

2022

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Recommended Citation

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The Structural Clinical model: Disrupting oppression in clinical social work through an integrative practice approach

Maria del Mar Fariña¹ · Peggy O'Neill²

Accepted: 23 March 2022

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Abstract

It is critical that clinical social workers become actively aware of the endemic processes and manifestations of racism, social inequities, structures and dynamics of white supremacy within and across organizational, supervisory and clinical relationships. The Structural-Clinical Model (SCM) is presented, providing a multi-layered and theoretically rich pathway for clinical social workers to examine the intricate, and multifaceted interconnections expressing racialized oppressive forces across macro, meso and micro systems that impact the totality of clinical practice. SCM integrates critical race theory, liberation psychology, and relational theories bridging long standing theoretical and conceptual divides. The SCM aims to de-pathologize clients, recognizing instead the pathology of white supremacy, racism, and other oppressive structural forces affecting organizations, relationships and people's lives, particularly those most racially, ethnically and historically marginalized within our society. The SCM is introduced with a structural assessment framework designed to explore how structural social inequalities produced by white supremacy impact social work organizations, the clinical supervisory relationship and the supervisor-therapist-client relationship. A multilevel case example is provided to demonstrate how structural power dynamics that influence service delivery can be identified through critical dialogue using the SCM in the clinical supervisory relationship and between the clinical social worker and client.

Keywords Clinical practice · Race · Structural assessment · Critical dialogue · Clinical social work supervision

Introduction

Systemic racism, white supremacy and injustice surround and invade the lives of Black and Hispanic/Latino/a/x populations in the United States. Life expectancy, infant and maternal mortality, health and mental health trajectories are strongly affected by zip codes codifying the scale of the public health impact on Black and Hispanic/Latino/a/x and poor communities. Despite knowledge of these realities, clinical social work practice, predominantly provided for the populations in focus through mental health agencies, continues to rely on theories and empirically supported practices grounded in individual and dyadic models further

influenced by the medical model. This paper presents the Structural-Clinical (SC) model. We offer tools for assessment and dialogue informed by an integration of Critical Race Theory (CRT) (Delgado & Stephanic, 2015), relational theory (Wachtel, 2014; Altman, 2010, 2015) and liberation psychology (Comas-Diaz & Torres Rivera, 2020; Freire, 1970; Martin-Baró, 1996). A multi-level model, the SC model is designed to explicitly integrate both macro and micro direct practice processes, to promote equity of care in mental health services, addressing systemic racism in mental health services delivery and practice.

In fact, the emphasis on individual psychological processes and the overreliance on the medical paradigm and psychopharmacology, has often pushed clinicians to focus on individual symptoms organized according to diagnostic categories, turning racism, oppression and discrimination into individual psychological problems. In so doing, systemic and structural racism continue to operate unabated, while those deeply affected by it are constructed as clients, are over-pathologized and as a result in need of medicalized mental health services. An individual's experience of

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psychological symptoms in response to the forces of racism may present as despair, hopelessness, anger, irritability, difficulty with concentration, lethargy, aggression, or alternatively, passivity and disassociation or other numbing. To understand such expressions of distress solely from an individual perspective leads a well-intentioned clinician to consider treatment of the symptoms and potential for pharmacological intervention to provide some relief for the individual (Altman, 2015). The SC model provides a pathway to unpack the structural forces that limit an integrative, expansive perspective including a person's distress, symptoms, and lived experience in context of systemic structural forces.

Additionally, although much has been written about multicultural clinical practice, the focus has often been on "the other" as "the cultural other," centering rather than decentering whiteness. These approaches, whilst emphasizing the exploration of power relations within the treatment relationship, inadvertently maintain problematic racial and racist implicit biases. The privileged dyadic relational focus further exacerbates the artificial divide between internal and external processes that has characterized clinical theory and practice (O'Neill & Farina, 2018; Farina, 2020). Compounding the problem, little attention has been paid to dyads in which the therapist is "the cultural other" working with a white identified client, or within cultural, racial or ethnic sameness and otherness (Altman, 2021). Furthermore, although race, culture and ethnicity are often considered peripheral issues in clinical practice, when identified as pertinent, they seem to be solely discussed from the perspective of oppression and marginalization (Farina, 2020).

The SC model is introduced with a structural assessment framework designed to explore how structural social inequalities produced by white supremacy impact social work organizations, the clinical supervisory relationship and the supervisor-therapist-client relationship. A multilevel case example is provided to demonstrate how structural power dynamics that influence service delivery can be identified through critical dialogue using the SC model in the clinical supervisory relationship (O'Neill & Farina, 2018) and between the clinical social worker and client. SC model is applied to the case example to illustrate how dynamics of dominance, subjugation, exclusion and inclusion can be addressed using critical dialogue cultivating critical consciousness and action to mitigate and gradually dismantle the effects of racism in clinical practice and service delivery.

The Structural-Clinical (SC) Model

The SC model is a pedagogical and clinical model designed to integrate clinical and anti-racism practice in social work education and clinical practice. The SC model examines and

explores the processes and manifestations of social inequities and structural forces within and across organizational, supervisory and clinical relationships. The model aims to foster and promote social justice in social work education, supervision, and clinical practice and to bridge conceptual divides that separate macro level social work practice from mezzo and micro practice.

