2010

Racial micro-aggressions in the clinical dyad : a qualitative study of African American clinical social workers : anti-oppression with same race clients : a project based upon an independent investigation

Illana Cathleen Jordan
Smith College

Illana Cathleen Jordan
Racial Micro-Aggressions in the
Clinical Dyad:
A Qualitative Study of African
Clinical Social Workers: Anti-
Oppression Clinical Work with Same
Race Clients

ABSTRACT

In this qualitative study the experiences of African American clinicians working with African American clients regarding racial micro-aggressions that occur both in and outside the clinical dyad are explored. Twelve African American clinicians participated in structured interviews for the purposes of exploring their experiences talking about race and racism when working with same race clients. Participants worked in a variety of clinical settings but all provided individual therapy to African American clients.

Participants reported that they allowed their clients to guide discussions pertaining to the issue of micro-aggressions. Clinicians felt that "race talk" bears critical importance on the therapeutic alliance and that when utilized can deepen the alliance as well as expose other equally immobilizing dynamics in the client's life. For the most part clinicians felt little anxiety about "race talk". majority of participants felt that more research on and developing a framework for having such conversations would be of benefit for same race treatment relationships. A majority also reported that they all made certain to remain in constant attendance to issues of boundary maintenance. Clinicians believed that a framework would both give permission to a deeply important issue as well as provide insight as to the best practices for facilitating effective race attentive work with clients of color.

RACIAL MICRO-AGGRESSIONS IN THE CLINICAL DYAD:
A QUALITATIVE STUDY OF AFRICAN AMERICAN CLINICAL SOCIAL
WORKERS:ANTI-OPPRESSION CLINICAL WORK WITH SAME RACE
CLIENTS

A project based upon an independent investigation, submitted in partial
fulfillment of the requirements for the degree of Master of Social Work.

Illana Cathleen Jordan

Smith College School for Social Work
Northampton, Massachusetts 01063

2010

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Racism persists an issue both in and outside this country. The impact of racism can be seen in the ways that this country continues to find its jails and impoverished neighborhoods populated by people of color while we continue to see our institutions of higher education and corporations populated by white people. Just as this fact is easily observable we see that despite these societal circumstances we have had, in ever growing number, people of color matriculating into higher education and then being hired into corporations. In these corporations we also see that people of color are experiencing lower pay rates than their white counterparts who are equally educated with comparable number of years in the field.

As a framework cultural competency has offered a useful model that promotes cross cultural acknowledgment and comfort for persons of minority status. Use of this framework has provided opportunity for individuals and organizations to be conscious of euro-normative constructs in a way that creates softer boundaries regarding what is "cultural" and what is personal. Cultural competency has also in some ways perpetuated a philosophy of "otherness" in agencies and while tolerance has been enforced and expected it has not made available more acceptance and appreciation for difference. In exploring the experiences of people of color in predominately white environments researchers have found that the expectation of assimilation is prominent and that the environments in which they work seem to isolate and normalize Western-European

customs by virtue of their decor and holidays observed and what is considered professional behavior and attire.

Additionally, and even more so, conversations that occur between individuals of color and white people seem to illustrate subtle aggressions and insults that communicate either the white individual's underexposure to people of color, their under-exploration of the experiences of people of color or the latent manifestations of their feelings about said individuals of color. The purpose of this study is to explore attendance to the subtle revilement that occurs for clients and clinicians of color both in and outside the clinical relationship.

CHAPTER II

LITERATURE REVIEW

The prevalence and impact of racism in America continues to be an area of great debate both in and outside clinical settings (Sue et al. 2007 & Sue, 2003). While "much of racism today is less blatant than it was 50 years ago and is more subtle, although equally damaging" (Miller & Garran, 2008 p. 25). Although covert acts of racism no longer persist with quite the same fervor, the heritage of slavery in the United States continues to impact the development of African Americans (Wilson & Stith, 1991). Slowly there has been a shift in the zeitgeist of clinical inquiry attending to this fact. From early psychoanalysis to the surge of exploration into trauma and current concepts in treatment, researchers have been working to understand the inner worlds of their clients (American Counseling Association, 1999). Acknowledging, and then attending to the legacy of racism in America is arguably a necessity when exploring and attempting to understanding the current relationship between accessibility to mental health care and longevity of treatment for African Americans (Hollar, 2001).

