptive or healthy direction of change (Parker, Moore & Neimeyer, 1998), which ultimately moves an individual towards the adaptation of a non-racist identity.

The dominant theory of white racial identity development created by Janet Helms (1995) asserts that whites further along in the process endorse attitudes, behaviors, and emotions that demonstrate acceptance and appreciation of diversity and multiculturalism; exhibit higher levels of interracial comfort and openness to racial concerns; accept personal responsibility for individual, institutional, and cultural racism; and strive for a nonracist identity (Parker, Moore, & Neimeyer, 1998). Subjects in the current study appeared to exhibit the more mature attitudes of an advanced white racial identity by cognitively and affectively engaging dynamics of power, privilege and difference in the treatment; examining and being open to their own racial biases, and attempting to understand the manifestations and implications of their own racism. As supported by the

literature (Constantine, Juby & Liang, 2001), this increased racial identity development may have positive implications for the treatment of clients of color and be associated with greater multicultural competence by white therapists in cross-racial treatments.

Participants self-reported evolution in their cross racial work over time, therefore may have been reflective of increased racial identity development over the course of their careers, and a resultant ability to work more adeptly with race and racial difference in session.

**Psychodynamic therapy as a treatment for all.** In the current study, subjects spoke of the ways in which psychodynamic/psychoanalytic therapy could conceptualize and engage issues of race, racism and difference in the treatment both apart from, and above and beyond, other forms of therapy. Subjects appeared to appreciate the ways in which dynamic treatment could make room for conceptualizing racism on both an individual and societal level. Others acknowledged how relational theory placed the onus on the therapist to examine their own impact on the treatment dyad (including personal bias and racism) through the transference/countertransference relationship. While subjects acknowledged the Westernized subjectivity of some psychoanalytic thinking and asserted that certain psychoanalytic goals regarding separation individuation for example, sometimes conflicted with cultural mandates of interdependence and connectedness, subjects noted that a more relational approach often took a strong accounting of culture and context.

Some subjects, including one working at a college counseling center, noted that other orientations, including traditional cognitive behavioral or more problem-focused therapies, often did not allow for the exploration of racial issues unless they were directly

and explicitly related to a presenting problem, due to the time-limited nature of the interventions. Finally, one subject in defending the use of dynamic therapy for persons of color, equated certain contemporary criticisms regarding its inappropriateness for persons of color to a subtle form of racism:

I do want to comment on something that I think is a symptom of racism and that's the idea that a psychotherapy that is very helpful for white people with needs, would not be the right therapy for black people with needs. I think there's racism in the idea that this talk therapy... might not be their mode... I've never seen any evidence that African American patients can't use talk therapy or psychodynamic therapy... so the whole idea that psychoanalysis was a treatment for the privileged and that there was no applicability to black people who should be given something more useful to them, I think contain[s] huge amounts of racism and it protected people from having to exert the discipline to find a way to cross whatever boundaries there were and make what they had to offer relevant to people from different backgrounds.

Much of the literature on race in psychoanalytic therapy and the cultural competence of psychoanalytic practice involves either the criticism or defense of its use with diverse populations and persons of color. Some authors have criticized psychodynamic theory's Westernized subjectivity and emphasis on individualism and the intrapsychic, as excluding contextual and socio-political factors that are essential to understanding race in therapy (Comas-Diaz, 2007; Curtis-Boles 2002; Greene, 2007; Herron, 1995; Moodley & Palmer, 2006; Suchet, 2004; Sue & Sue, 1999; Walls, 2004). Others; however, have noted that dynamic theories and principles are not only relevant

and useful for individuals of all racial backgrounds, but are helpful for exploring cross-racial dynamics and race in the therapy relationship (Altman, 2010; Javier & Rendon, 1995; Perez Foster, 1993) through concepts such as the transference and countertransference (Holmes, 1992; Leary, 1997, 2001; Yi, 1998), attachment (Harris, 2007), the self (Bonvitz, 2009; Dalal, 2006), and defenses (Holmes, 1992).