Aligned with CRT, SC is grounded in the knowledge that societal and structural forces of racism and intersectionality associated with power, privilege and oppression are endemic in the US society and are deeply present in the systems, policies and organizations (Delgado & Stephanic, 2015), that provide educational and clinical services (Koliwoski, Weaver, & Constance Huggins, 2018). Such external realities can be integrated and internalized by historically, racially and ethnically oppressed people as part of the self, within a process of social identity development. These problematic, devaluing and dehumanizing internal representations of the self can further impact and manifest within interpersonal relationships, as psychological internalizations happen largely out of a person's conscious awareness. Problematic white supremacist narratives about "the other," have real and lived personal, emotional, socioeconomic and health consequences for historically, racially and ethnically oppressed people in the United States. These white supremacist internalizations, that operate out of conscious awareness, can produce psychological confusion about who one is, and interfere with the realization and actualization of the person's self; that is, these toxic internalizations can be (mis)understood by the person, as well as by others, as actual aspects of the self that in reality are part of the racist, oppressive and subjugating white supremacist psychological externalizations (O'Neill & Farina, 2018). Integrating these inherent realities, and their implications for a person's emotional, psychological and physical well-being in the clinical assessment process is essential to supervision and clinical practice. As such, this assessment process needs to be conceptualized as a structural-clinical assessment process.

The SC model fosters and deepens critical analysis skills to co-identify structural dynamics of oppression as they infiltrate interpersonal spaces within and beyond the supervisory and clinical context. The SC model, consistent with its relational conceptual roots, enables and provides an integrative road map for social workers to intentionally practice self-reflection and critical reflection with others, regarding context, social identity, and power dynamics (Safaran & Kraus, 2014; Wachtel, 2014, 2017). The recognition and naming of structural factors and their effects are then explored dialogically with clients and understood as psychologically interactional in the production of psychological distress. SC aims to de-pathologize individuals, especially

historically racially and ethnically oppressed individuals, to counter the contemporary privileged medical, individualistic mental health paradigm. The model creates space for a structural-clinical, interactional and dialectical formulation and understanding of mental health, that then guides the treatment process at the micro, mezzo and macro levels of social work practice (Farina, 2020).

The SC model is further invigorated by core elements derived from liberation psychology that emphasize the recognition and integration of the historical, economic, and sociopolitical context that contribute to psychosocial development, relationships and capacities to make change in one's life and the larger world (Comas-Díaz, 2020). Described as a decolonial approach, liberation psychology is rooted in recognition of the domination and exploitation of colonization, controlling distribution of resources, education, and the propagation of western ideologies, such as white supremacy (Burton & Gomez, 2015). Torres Rivera (2020) describes liberation psychology as an anti-oppressive theory that focuses on challenging oppression and marginalization, generates knowledge based on lived experience and interaction with others, recognizing social forces of power (Freire, 1970) particularly for those most subjugated. Individuals are viewed as intricately connected to the larger social world. Hence, clinical practice with individuals affects other individuals, families and communities as well as systems. Liberation psychology calls for clinicians to accompany clients on their journey of healing, to enable individuals to become actively engaged in transforming themselves and others through the intersections of their personal, interpersonal and social context (Comas-Díaz, 2020).

Structural Assessment Tool

The SC model incorporates the use of the Structural Assessment Tool developed by the authors with faculty field advisors working with MSW students in field placement throughout the United States, predominantly in community-based agencies in urban areas. Informed by other structural assessment models (Samartzis & Talias, 2019) and anti-racism models (Metzl & Hansen, 2014; Talley et al., 2021), the Structural Assessment Tool (see appendix) examines agency factors and social worker factors across seven domains posing specific questions for each.

The first domain addresses the context of the organization/social structural dynamics including questions such as: What is the demographic composition of the community? What are the notable assets/resources available in the community? Examples of questions posed regarding the social worker include: What are the intersecting social identity locations of the social worker? What is the social worker's relationship with the community? What are the impacts on

the social worker and clients of structural pressures in the community?

The second domain focuses on the mission, vision and values of the agency and of the social worker. In addition to the straightforward questions regarding the expressed mission, vision and values, inquiry extends to how the history of the organization may shape and influence how it operates today. The social worker is asked to consider their own values and mission in their work and life and to connect these to the types of service and the community they are serving in the agency.

The third area explores organizational culture and focuses on operational aspects including how time is allocated, how decisions are made and any shifts in power along with inquiry regarding the payment structure and modes of practice. The social worker asks themselves questions regarding how they prioritize and allocate their time, how they make decisions that involve a client; do they involve the client in the decision or not? How does the social worker experience their own power in the organization? How does the social worker get paid (e.g., fee for service; funding stream; full pay with benefits). What is the social worker's level of engagement with their own critical thinking in relation to power, privilege and positionality, especially in relation to clients?

The fourth domain explores the leadership, leadership style and structure within the organization. How does the demographic make-up of leadership reflect the community served; of the agency staff; does it vary by position, etc.? Are leaders open to feedback and reflection on their leadership? How does the leadership style translate into organizational policies? Do organizational policies reflect a commitment to social justice and awareness of differential experiences of systemic oppression? The social worker is asked to reflect on their own intersecting identities and their interaction with the organization's leadership style and structure while focusing also on the leadership structure and its implications/effects in relation to clients, staff, supervisors/supervisees, and colleagues.