More recently, in the movement toward multicultural competency, researchers have been begun to explore the cultural experiences of clients of color so as to minimize the amount of prejudice they experience in the clinical relationship (Rogers-Sinn 2008). In doing so researchers have reported that, in an effort to isolate the variables which contribute to multicultural competence, the over attendance to these variables has in itself proven marginalizing. Further, throughout the complex task of learning to understand the

different cultures present in our society, conclusions have been elusive, and the process itself may have served to feed stereotypes (Stuart, 2004). This is because when in the absence of information that individuates one person, let alone culture from another, people have a tendency to draw conclusions based upon stereotype (Pennington et al, 2008).

Nonetheless, issues remain unresolved; therefore researchers have persisted in their drive to better understand the psychological as well as intra-psychic experiences of African Americans believing that better understanding would lead to better treatment interventions (Delphin & Rowe, 2008). Historically, mental health treatment has followed a medical model which assumes that treatment is cross-culturally applicable and that one intervention is adequate in every therapeutic exchange no matter the race. The medical model in this country is based on a Western European paradigm and as such it attends to a homogenously white cultural construct. Subsequently, this is the lens through which clinicians then view their clients. The use of empathy traditionally informed their capacity to understand the experience of their clients. However empathy from the white clinician perspective is based upon this Western Euro-American value system (Chung & Bemak, 2002) and simply cannot be accurate if it negates or even ignore the racial experience of the client.

Indeed, research, assessment and application techniques seemed only to isolate and further destabilize and oppress African Americans as they failed to take into consideration their unique racial and cultural contexts (Ridley, 2005). At that point psychotherapy clinicians misunderstood or otherwise minimized the prevalence and impact of race on their clients in the clinical exchange and how strategies have increased

racism (Pedersen, 1991). Thus the research and subsequent treatment application paradigm at that time seemed fallible. For instance, the nuclear family is based up Western cultures definition of family (Strong & DeVault, 1995 as cited in Brock et al., 2009). This bias places expectations on the African American client to consider functional family dynamic to be that of the Western European paradigm. However, slowly, race began to come into focus as one of the stressors that clients of color where up against. In exploring this, researchers began to recognize that the treatments employed to support them seemed not able to directly respond to their unique cultural needs (Wilson & Stith, 1991). Race then began to come into focus as one of the stressors that clients of color were up against in the treatment relationship. Not only was it becoming more clear that the extant principles fell short of attending to the basic needs of clients of color but clients reported feeling as though they were being alienated from services as a result of techniques used to support them (Buckard, & Knox, 2004; Kearney, Draper, & Baron, 2005).

These deficiencies in treatment models and delivery require that attention be given to both to the importance of acknowledging the clients' racial, social and their unique psychological vulnerabilities. There has been, **in the last few decades, more** exploration into what impact being a person of color in a racist society has on the psyche. In other words and simply put clinicians can no longer be allowed to endorse practices that where developed in one cultural context but are implemented in a different one (Mueser, et al. 1998). The majority derived and created clinical techniques not only failed to be directly applicable to the needs of African Americans but seem to perpetuate a communal dysthymia through invalidation of the experiences and subsequent needs of

the treatment seeking, African American population (Banks, 1972; Banks, 1985; Gibbs, 1985; Hayes & Banks, 1972; Jackson, 1980; Taylor, 1976; White, 1980 as cited in Robinson, J.B.). Indeed, invalidation stifles the necessary acknowledgment that can in some cases propel relief, insight and motivation for change for oppressed persons. Inadequate acknowledgment of the impact of racism serves as an agent of invalidation as transmitted by clinician to client in the treatment relationship (Constantine & Sue, 2007). This invalidation established a disconnection between effective treatment and the attunement that is required in order to promote effectiveness and longevity of treatment. When the client does not feel that the clinician is responsive toward addressing the race of the client, the clinical relationship is weak causing the clients to be less invested (Ponterotto, et al., 2003). Many authors, via a heavily researched history of invalidation and subsequent misdiagnosis of African American clients of psychotherapy have informed their readers, at least topically, of some of the reasons why individuals of color maintain the weakest capacity for longevity of treatment while at the same time also maintain a more prevalent need for services.