Subjects in the current study seemed to ally with the latter camp and shared a belief in the utility of psychodynamic therapies for persons of color in general and African Americans in particular. While participants acknowledged that the psychodynamic field has a long way to go in more fully integrating traditional theories with a multicultural perspective, many found dynamic thinking to be an asset in working with issues of race and difference, providing a language and structure with which to think about racial issues in the treatment dyad that ultimately facilitated a deeper discussion and analysis of race in therapy.

### **The Person of the Researcher**

According to Kvale (1996), examining researcher bias and perspective is critical to the qualitative research process as the positioning of the principal investigator (PI) can impact data collection, analysis, and interpretation. In the present study the principal investigator was a white woman in her early-mid 30's with an interest in psychodynamic psychotherapy and race in treatment. The PI created all instruments used, administered all interviews, analyzed all data, and interpreted the results. In this way, the researcher's identity and identifications may have impacted study design and implementation, and the analysis of information obtained.

One way in which scholars have minimized the impact of bias is through employing a diverse team of researchers to carry out the work. In the present study the PI's dissertation committee consisted of an African American female clinical psychologist and professor practicing from a family systems perspective with an expertise in multicultural psychology, and a white female clinical psychologist and professor practicing from a psychodynamic perspective. In addition, the PI participated in a dissertation working group consisting of other graduate students in clinical and school psychology from a variety of racial and ethnic backgrounds and identifying with diverse theoretical orientations (including CBT, family systems, and psychodynamic therapy). The purpose of this group was to provide peer feedback on all stages of the dissertation process. While the researcher's participation in this working group may have mitigated investigator bias, the fact remains that the PI carried out all aspects of the research herself.

In considering the PI's identity, her positioning as a young white female graduate student may have allowed subjects to feel more comfortable sharing their experiences with and reactions to cross-racial work. This may have contributed to the sense of openness that participants exhibited in their interviews and allowed them to share more of their internal experience. If for example, the PI had identified as African American or a person of color it is possible that subjects may have felt more constrained in their answers. As one subject noted, prior to meeting the PI he had believed that she was black and wondered aloud during the interview how this may or may not have impacted his answers. Thus in considering the findings of the current study, it is important to be mindful of the impact of the person of the researcher on the data obtained.

## **Limitations of the Current Study**

A number of limitations should be considered in interpreting, utilizing, and applying the results obtained in the present study. Firstly, factors impacting the generalizability of the results included a small sample size, selection bias, and a non-random sample. With regard to sample size, participants consisted of eight white therapists identified by their connection to an academic institution in the mid-Atlantic and to a New Jersey psychoanalytic institute and membership organization. Geography and professional affiliation may have impacted the results obtained and the generalizability of findings to the larger population of white therapists working with race and difference in African American-White treatment dyads. Selection bias may have also impacted the findings. Specifically, those subjects responding to advertisements for this study and ultimately selected to participate may have been those who: 1) had an interest in cross-racial work or issues of race and racism, 2) had more experience or training working cross-racially, 3) were more advanced in their racial identity development, and/or 4) may felt more comfortable reflecting on issues of race and racism in their work. Current findings, therefore, may not be indicative of the average white psychodynamic therapist working cross-racially. Additionally, because this was a qualitative study, the current research did not make use of a random sample or control group, further impacting the generalizability of the results.

A second limitation of the current study included restricting the sample to those therapists who were licensed and had been practicing for five or more years. In addition, the average age of the current sample was 60.4 years old (range of 51-71 years old), with the majority of participants completing their training in the 1970s, 1980s, and 1990s.

Because the range of data was restricted to those subjects who had been practicing for five or more years and the sample skewed older and included those who received their training 15-30 years ago, it is possible that present findings are not reflective of the experiences of the current generation of dynamic therapists, or therapists in training, who may have had more exposure to working with race in therapy either on a graduate level or at an analytic institute. Restricting the range of data to subjects with five more years of experience and interviewing participants trained over a generation ago may have compromised the validity of the data.

### **Implications**

**Implications for future research.** The implications for future research suggested by the current study are vast. Few studies have examined the experiences of white therapists working cross-racially, and even fewer have explored these experiences within a psychodynamic framework. As Qureshi (2007) states, “interracial and intercultural psychotherapy process research is in its infancy (p. 468)” leaving the field wide open for further inquiry.