The fifth domain addresses the funding structures for the organization and economic pressures the organization might be facing. The social worker is invited to explore the organization's as well as their own source of income's stability, financial resources and how this might affect the services provided to clients, as well as the social worker-client relationship.

The sixth domain explores structures that affect staff, student interns and volunteers. How are program staff, interns and volunteers recruited? How are they compensated? Do program staff, interns and volunteers feel safe and valued as members of the organization? How does the program address staffing shortages? What are the levels of cohesion

among staff? The social worker asks themselves about how well sustained they feel with the level of compensation/benefits they receive, as well as the effects of staff retention/turnover on the clinical services provided to clients, including the direct effects of high or low retention rates on clients and the quality of care provided to them.

Finally, the seventh domain addresses the level of client and community involvement in the assessment and evaluation of the organization's services. The social worker asks themselves about how they, and the organization or program, collect treatment outcomes paying special attention to the inclusion/exclusion of clients' experiences, beyond quantitative outcome measures. How responsive is the social worker and organization or program to the feedback in adjusting practices and services accordingly?

The structural assessment tool is designed to provide a detailed and nuanced assessment of the organizational and structural factors that surround and affect provision of clinical services. Attention is focused on the social/structural forces that infuse the infrastructure and culture of the organization, including the social worker's analysis of their own positionality and experiences in context. The structural assessment, a co-constructed tool, is open to change and influence from all stakeholders, including clients and community members, and is integral to the SC model.

Critical Conversations Model

The SC model integrates the Critical Conversations framework derived from the Critical Conversations (CC) model (Kang & O'Neill, 2018), a dialogic method designed to directly identify and address the social/structural power dynamics affecting personal and interpersonal communication and relationships.

Critical conversations are those in which power dynamics in social context are illuminated, substantively examined in the moment, and subsequently reflected upon in order to produce change, personal, interpersonal, and systemic (Kang & O'Neill, 2018). The CC model, grounded in dialogic and critical pedagogical theory (Buber, 1966; Friere, 1970), liberation psychology (Comas-Diaz, et al. 2020; Martin-Baró, 1986; Montero, 2009) and informed by intergroup contact theory (Allport, 1954; Pettigrew et al. 2011), is a model for facilitating conversations that surface conflicting ideas and experiences related to oppression, power and inequities that often activate tension. Such conversations can produce fertile dialogue that supports multiple perspectives, critical analysis, learning and growth for all involved. Encouraging critical reflection of self and group process, the CC model aims to cultivate participants' deeper awareness of power, privilege and structural inequities and the immediate impact these have on the learning environment,

interpersonal relationships, communication, all in order to activate energy to create change across personal, interpersonal and structural levels - in the moment and beyond. The steps of the CC model include (1) Confirming mutual consent to engage in a critical conversation about complex and intersecting issues of power and oppression and the interpersonal interplay potentially relevant to the situation; (2) Establishing the scaffold or frame: determining common agreements about engagement in order to make the conversation meaningful, particularly when conflict is at the center, being clear about the time available for the conversation, and identifying the focus of the conversation; (3) Diving into the conversation, paying attention through a critically reflexive process of noticing power dynamics, pausing and reflecting, naming and sharing what is noticed as social/structural power dynamics are at play interpersonally and doing so in a manner that invites dialogue and exploration of assumptions in context. An ongoing process of noticing, reflecting, naming/sharing and discussing toward activating energy to create change toward social justice in the moment and beyond ensues; (4) As time limit is met, transition is made by honoring the contributions of each participant and expressing appreciation, acknowledging the ongoing nature of critical conversations, and encouraging critical reflection and care. The CC model provides opportunities to practice reflective and active listening, pausing to pay attention to one's own and other's reactive process, assumptions, and defenses, while taking time to consider what is at play that may reflect social/structural forces. Gaining access to such power dynamics in process, can provide an opening for reconsidering one's contributions, tending to one's needs for space, realizing patterns of complicity in oppressive dynamics, potential alliances, and finding pathways forward toward understanding and changing one's thoughts, feelings and actions.

Recent qualitative research findings indicate generative effects of creating intentional space for critical conversations about race, class and gender among 100 undergraduate women (Gockel et al. 2022) contributing to the development of critical consciousness among participants (O'Neill et al. 2022). For more detailed descriptions and steps see Kang & O'Neill, 2018 and O'Neill & Farina, 2018.

Psychological theory integration

The SC model is grounded in the Integrative Sociopolitical and Psychological Analysis (ISPA) theory developed by Farina (2018, 2020). In ISPA theory, an individual's identity and that of the group(s) to which they belong, are mutually constitutive, both producing, reinforcing and shaping the identity of the individual, as much as that of the collective large group(s). The ISPA theory and analysis model

incorporates aspects of Critical Discourse Historical Analysis, Volkan's theory of collective group identity formation (2009a, 2009b, 2013a, 2013b, 2018) and relational theory. ISPA first links large collective, psychological affective-based identity processes to those occurring at the individual level in a mutually, constitutive manner. ISPA emphasizes the partially conscious and largely unconscious nature of this affect-laden identity process and subsequently links them with the associated collective, large-group and individual sociocognitive (social and cognitive) identity manifestations. Within this context, individual psychological "symptoms" are understood as resulting from intrapsychic conflict produced by the person's large-group and individual affective, sociocognitive identity processes in the context of societal/structural forces (Luca, Rodomontia, & Gazzilloa, 2017; Silberschatz, 2010, 2017; Volkan, 2013a, 2013b, 2018; Wachtel, 2014).