Indeed, researchers have reported that African American clients are often quite reluctant to participate in counseling and that they often do not continue treatment past the initial stages (Terrell & Terrell, 1984 as cited in Wilson & Stith, 1991). This problem has persisted for decades and has resulted in a perseveratively low faith in the medical and mental health services clients of color receive. This lack of faith is made viable by the persistent minimization, misdiagnosis and consistent misinterpretation of their needs and of their lived experience. Invalidation stifles the necessary acknowledgment that can **in** some cases propel relief, insight and motivation for change for oppressed persons.

Inadequate acknowledgment of the impact of racism serves as an agent of invalidation as transmitted by clinician to client in the treatment relationship (Constantine & Sue, 2007).

Researchers have informed us that if the clinician providing the treatment is aware of the relationship between oppression and mental health but does not attend to it, what's left is mere rhetoric (Hansen et al, 2006). Researchers have reported that when clinicians are direct in attending to the race of their clients, clients perceive this as helpful in intimacy and alliance building (Fuertes, Meuller, Chauhan, Walker, & Ladany, 2002). Additionally, white clinicians need to develop a greater awareness of their own attitudes about race (Todisco, et. al., 1991), an astute clinician aware of the subtleties of racism and the ways in which those subtleties manifest in practice, process and implementation of treatment can more aptly engage in a treatment that benefits the complexity of the experiences of people of color (Sue et.al, 2007). Although many similarities between races exist by virtue of being human, it is important to recognize and not be oblivious to the ways in which racial groups, subgroups are different and what those differences mean (Sue, 1978) culturally, individually as well as diagnostically.

As overt acts of racism have diminished, our society had become conditioned to be more "politically correct", to be less outwardly offensive, oppressive and racially provocative i.e., prohibiting African Americans from simple privileges such as riding in the front of a bus. This societal inclination toward professional and political correctness has launched opportunity for latent manifestation of more covert acts of racism (Sue, 2007), "adversive racism" (Dovidio & Gaertner, 2004 & Gaertner & Dovidio, 1986 in Penner et. al), and "discrimination in contact" (Loury, 2001). These more mild enactments impose themselves upon the subjugated while at the same time diminish this

countries observation of the overt acts of racism this country was built upon (Miller & Garran, 2008).

One of the more recent organizing principles for acknowledging and exploring racism is the latent manifestation referred to as microaggressions. Microaggressions are defined as "Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color (Sue, D.W. et.al, 2007). Microaggressions occur both in and outside the clinical exchange and although by their nature they may seem, because they are clandestine, to be less afflicting, quite the opposite it true. It is due to their cumulative effect that individuals become burdened (Homes & Rahe, 1967 in Sue et. al, 2008).

This nascent racism is often disguised so effectively that it may resemble a more general invalidation that imposes a false reality upon the individual, slowly depreciating their self esteem (Franklin, 2004 & Sue et al., as cited in Sue, 2008). It is only after some reflection and attendance to the residual feelings that the individual who was aggressed realizes that they are offended (Solorzano et al, 2000). Because of the subtle, often times unconscious, delivery, and slow temper of the assault both the aggressor and the recipient are powerless to stop the aggression.

The United States is a fundamentally racist society and as such there is a societally endorsed power differential between that of African American and White persons (Goldstein, 2008). It takes little thought to understand just how complicated this relational pairing can become if the person of color is cast inferior, feeling unheard, invalidated or otherwise misunderstood. Racial microaggressions "lead to race-related

8

stress" and this stress may persist for "days, weeks, months and even years" and can be "

perpetuated by all types of people- strangers, casual acquaintance and even personal

friends" (Sue et al, 2008 p. 336). In an article by Constantine (2007) we learn that:

> … when a helping professional, such as a counselor or psychologist, unconsciously enacts a form of racial oppression, such as a racial microaggression, it may have even more profoundly negative effects than a microaggression enacted by a non-helping professional. Not only may the therapeutic working alliance be weakened when African American clients perceive White counselors to be biased or prejudiced, but it also might lead to the premature termination of counseling relationships by these client (p.11).