Several directions for future research are apparent. First, as this is one of the only studies examining the experiences of white psychodynamic therapists working with African American patients using a qualitative study design, replication of this study and its findings are warranted. Quantitative research testing of the theories derived from the data would also be helpful to determine the generalizability of results. Second, because the positioning of the principal investigator as a white female interested in psychodynamic therapy and race in treatment may have biased the results obtained, replicating the current study employing a diverse research team at all phases of the



research process (e.g. study design through data collection, analysis and interpretation) would also serve to reduce investigator bias.

A third area of future inquiry involves examining therapy process in cross-racial dyads consisting of therapists and patients of various racial backgrounds. While the current study found that dynamics of power and privilege permeate a white therapist's treatment of African American clients, it would be interesting to see if and how these same dynamics play out in dyads of varying racial compositions including white therapists treating Asian or Latino clients, or therapists of color treating white clients and/or clients of differing racial backgrounds. Because power dynamics and societal disparities often enter into the therapy relationship (Yi, 1998), an important area of future research could involve examining how US socio-political dynamics emerge in treatment dyads of differing racial compositions.

A fourth area warranting further study lies in the examination of therapy technique in cross-racial treatment. In the current study, subjects noted that talking about and working with racial difference in therapy served to deepen and advance the treatment. It was beyond the scope of the current study to examine how African American clients received white therapist interventions around race. It is possible; however, that what white therapists in the current study experienced as "deepening the work" could have been perceived by the client as helpful, intrusive, irrelevant, or something else. While some researchers have employed quantitative and qualitative methods to better understand the experiences of ethnic and racial minority clients in cross-racial therapy (Chang & Berk, 2009; Pope-Davis, et al., 2002), few researchers have examined the concurrent experiences of both the client and the therapist as therapy

unfolds. Studies of therapy transcripts would be useful to uncover how psychotherapy process progresses in cross-racial dyads and those factors or techniques that are critical to client satisfaction and treatment outcomes. Studies of cross-racial treatments examining both therapist and client experiences of race in therapy could be critical to discovering factors that are essential to successful cross-racial work.

Finally, while the current study explored therapy from a psychodynamic perspective, it would be interesting to see how race and racial difference is or is not addressed in treatments grounded in other theoretical orientations. As subjects in the current study noted, those treatments that were more time-limited, solution focused, or from a CBT perspective often did not allow for a more in-depth discussion of race and racial issues in the therapy relationship. While other studies of cross-racial therapy have explored the experiences of both white therapists and therapists of color from a variety of theoretical orientations and approaches (see Knox et al., 2003), none have isolated theoretical orientation as a variable impacting therapist racial competence and clients' experience of cross-racial therapy. Examining how theoretical orientations and associated techniques can facilitate or inhibit working with race and difference would serve to broaden our understanding of cross-racial therapy from a variety of different perspectives.

**Implications for training.** The current study elucidated several implications for the training of white psychologists working with clients of color. Implications included a need for a more intense focus on race apart from other markers of identity in multicultural training, the need for affective and experiential work around race, the incorporation of race and multiculturalism into all coursework and training, an emphasis

on white racial identity development, and the need for more advanced levels of multicultural training.

Subjects in the present study spoke with disappointment about the level and types of multicultural and race-related training that they had received throughout their graduate education and careers. Many noted having only one required “diversity” course in graduate school, and minimal to no training in their analytic institutes. Consistent with the literature (Ponterotto, Fuyertes, & Chen, 2000) subjects indicated that most training they received centered on knowledge of the “other” (i.e. various racial and ethnic groups) and remained at the level of consciousness-raising, lacking the affective/experiential work and self-knowledge that they felt was critical to their understanding of and evolution in cross-racial work. As Sue et al. (1991) have asserted “immersion experiences” are essential to high-quality training and cultural competence. This affective work may also be critical for white therapist’s to engage their own racism and racial attitudes and to advance their white racial identity – factors that are integral to racial competence (Altman, 2010; APA, 2003; Constantine, Warren & Miville, 2005; Gushue, 2004; Sue & Sue, 2008).