The SC model is designed as a flexible integrative model that allows social workers to combine the ISPA identity theory with an array of relational psychodynamic theories, including cyclical psychodynamic theory (Wachtel, 2014), intersubjectivity (Stolorow, 1991; Odgen, 2004, Mitchell, 2000; Saffran & Kraus, 2014) and in particular Altman's (2015, 2021) intersubjective, three person psychology. These theories, despite internal differences, are postmodernist theories that emphasize the importance of the social worker's identities and the context in which the clinical encounter takes place, highlighting also the role played by the social worker's subjectivity in the therapeutic encounter.

These theories acknowledge the effects of structural oppression and marginalization, while encouraging social workers to reflect on relational power dynamics, including their negotiation, exploration and inherent manifestations within the clinical process. Whereas classical theories focused on the nature of the countertransference as a derivative of, or reflective of the client's transference, relational theories emphasize the role of the social worker's characteristics and internal psychological world, in shaping the nature of the client's transference. Relational theory and ISPA theory provide a mechanism for social workers to reflect on their intersecting social identities and their influence in shaping the nature of the client's potential transference—as co-determined and in dialectic interaction with larger, socio-structural systemic forces and with the client's own personal characteristics, intersecting identities and internal organization. Together, these interacting and intersecting structural and interpersonal fields comprise and form the evolving social worker-client relational matrix during the therapeutic encounter (Wachtel, 2017). As such, countertransference and transference are no longer conceptualized as responses related to unprocessed earlier developmental experiences, or as reactions to a client's transference when speaking

about the countertransference. Relationally, and in the ISPA theory, countertransference and transference are understood as reflecting both *objective* and *personal-historical* elements and reactions belonging to the social worker and the client.

ISPA theory posits that these subjective, and yet *objective* and *personal-historical* responses that emerge in the inter-subjective clinical process, are also a product of, and reflect specific aspects of the larger, historical, socio-political, structural dynamics of the societies in which the client and the social worker have developed and lived (Farina, 2018, 2020; Hooper, 2018; Volkan, 2020). More specifically, they also reflect the larger trajectory of the inter/intra group historical dynamics that the client and the social worker represent to each other, whether these identifications are or are not congruent with their own internal self-representations, as they are often ascribed, imposed or assumed. These larger, unprocessed historical group dynamics, that have both constituted and been constituted by all members of a particular group, include specific wounds and traumas, such as racial trauma that come to bare in the relational matrix that unfolds during any clinical encounter (Farina, 2018, 2020; Tummala-Narra, 2021; Volkan, 2018). These unprocessed, historical, group wounds and traumas are specifically highlighted in clinical dyads where one of both members of the dyad belong to historically, racially and ethnically oppressed groups. The unprocessed, preverbal affects that inhabit the internal world of both social worker and client, linked to their group specific historical wounds and traumas, activate during therapeutic moments in which aspects of their lived experience intersect with their groups' histories of domination, subjugation, oppression and dehumanization, resulting in historical, sociopolitical-personal relational enactments that cannot be articulated but induce trauma responses of fright, with ensuing dynamics of perpetrator, victim, bystander and rescuer, and accompanying defenses such as denial, repression, minimization, splitting and dissociation (Chu, 2011; Courtois, 2016; Herman, 2015). During such enactments, both the social worker and client often adopt learned, unconscious, preverbal, sociocognitive schemas and behaviors that mimic their larger inter and intra group sociopolitical histories and contexts. For further discussion refer to Farina, 2018, 2020; O'Neill & Farina, 2018. These clinical relational moments, therefore, become interpersonal and larger, historical inter/intra group structural enactments that manifest in the form of ethnocultural transferential and countertransferential dynamics, which often-times involve white supremacist, racial microaggressions and/or manifest as aversive racism (Comas-Diaz, 1995, 2020, 2021). In the case of aversive racism, clients belonging to historically, racially and ethnically oppressed groups in the United States experience internal confusion and disorganization, and eventually may dissociate aspects of their internal self

to maintain the relational homeostasis of the clinical relationship, akin to larger structural/societal dynamics. Treatment relationships marked by such dynamics perpetuate, long standing collective group affect-laden, sociocognitive and behavioral patterns of relating that constrain and circumscribe both dominant identified and historically oppressed social workers and clients alike, in racial/ethnic trauma related roles that reinforce long standing dynamics - perpetrator, victim, bystander and rescuer - at the expense of the self and the clinical relationship (Farina, 2018, 2020; O'Neill & Farina, 2018). It is under these circumstances that historically, racially and ethnically oppressed and subjugated clients may prematurely end treatment, or if persisting despite racial enactments, may experience poorer treatment outcomes (Elkin, 1992; Tummala-Narra, 2016).