In developing trainings for white therapists, graduate schools and analytic institutes should maintain a greater focus on race as opposed to other aspects of identity, work to more seamlessly integrate race-related issues into standard and foundational coursework, and provide affect-laden training experiences encouraging self-knowledge and the examination of one’s prejudices. Training from an anti-racist or social justice perspective may be particularly helpful in addressing the shortcomings identified by subjects in the current study as these perspectives facilitate the affective “interrogation of

whiteness” that many multicultural trainings neglect (Ahmed, 2008 in Pieterse, 2009) and confront and engage an individual’s defenses around race. Deepening training in these ways could have profound positive impacts on the delivery of racially competent mental health services in the field of psychodynamic therapy in particular and clinical psychology in general.

**Implications for white practitioners.** The current study offers several implications for white therapists working with African American clients. These include recommendations for a practitioners’ therapeutic stance and recommendations for practice and technique.

With regard to the therapeutic stance, subjects in the current study noted the importance of exploring one’s white racial identity, racism, and power and privilege as critical to cross-racial work. Subjects also discussed the importance of exploring their socio-political positioning within the context of US racial history and racial dynamics. Consistent with the literature (Altman, 2010; APA, 2003; Constantine, Warren & Miville, 2005; Gushue, 2004; Sue & Sue, 2008), subjects described self-knowledge, and not just knowledge of their clients’ racial experiences, as essential to racially competent practice.

Subjects also indicated that shame, anxiety, guilt, and humility were also a common part of their experiences of cross-racial work. As others have noted elsewhere (Knox et al., 2003; Qureshi, 2007; Richeson & Shelton, 2007; Utsey, Gernat & Hammar, 2005) subjects in the current study reported an anxiety about saying the wrong thing, experiencing a rupture over race, and exposing their own racism and prejudice in session. This anxiety sometimes led subjects to be more tentative, or conversely more hypervigilant, in their cross-racial work. While there exists a lack of research on the

implications of these reactions for cross-racial treatment, white practitioners should expect to encounter these feelings in their cross-racial work, and seek to understand and anticipate how these reactions may impact their clinical work and behavior.

A third implication involves the maintenance of racial competence for white therapists over time. While subjects noted that their sense of anxiety, shame, and self-consciousness about cross-racial work diminished over the course of their careers, participants noted that cultural and racial competence was a lens that could become clouded or lost without continuous efforts in this area. White therapists looking to maintain or deepen racial competence should consider it a life-long pursuit and continue to seek out opportunities for training, supervision, and exposure to cross-racial work throughout their careers.

Finally with regard to practice and technique, several recommendations can be gleaned from the current study. These include the importance of discussing race and racial difference to the therapy relationship, the expectation of encountering dynamics of power and privilege in the therapy process (in particular in the transference and countertransference and in enactments), and the importance of addressing and working with clients' experiences of racism in the treatment. Of note, one area of confusion expressed by subjects in the current study was working with the realities of the racism encountered by their clients and how these experiences mapped onto defensive structures. Given the importance of working with racism for clients of color (Curtis-boles, 2002; Leary 2012; Sue et al., 2007) white practitioners working cross-racially should seek consultation when finding themselves wrestling with their patients' experiences of racism

and attempting to determine both the reality of the experience and/or its defensive functioning.

**Implications for organizations.** Subjects in the current study who worked within an organizational setting noted the ways in which systems constraints could impact the ability to work with race in therapy. These subjects noted that time limits on treatment, theoretical orientation, and a problem-focused approach and/or treatment goals promoted by the organization could inadvertently obstruct therapists' abilities to address race and racial difference in session. Given the experiences of participants in the current study, institutions should examine how organizational policies may facilitate or inhibit racial competence, and how institutional goals and practices may obstruct discussions of race and racism particularly in treatment dyads in which the client may not feel empowered to broach the subject. While systemic constraints such as limits on the number of sessions and a more problem-focused approach may not be negotiable, organizations could establish policies to ensure that therapists make space to discuss race at various points in the therapy (for example at intake).

Subjects in the current study also asserted the need for more advanced and on-going training in race and multicultural issues in general. From an organizational standpoint, the establishment of workplace diversity committees or working groups could serve to create an organizational culture of reflection and evaluation around issues of race at the consumer, staff, and organizational levels. In addition, these committees could be important for developing tailored and intensive trainings or professional development opportunities around race and difference for staff members that might not be available in the field.

**Implications for the field of psychodynamic psychotherapy.** The current study also offered several recommendations for the field of psychodynamic psychotherapy. Participant answers reflected the importance of learning from colleagues, faculty, and supervisors of color and at the same time noted the lack of persons of color at psychodynamic institutes and the field of psychodynamic therapy in general. Attracting racial minority faculty, supervisors, and candidates of color is essential to raising the level of conversation around race at psychoanalytic institutes, and to asking better and more relevant research and practice questions. Racial diversity at institutes can serve to expand the clinical lens on issues of diversity within organizations that currently remain predominately white. Not only is attracting practitioners of color important to attracting clients of color and to ethical practice, but also as some have asserted, it is the *only* future for psychodynamic practice (Aron, 2011).

At the same time, psychoanalytic institutions should not rely solely on psychologists of color to educate the field, and should begin independently to “negotiate the margins” of psychodynamic practice to include broader socio-political constructs impacting the intra- and interpsychic (Leary, 2012). While subjects in the current study, without much dynamic training on race, often considered the socio-political in their treatment of their African American clients, the field should begin to devote more time, resources, and intellectual energy to integrating racial and multicultural competence at a foundational (versus elective) level. As one subject in the current study offered, looking to other fields such as family therapy or social work, where issues of race and culture are seamlessly integrated into research and practice may be important to learning how to do so within a dynamic framework.

Finally as current participants indicated, psychodynamic therapy in some ways is uniquely positioned to explore issues of race and difference in the therapy relationship through constructs such as the transference, countertransference, enactments, and concepts such as defenses and the unconscious. From a relational perspective the focus on the contributions of both the therapist and client to the treatment dyad creates space for the examination of race in therapy. Thus, while psychodynamic therapy currently has a lot to offer clients of color, as a field it should continue to evolve in the conceptualization and treatment of issues related to race and culture.

**Implications for policy and the field of psychology.** An important recommendation for policy within field lies in the establishment of specific competencies for cross-racial work. While the American Psychological Association established guidelines for multicultural practice in 2003, there still does not exist a formal position paper or guidelines establishing racially competent practice. This is particularly important in the US, given that racial dynamics inevitably enter into the treatment relationship (Curtis-Boles, 2002; Knight, 2013; Shonfeld-Ringel, 2000) and that addressing these dynamics can be crucial to racially competent therapy.

In establishing guidelines for racially competent practice, the field may wish to consider tying licensure and continuing education requirements to training in race in general, and in racism, power and privilege, and the exploration of therapists' racial identities. Subjects in the current study spoke of a need for more advanced trainings in race and the significance of continuously exploring and working with issues of race as a white therapist lest one regress. Establishing a hierarchy of training tied to CEUs and the maintenance of one's licensure could promote the development of a broader and more



intensive curriculum on race and would establish this as a priority area for therapists throughout their careers.

## **Conclusion**

The current study sought to illuminate how white psychodynamic therapists work with African American patients in treatment. Specifically, it hoped to determine how white therapists address and work with race and racial difference from a psychodynamic perspective. While some participant responses were consistent with the literature on cross-racial therapy, the present study remains one of the few, if not the only, study of cross-racial therapy within a psychodynamic framework and provides rich detail due to the use of qualitative methodology.

This study revealed that though the present sample considered race and difference as foundational to the treatment of patients of color that the training in racial competence from an analytic perspective and within the field of clinical psychology in general is lacking, as many subjects received little training at the graduate, post-graduate, or professional development level. In terms of conceptualizing clients from a dynamic point of view, contrary to the prevailing criticism of psychodynamic theory, a majority of the participants in this study considered race to be paramount, viewing it as an organizing principle upon which concepts of self, other, and society are formed. With regard to therapy process, all subjects described how US African American-white racial dynamics permeated the treatment relationship and contributed to unique racialized manifestation of power and privilege in the transference/countertransference, enactments, and defenses. While some subjects struggled with the concept of racialized defenses, specifically pulling apart what for a patient might be reality versus a defense against more basic