The acceptance of the social worker's subjectivity and its potential effects on the relational matrix, also acknowledges the presence of two unconscious subjective individuals, that are both shaping and constituting the nature of the relational clinical matrix and responding to each other. Altman's three person psychology and Stolorow's conceptualization of ruptures and repairs, grounded on primary and secondary self-self-object needs and failures provide a path forward in further reflecting on the sociopolitical-interpersonal enactments that transpire within the clinical treatment process. This conceptual framework, informed by the ISPA theory, enables social workers to engage with reflexivity in the recognition of these enactments, and its accompanying primary self-self-object needs and failures. By recognizing these primary self-self-object failures, individual secondary self-self-object needs can in turn be recognized, validated and met, such as those embedded in white supremacist, racist, structural and interpersonal enactments (Atwood & Stolorow, 2014; Stolorow, 1993; Stolorow, Atwood, Brandschaft 1992). This recognition and relational working through, allows clients of historically, racially and ethnically oppressed groups to begin to dis-identify (Wachtel, 2017) from problematic, large group white supremacist internalizations, while reinforcing existing internal mechanisms that they have previously mobilized to resist similar problematic internalizations and their associated effects (Layton, 2020). Under these circumstances, both social worker and client meet as subjects to co-create a therapeutic environment conducive to self-liberation, where historical racial/ethnic and interpersonal trauma, and its effects, can be recognized and acknowledged in its complexity (Armenta et al. 2021; Farina, 2018, 2020; Tummala-Narra, 2021). As Hanish (2000), and hooks (2000) state, the personal is political and the political is personal; clinical practice needs to use an integrative sociopolitical, structural, psychological and dialogical approach to address historical racial structural inequities and promote social justice in mental health care.

SC Model: Application to Clinical Supervision and Direct Clinical Practice

The case of the clinical social worker (Ana) and supervisor (Vivian) has been adapted from a previous publication (O'Neill & Farina, 2018) to first illustrate the application of the SC model to clinical supervision. The SC model will then be applied to direct clinical practice to illustrate both its relevance to clinical practice and to the triadic supervisor, clinician and client relationship. The case applications will illustrate how the SC model enables supervisors, clinical social workers and clients alike, to examine the complex structural and personal-historical relational dynamics present in clinical racial enactments; while also providing a conceptual map to dis-identify from damaging structural, personal-historical identity based intrapsychic internalizations using a dialogic approach embedded in the critical conversations model. The seven domains of the Structural Assessment Tool (online Appendix) are integrated throughout and notated by numbers one through seven (1–7) to guide the reader.

SC Model - Application to Clinical Supervision

Ana is fairly new to the clinical social work field. She has been working for almost two years at a mid-sized mental health community-based clinic. Services provided include individual, group and family therapy, as well as case management. 40% of the people served by the clinic identify as Black, African American, Asian American, multiracial, Indigenous people and Hispanic, Latina/o/x, predominantly Puerto Rican and Spanish speaking. Ana identifies as Puerto Rican, bi-lingual and has lived on and off in Puerto Rico. Phenotypically, her complexion is brown. She is the only bi-lingual social worker and one of two social work clinicians of color. She is also the most recently hired social worker. She was excited to be joining the clinic that has had long-standing reputation in clinical training, but less connected to the immediate community, that was now re-organizing to align the organization's mission to the needs of the immediate community through partnerships and grant-based opportunities (1, 2).

Vivian is Ana's supervisor. She identifies as bi-racial (African American and white). Because of her light complexion, she is often read as only white. All of the other 10 professional staff identify as white. Vivian is an experienced clinical social worker who has been at the clinic for eight years, is highly respected by her colleagues and the program director. Vivian was instrumental in hiring Ana, having advocated for the hiring of bi-lingual staff and dedicated efforts to diversify by race and ethnicity (1, 2, 6). Vivian thinks very highly of Ana who stepped into her role as a

clinical social worker with very good skills in interpersonal engagement, clinical assessment, establishing therapeutic relationships and care plans. She also found her to be very open to supervision, reflection and valuing of learning. Ana finds supervision with Vivian to be supportive and informative. She appreciates the space to reflect, and the insights she gains when discussing her clinical work with clients. Weekly supervision and professional development have been a long-standing expectation and benefit in the clinic (3, 6). This has been hard to sustain given the financial infrastructure and dependency on insurance-based reimbursement (5).

Ana is reluctant to raise her concerns about disparate caseloads and the extra intake responsibilities being given to her as the sole bi-lingual social worker (6). It is quietly surprising Ana that Vivian is not intervening, assuming that Vivian is aware of the imbalance by the fact that the need for bi-lingual clinical services is disproportionate to the staffing capacity (2, 3, 6). Gradually, Ana begins to cancel supervision to meet with clients and starts to fall behind on her record keeping. Her client schedule is very full with back-to-back appointments each day. Ana realizes that she is overworking, but does not see a choice. Intellectually, she knows she cannot continue to accept new Spanish speaking clients, but she is reluctant to say no because they would then be unable to access needed services at the clinic (1,3, 5, 6). There are limited mental health services for members of the Spanish speaking community meaning they would need to be placed on a waiting list or travel a fair distance to a public hospital-based clinic that is also understaffed (1). Ana knows the problems are systemic but feels compelled to meet the need as much as possible. She feels very connected to the community (3).

Things come to a head when Vivian's supervisor, the program director, raises serious concerns regarding Ana's missing records and the financial implications. The clinic is facing an insurance audit that could have implications for their plan to expand staff and services to the community (3, 4, 5). They have faced criticism from a few community leaders regarding the long waitlist for care (1, 7). The program director feels political pressure as well with a grant under review for a collaborative effort to provide clinical services in a local high school. She has been distracted from the day-to-day operations of the clinic and now has concerns about the upcoming audit (3, 4, 5). The significant lag in Ana's clinical documentation leads the director to question Ana's competence, her ability to manage time, set boundaries, and follow through with expectations. Vivian feels pressured and begins to remember the barriers she had initially faced to earn her professional standing in the clinic as a bi-racial woman in an all-white professional environment. She was affected by hearing some of her colleagues

question the competence of previous clinicians of color. She finds herself becoming inexplicably anxious and fearful of being perceived as an inadequate supervisor by the program director or others. She is aware of the perceptions of her being tied to those held about Ana, especially given her advocacy to hire Ana. She is also perplexed by the changes in Ana's performance (3, 6).

Given the overt validity of the program director's concerns, Vivian conveyed the criticism and concern to Ana in their following supervision. Ana became silent. She felt confused. Her body became hot and uncomfortable. She couldn't look at Vivian. Vivian felt suddenly anxious and defensive. She also became confused, had difficulty gathering her thoughts and found her heart racing. They ended the meeting without resolution other than the expectation that Ana prioritize bringing her records up to date. After the meeting both Ana and Vivian approached each other with hesitation and doubt. Vivian wanted to support Ana through this difficult situation, but felt unable to connect with her. Ana felt increasingly distant from Vivian, largely misunderstood and betrayed. She was surprised that Vivian couldn't see the inequities of the workload and the systemic basis. She expected Vivian to be an advocate, not to be blaming her for larger problems. Even with this understanding of the problems, Ana began to feel paralyzed, and started to doubt her skills as a clinical social worker, wondering if in her efforts to be helpful to clients, she inadvertently created more problems. Ana fell further behind in her clinical documentation, raising further concern for the program director (4, 5, 6). Vivian began to question her own judgment and her initial perceptions of Ana. She increasingly questioned Ana's level of motivation and clinical capacity. Both Ana and Vivian were caught in a vicious circle of self-doubt, doubt in each other, shame and insecurity.

With greater knowledge and awareness of the structural maelstrom of forces impacting clinical services, Ana and Vivian, and their supervisory relationship, how might they have been able to handle the situation differently?

Application of SC Model - Supervision

Vivian and Ana both were recently introduced to the SC model which included the Structural Assessment Tool and key components of the Critical Conversations model, and the ISPA theory and model, as part of a professional development training. They both wondered if the conflicts they were experiencing were related to structural power dynamics (1–7). Ana had been wondering silently about how Vivian had been focusing solely on the documentation issues, and not on the disproportionate impact of unbalanced caseloads, staff capacity and community needs (1, 3, 5, 6). Vivian responded to Ana's silence in supervision by asking if

Ana could be direct with Vivian about her concerns. Vivian quietly braced herself, sensing that they were going to address conflict more immediately and directly, and was aware of her anxiety. Ana responded: “I was planning on bringing this up today, so I appreciate that you’re asking Vivian. There’s a lot more going on here than me being late on record keeping. Can we discuss this directly? Can we use the SC model? Vivian found her anxiety shift to a surprising sense of relief and said, “Yes, that’s a great idea. I have the Structural Assessment tool, ISPA model training notes and the CC model here on my wall. It looks like we’re deciding to have a critical conversation. Thank you for thinking of that.” Ana pulled out her notes and they each chuckled. “Ok,” Ana said, let’s tune in and reflect on our structural context and our intersectional social identities in relation to the structures and to each other and to the people we’re serving.”

Ana and Vivian alternated setting up the scaffold: coming up with agreements so as to make it possible for them to have an authentic critical conversation about the conflicts. They agreed to listen deeply to each other, reflect back what they heard to ensure understanding, to not interrupt, to pay attention to how their own assumptions were present and to be open to learning from each other. They set the rest of the supervision time, about 30 min and said they would make plans for continuing the conversation in the next supervision if they both thought it was important to do so. They both acknowledged that the need to have the conversation was apparent and they hoped that it would help them move forward.

Vivian says, “Let’s dive in.” Having noticed and reflected a fair amount on the structural context, power dynamics and their identities, Ana intentionally states, “We have to name the racism, Vivian. I’m the only Puerto Rican, Spanish speaking clinician and it’s you and me (1, 2, 3, 6). I have more clients than any of the other clinicians, I probably get paid less, because I am newer, but the inequities are real” (2, 3, 5, 6). Vivian affirms Ana’s perspective and suggests, “we need to understand how we are each playing a role in this. Ana pushes back a bit and states, “The conflict is being put on me! And us! It’s always the way it happens. We’re the ones carrying the burden when it’s the system that is rife with inequities and racism. How could this clinic function with only one Puerto Rican, Spanish speaking clinical social worker? I can’t do it all and feel like I’m failing my clients. How can you be blaming me?” (1, 2, 3, 5, 6). Vivian opens up about having not looked at the situation more critically. She shared how she felt concerned about not meeting the standards of performance for herself and for Ana (4, 5, 6). She recognized the racialized structural dynamics, particularly as they are linked to institutional policies and reimbursement structures (3, 4, 5). Vivian and Ana explore