disavowed emotions, participants also noted the importance of working with and acknowledging racism in all of its subtle, overt, and internalized forms. An unexpected finding of the current study was found in the subjects who spoke of organizational and systems-level barriers to addressing race and difference in treatment. While this phenomenon has been discussed in the literature, the qualitative nature of this study allowed for a rich discussion of the ways in which organizations can obstruct racial and cultural competence. Finally, participants also emphasized the utility of psychodynamic thinking and approaches to working within a cross-racial relationship and countered those in the field that disparage psychodynamic therapy for not considering issues of race in treatment. While subjects noted that psychodynamic theory, research, and practice needs to evolve in such a way as to more formally include the socio-political within the treatment dyad, they also asserted the value of dynamic principles in addressing difference within African American-white therapy dyads and considered this to be a valuable approach to working with persons of color.

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## APPENDIX A

Subject: Seeking white therapists working with African American clients for study on race and psychodynamic therapy

Body: Are you a white therapist who has worked with one or more African American clients in the last five years? If so, please consider participating in a new study on cross-racial therapy relationships in treatment. White, doctoral-level, licensed psychotherapists who identify primarily as psychodynamic are being recruited for a doctoral dissertation study at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University.

Participants will be interviewed about their experiences conceptualizing, understanding and working with race and racial difference in cross-racial treatments. Results obtained will be used to inform the training and practice of therapists looking to work with diverse populations from a psychodynamic perspective.

If you are interested in participating or learning more about the study please contact Bonnie Gordic, Psy.M at 203.589.6761 or at bgordic@gmail.com for more information.

Interviews will last approximately 90 minutes and will be conducted in person or via telephone or Skype. All interviews will be audiotaped to ensure accuracy in transcription. Confidentiality of all data obtained is ensured. Participants will not be compensated for this study.

Study on Race and Racial Difference in Treatment  
Bonnie Gordic, Psy.M.  
Graduate School of Applied and Professional Psychology  
Rutgers University  
Piscataway, NJ 08854  
203.589.6761  
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## APPENDIX B

### Informed Consent Agreement

#### Working with Race and Difference: An Exploratory Study of Cross-Racial Therapy Relationships in Psychodynamic Psychotherapy

You are invited to participate in a research study. Before you agree to participate it is important that you know enough about the study in order to make an informed decision. If you have any questions about the nature of this study, please ask the principal investigator (PI). You should be satisfied with the answers you received from the PI before you agree to participate in this study.

#### **Purpose of the Study**

This study examines the experiences of white Psychodynamic psychologists working with race and racial difference in cross-racial therapy relationships. The study seeks to understand how therapists conceptualize, understand and work with race and difference in psychodynamic treatment. Of interest are how race and racial issues have influenced your relationship with patients of color and how it has impacted the goals, interventions and course of treatment.

The principal investigator (PI) is a doctoral student at the Graduate School of Applied and Professional Psychology at Rutgers University and is conducting this study as a fulfillment of dissertation and doctoral requirements. It is anticipated that 8-10 individuals will participate in this study. If you wish to be provided with the general results of this study, you should notify the PI, and this information will be shared with you at the completion of the study.

Study Procedures: You will be interviewed about your experiences working with clients of color and how you have understood, addressed and worked with race and racial difference in therapy. The interview will take about 1-1.5 hours.

Interviews will be audio taped in order to ensure accurate transcription and authenticity of the data obtained. Interviews will be transcribed and tapes will be destroyed after transcription. The PI will maintain any tape recordings, transcripts of interviews, or other data collected from you in confidence in a locked file cabinet. These materials will be destroyed at the end of the study.

Risks: The interview focuses on your experiences working cross-racially with African American patients in a treatment setting. It is the PI's belief that this will be a positive and thought-provoking experience for you. If however, in reflecting on issues of race and racial difference, you experience discomfort or distress recalling unpleasant memories or discussing matters of a personal nature, it is important that you notify the PI immediately so that she can discuss these feelings with you and provide you with referrals to local counseling services if necessary. Note that the study will not pay for any counseling services recommended following participation in this study. In this event, you would assume all financial responsibility for such services.

Benefits: Your experience and knowledge have tremendous value in helping the field of Psychodynamic therapy better understand how to work with race and racial difference in the treatment relationship. The information shared has the potential to help both white therapists and patients of color who are working together in a treatment setting. Results obtained could also be used to better inform the training and practice of future psychodynamic practitioners who are interested in working with diverse populations.

Additionally, the opportunity to share your own clinical experiences on this topic may be valuable to your own reflection and practice. There is no compensation for participating in this study.

Confidentiality: All records will be stored in locked files and will be kept **confidential** to the extent permitted by law. The data obtained from your interview will be stored on an electronic data file in the PI's password protected personal computer in order to keep it confidential.

The data will be available only to the research team and no identifying information will be disclosed. Audiotapes and other paper work will be assigned a case number. Your responses will be grouped with other participants' responses and analyzed collectively. All common identifying information will be disguised to protect your confidentiality. This will include changing your name and other demographic information (i.e. age, occupation).

Research Standards and Rights of Participants: Your participation in this research is **VOLUNTARY**. If you decide not to participate, or if you decide later to stop participating at any time during the interview, you will not lose any benefits to which you are otherwise entitled. Also, if you refer other individuals for participation in this study, your name may be used as the referral source only with your permission.

I understand that I may contact the investigator or the investigator's dissertation chairperson at any time at the addresses, telephone numbers or emails listed below if I have any questions, concerns or comments regarding my participation in this study.

Bonnie Gordic, Psy.M. (Investigator)  
Rutgers University  
GSAPP  
152 Frelinghuysen Rd  
Piscataway, NJ 08854-8085  
Telephone: 203.589.6761  
Email: [bgordic@gmail.com](mailto:bgordic@gmail.com)

Nancy Boyd-Franklin, Ph.D. (Chairperson)  
Rutgers University  
GSAPP  
152 Frelinghuysen Rd  
Piscataway, NJ 08854-8085  
Telephone: 848.445.3924  
Email: [boydfrank@aol.com](mailto:boydfrank@aol.com)

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:  
Rutgers University, the State University of New Jersey  
Institutional Review Board for the Protection of Human Subjects  
Office of Research and Sponsored Programs  
3 Rutgers Plaza  
New Brunswick, NJ 08901-8559  
Tel: 848.932.4058  
Email: [humansubjects@orsp.rutgers.edu](mailto:humansubjects@orsp.rutgers.edu)

I have read and understood the contents of this consent form and have received a copy of it for my files. I consent to participate in this research project.

Participant Name (Print) \_\_\_\_\_

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

Investigator Signature \_\_\_\_\_

Date \_\_\_\_\_

Informed Consent Agreement:  
Audiotape Addendum

You have already agreed to participate in a research study entitled *Working with Race and Difference: An Exploratory Study of Cross-Racial Therapy Relationships in Psychodynamic Psychotherapy* conducted by Bonnie Gordic, Psy.M. This form requests your permission to allow the Principal Investigator (Bonnie Gordic) to make a sound recording (audiotape) of your interview as a part of this research study.

You do not have to agree to be recorded in order to participate in this study.

If you do agree to audio-taping, the recording(s) will be used for analysis by the primary investigator (Ms. Gordic).

The recording(s) will be distinguished from one another by an identifying case number. Your name will not be used or linked in any way to the recording except through a case number held by the Principal Investigator.

The recording(s) will be stored in a locked file cabinet by identifying number not by name or other information that might disclose your identity. The tapes will be retained until the project is completed and the dissertation has been successfully defended. It is expected that the tape will be destroyed within four years after your interview.

Your signature on this form grants the Principal Investigator permission to record you during your participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Participant Name (Print ) \_\_\_\_\_

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

Principal Investigator Signature \_\_\_\_\_

Date \_\_\_\_\_

APPENDIX C

**Demographic Interview**

**Demographic Information**

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Racial and Ethnic Background: \_\_\_\_\_

Professional degree(s) & Year(s) Attained: \_\_\_\_\_

Year in practice:

Professional settings worked in throughout career:

Percentage of current caseload that is racially different from your own racial background (& list racial background of current clients):

Percentage of typical caseload that is racially different from your own racial background if different than above (& List racial background of typical caseload if applicable):

Three most common diagnoses in your individual adult caseloads:

What is the average length of treatment for your typical client? Does the average length differ in any way for clients from racial backgrounds that are different than your own?