what else might be happening with the shift in the agency mission and goals. They identify the burden of institutional change is falling disproportionately on Ana as well as Vivian to represent the changes, when the disproportional impact of the work is not being recognized, addressed and changed (1, 2, 3, 4, 5, 6, 7). Vivian and Ana explore and recognize how the power dynamics are affecting their working relationship. Ana realizes that she has not asked for the needed support or brought forth her concerns about the racialized systemic issues. Vivian begins to examine her complicity and ambivalence about aligning with the program director. Each challenges their assumptions. They note the time went quickly and Vivian expresses her gratitude for Ana’s openness and critical awareness. Ana expresses her appreciation for Vivian’s openness and immediate shifts in her understanding through the discussion. They committed to continuing using the critical conversations model to support their work and each other in their efforts to make change in the organization. Using the SC model to directly and authentically address the power dynamics affecting their relationship and experiences within the organization facilitated their ability to move through disconnection to connection. They expanded and deepened their critical consciousness making it possible to avoid enactments of structural oppression in their relationship as well as to plan and take informed action personally, interpersonally and within the larger system.

SC Model Application – Clinical Supervision leading to Direct Clinical Practice

During the escalation of the tension between Ana and Vivian, Ana had been working with Carmen, a 35-year-old Puerto Rican woman, born and raised in Puerto Rico and primarily Spanish speaking. Carmen had sought therapy due to struggles with depression, reporting a sense of hopelessness and helplessness, increasing fatigue and chronic sleep difficulties. Carmen’s family history was marked by intergenerational trauma, her mother as well as her grandmother had endured domestic violence with their partners and despite hoping for a different future for the next generation of women in the family, the pattern persisted. Carmen was the first woman in her family to graduate high school, and although she had attempted to earn an associate’s degree, she was unable to finish. At twenty, she met her partner, Jose, and became pregnant soon thereafter.

At the beginning, Jose and Carmen had a nurturing and rewarding relationship but soon problems emerged, intensified by economic difficulties and the need to support other extended family members. Eventually, Carmen and Jose decided to move to the US mainland to seek better living conditions for their young family. However, neither of them spoke English well. Carmen focused on raising their

daughter while Jose worked a number of minimum wage jobs. Eventually, Carmen and Jose had a second child and Jose began to work two different full-time jobs, leaving little time to be with Carmen and the children. The strain of working two jobs was deeply felt on Jose's health and also their marriage. Jose began to drink when at home, feeling disconnected from Carmen and the children. Instead of expressing his feelings, Jose withdrew even further, while also beginning to have angry outbursts that eventually culminated into domestic violence, characterized by mutual physical pushing and verbal intimidation and devaluation. Despite being a hard worker, Jose had been passed over for promotion a number of times in his primary job, but had not shared this with Carmen due to shame and embarrassment. Jose suspected he was denied promotions due to his accent and difficulty speaking English fluidly, although he was an excellent worker. As Jose grew increasingly volatile, Carmen became increasingly depressed and felt largely alone, eventually seeking mental health services. It's important to note that Carmen did not feel her safety was ever compromised and was worried about the way in which they were both managing disagreements and conflicts.

When Carmen first met Ana, she felt a sense of familiarity and comfort. The feeling was mutual. Ana had become protective of Carmen, and although Carmen's depressive symptoms had somewhat abated, therapy had become somewhat stuck. Ana had recognized the "stuckness" yet felt a sense of the twinship with Carmen, feeling that they were both trapped in difficult structural circumstances, recognizing racism as a significant component (Comas-Diaz, 1995, 2020; Safran & Kraus, 2014; Tummala-Narra, 2016, 2021; Watchtel, 2014, 2017). Ana did not discuss her work with Carmen in supervision, nor had she reflected with Carmen on the "feeling of stuckness" or the possibility that some of Carmen's depression and marital difficulties could be related to the effects of the capitalist, racist environment that she and Jose needed to navigate, although she suspected as much (Altman, 2010, 2015; Farina, 2020). Ana recognized Carmen's strengths, but saw her in a rather unidimensional manner, as a powerless victim of the system. This was a feeling that Ana sometimes experienced herself. Therapy provided mutual comfort and a sense of "us vs. them" (Comas-Diaz, 1995).

As Ana and Vivan began to work through the racial structural enactment that had taken place between them in the context of the social/structural racialized forces operating in the agency, Ana began to reflect on her own internal sense of powerlessness, and to examine the reasons why she hadn't discussed this case with Vivian. As she continued to reflect, she began to see that there had been a parallel process and larger re-enactment. Ana had grown distant from Vivian as she felt the effects of structural racism, just as Jose

had grown distant from Carmen under the similar yet different oppressive forces. Carmen, unable to reach her husband, had "abandoned" him to focus instead on her role as a mother, fueling Jose's sense of rejection and isolation, at the core of Jose's outbursts.

Ana realized that therapy had become Carmen's refuge. At the same time, the relational matrix that had unfolded between Ana and Carmen required Carmen to maintain a very familiar pattern of relating that she feared would be disrupted if she continued to feel progressively better (Watchtel, 2014, 2017). She feared that therapy would end, leaving her again alone and isolated. By working through the supervisory rupture in which forces of oppression and their implications were gradually acknowledged, Ana now experienced a new pattern of relating, having reconnected with her own sense of agency (Comas-Dias, 2020, 2021). Ana eventually brought Carmen's case to supervision.