Theoretical orientation and specialization:

Treatment specialty/focus:

## APPENDIX D

### Semi-Structured Interview

#### Multicultural Competence and Race: Understanding and Training Experiences

- 1) What is your definition of multiculturalism?
  - a. Prompt: what dimensions or aspects of the person does this include? (e.g. race, ethnicity, religion, socioeconomics, etc.). What role does race have in your definition?
- 2) What experiences have been most influential in your understanding of race in therapy?
- 3) Please describe the experiences you completed during your *graduate education* addressing racial issues in treatment and working with clients from different racial backgrounds than your own?
  - a. Prompt: didactic/non-practicum, supervision, practicum? Personal?
- 4) Please describe the experiences you completed *during your post-graduate education* addressing racial issues in treatment and working with clients from different racial backgrounds than your own?
  - a. Prompt: didactic/non-practicum, supervision? CEUs? Personal?
- 5) Please describe any analytic or psychodynamic training you completed both during and post-graduate school.
- 6) Please describe experiences you completed within your analytic/psychodynamic training addressing racial issues in treatment and working with clients from different racial backgrounds than your own?
  - a. Prompt: if no, why do you think these issues were not addressed?
- 7) Please describe any work you have done exploring your own racial identity?

#### Working with Race and Racial Issues in Psychodynamic Therapy

- 1) How do you prepare to work with someone of a different race than your own?
- 2) What role do you think race plays in a client's life and experience?
  - a. Prompt: consider both minority and majority clients
- 3) How do you think of race in conceptualizing a client and their presenting problem?
- 4) Consider both majority and minority clients. How has the subject of race come up in treatment?

- a. Who typically brings up the topic? When is it typically addressed? (beginning, middle, end of treatment)? What types of issues are addressed?
- 5) How do you make the decision to bring up race?
- 6) Have you ever purposely not addressed race in a therapy relationship? If so, what were the circumstances and how did you make that decision?
- 7) Describe a time in which you thought bringing up race was beneficial the therapeutic relationship. Describe a time when you thought it was detrimental.
- 8) Has the topic of white privilege ever come up in treatment? If so what were the circumstances and how did you address it? If not, why not?
- 9) How do you think about racism in your work? In what ways has it come up in the therapy relationship and treatment?
- 10) How do you think racism impacts a client?
  - a. Prompt: consider intrapsychic dynamics, object relations, development, etc.
- 11) Thinking back to a time(s) when you worked cross-racially, how has race come up in the transference/counter-transference relationship?
- 12) Have you ever experienced an enactment around race or racial issues?
  - a. Prompt: E.g. you and your client playing out dynamics of privilege, marginalization, racism, etc.?
- 13) Have you ever experienced a rupture in the therapeutic alliance based on race?
  - a. If yes, what happened? Was this rupture repaired and how did that come about?
  - b. If no, why do you think this is the case?
- 14) What is your experience of race and racial issues playing out in the unconscious?
  - a. Prompt: consider client or therapist fantasies, dreams, etc.
- 15) What is your experience of race or racial issues playing out in the client's defenses?
  - a. Prompt: E.g. denial of racial vulnerability? Racial splitting (in- vs out-group), etc.
- 16) How do you work with multiple racial selves in treatment?
- 17) Have you encountered a time when the goals of psychoanalytic psychotherapy clashed with a client's racial/cultural needs, goals, or experience?

- a. If yes, please describe
- b. If no, why not?

18) Are there any ways in which you find that you work differently with clients from majority vs. minority backgrounds?

<b>Closing Questions</b>
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- 1) What do you enjoy about working with clients from different racial backgrounds than your own?
- 2) What has been challenging about working cross-racially?
- 3) How have your thoughts, feelings, and approach to working with race and racial issues in treatment changed throughout the course of your career?
- 4) Is there anything I did not ask you about your experience with race and racial issues in analytic treatment that would be helpful to know or consider?
- 5) What has been your experience of participating in this interview?