Vivian and Ana used the SC model, beginning with the structural assessment tool, to gain further context to Carmen's case. Through the structural assessment, they realized that the triangulation they had recently experienced within the supervisory relationship, appeared to mimic the triangulation between Ana, Carmen and Jose's hostile work environment. Then, using the ISPA theory and the Critical Conversations steps to frame critical dialogue, they reflected on the larger, group and individual affective and sociocognitive processes embedded in the racial enactment between Ana and Carmen and Carmen and Jose. To deepen and translate this understanding to Ana's direct clinical work with Carmen, they also incorporated an intersubjective/relational approach.

Vivian and Ana discussed various ways in which Ana could invite Carmen to reflect together on the therapy and the relational pattern that had emerged (Watchtel, 2014, 2017). Vivian encouraged Ana to consider that these dynamics could be very familiar to Carmen, recreating a situation that Carmen needed to resolve but feared resolving – a fear that Ana knew well (Comas-Diaz, 1995, O'Neill & Farina, 2020). Having achieved a clearer understanding of the complex structural and interpersonal relational dynamics, Ana and Vivian began to role play how Ana could explore the complex racial, structural and interpersonal dynamics with Carmen. By the end of their supervision meeting, Ana felt comfortable enough to begin to shift her approach to working with Carmen.

SC Model -- Direct Clinical Application

When Ana met with Carmen for their regular weekly session, holding the SC model in her mind, she invited Carmen to reflect on their clinical work and relationship including paying attention to their sociocognitive process in the

context of structural forces impacting Carmen, and the inherent resonance Ana was experiencing (Farina, 2020; Saffran & Kraus, 2014; Wachtel, 2014, 2017). Although at first Carmen struggled some to examine the relational matrix that had unfolded between them, eventually, Carmen began to see some clear similarities between their way of relating and her past and present interpersonal relationship patterns. Slowly, Carmen began to articulate her fears, including her fear of getting better, which she equated to losing Ana and the support she had found in therapy—her fear of being alone again was profound. Through this process, Ana and Carmen started to perceive each other in a more three-dimensional manner. The idealization that had marked their relational matrix, started to give way to a more realistic appraisal of self and other (Comas-Diaz, 1995; Farina, 2020; Wachtel, 2014, 2017). By shifting the mode of relating, Carmen also grew increasingly curious about her relationship with Jose. She began to wonder if Jose may have also felt alone and abandoned, suspecting that Jose faced racism at work that he often brushed off and minimized (Comas-Dias, 2020, 2021; Tumala-Narra, 2021). Eventually Carmen was able to approach her husband, feeling a sense of strength. Despite the fear and difficulty, Carmen and Jose were able to open up in a different way, while recognizing for the first time the number of structural barriers they had faced, the effects these have had on their family, and on each of them as individuals (Farina, 2020; Tumala-Narra, 2021).

Carmen and Jose agreed to begin couples therapy, knowing they needed help to speak further with each other, as there was so much hurt and pain between them. Because they were able to see the social/structural forces impacting them that had become internalized, they were free to see each other in a more three dimensional (Altman, 2010, 2014; Comas-Diaz, 1995; 2020; Atwood & Stolorow, 2014; Stolorow, 1993; Stolorow & Atwood, 1992; Wachtel, 2014, 2017), realistic and eventually compassionate way as well, allowing the hurt and pain to begin to heal.

As for Ana, her clinical ability continued to grow with Vivian's supervision. Vivian's capacity to identify the social/structural forces operating with the agency and beyond led to a liberated approach to her clinical supervision. Although working through the structural and interpersonal racial enactment had been painful and complex, it provided fertile learning ground.

Vivian and Ana collaborated on case presentations that integrated the use of the SC model. They accompanied each other in their growth and learning, deepening their critical consciousness, and solidifying their alliance. They were active change agents in the agency, paying particular attention to how the agency was engaging with the community. Each found their work experience, as demanding as it often was, to be more gratifying and enlivening.

Implications for Clinical Practice

It is critical that clinical social workers become actively aware of the endemic processes and manifestations of racism, social inequities, structures and dynamics of white supremacy within and across organizational, supervisory and clinical relationships. The SC model integrates the ISPA and CC model, offers the Structural Assessment tool, and calls upon clinical social workers to examine the intricate, and multilayered interconnections expressing racialized oppressive forces across macro, meso and micro systems that impact the totality of clinical practice. The SC model integrates CRT, liberation psychology, and relational theories bridging long standing theoretical and conceptual divides. The SC model aims to challenge systemic and structural racism that continues across systems to center pathology within clients. In so doing, the SC model aims to de-pathologize clients, recognizing the pathology of white supremacy, racism, and other oppressive structural forces affecting organizations, relationships and people's lives, especially the lives of those who belong to historically, racially, ethnically marginalized groups within our society.

Authors' contributions Authors have contributed equally to the conceptualization, researching and writing, editing and revising the manuscript.

Funding Not Applicable.

Availability of data and material (data transparency) Not Applicable.

Code Availability (software application or custom code): Not Applicable.

Declarations

Ethics approval (include appropriate approvals or waivers) Not Applicable.

Consent to participate (include appropriate statements) Not Applicable.

Conflicts of interest/Competing interests Authors claim no conflicts of interest or competing interests.

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Publisher's note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

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