This is no less true for the same-race therapeutic dyad and given the level of trust,

attunement and vulnerability that is required for the longevity of treatment, it is

imperative the mis-attunements and covert slights be attended to, if not eliminated.

Holmes (1999) provides insight into the importance of the clinician participating in this

racial discourse.

> … race and countertransference operate similarly and synergistically. Both may impede treatment, but when either is made available for the therapist's reflection and analysis, therapist will be better able to assist the patient to grapple with his or her own racially-expressed issues… racial reactions are more potent and potentially more destructive of therapy than countertransference reactions in general since responses to race are determined and reinforced externally, that is, in the culture at large and intrapsychically… That is, through the use of externalizing defenses, blacks become a marginalized and impersonalized group onto whom unwanted urges are cast (p. 330).

In this study I explored how, if at all, African American clinicians addressed

micro-aggressions that occur in treatment between themselves and their African

American clients. I looked at how, if at all, the African American clinicians addressed

micro-aggressions that occur outside treatment, in the day to day lives, of their African

American clients. Lastly, I looked at whether participants perceived strengths,

weaknesses or any other ideas regarding and for facilitating discourse regarding micro-

aggressions within the clinical dyad.

CHAPTER III

METHODOLOGY

This research study was accomplished using a structured interview. Interviews were conducted over the phone *(n=10)* and in-person *(n=2).*

Participants

Twelve clinicians from the mental health field were recruited in the interest of soliciting information regarding their professional, in treatment experiences regarding discourse on racial micro-aggressions with their clients. Clinicians were recruited from a myriad of mental health clinical practice environments including but not limited to private practices, academic institutions, and community mental health organizations.

Participant eligibility was determined by the following criteria: (1) they have a Master's degree in Social Work; (2) had current and appropriate licensure to practice clinical social work; (3) had worked full-time as a clinician with primarily (more than 50% of their clients) in adult African American population for at least 12 month; (4) self-identify as African American; and (5) spoke fluent English. Participants self-reported ages ranged from 30 to 63. All participants were currently employed at the time of the study, and practicing in accordance with the aforementioned criteria.

Of the 12 participants, 10 identified as female and 2 identified as male. As required for the study all identified as African American. However, 4 participants also identified themselves as also being of Biracial, Puerto Rican, West Indian American or

Afro-Caribbean cultural or ethnic affiliation. As required for the study all participants had

an MSW and held the appropriate licensure to practice clinical social work. I made no

specification with regard to the clinical arena of the sample recruited. As such the

research participants were employed in the following clinical environments: community

mental health, behavioral health, private practice, and within institutions of higher

education. As specified and required for the study, all participants worked full-time with

primarily adult African American client populations.

Permissions and Recruitment

This research was approved by the Human Subjects Review Board at Smith

College School for Social Work on March 4, 2010 (Appendix A). Participants were

identified through personal and professional contacts. Specifically, recruitment email

(Appendix B) letters were sent to colleagues, both past and current, peers and academic

professionals. Prospective participants were furnished with a recruitment letter in an

effort to ascertain interest. Individuals interested in participating in the study called *(n=1)*

or responded by email *(n=11).* At which point they were sent the initial screening

questions to assure that they met criteria for this study. After this was determined, a time

and place for interviews was arranged.

Prospective participants were emailed a letter of consent explaining the purpose

of the study. They then received a phone call to discuss in detail all the steps utilized to

ensure confidentiality of their narratives. In an effort to minimize marginalization of

participants, or assume how individuals define themselves, the initial interview included

a demographic sheet which included questions on race, gender definition preference and

class. Participants brought with them, or had previously signed and returned a copy of the signed consent to participate in the research interview.

Nature of Participation

Interviews were conducted via structured dialogue that lasted between 15 and 55 minutes. I strictly adhered to the research questions which had been developed previous to interview process. Interviews took place in either participant's office or over the phone. Each participant and I worked in tandem to determine a comfortable, neutral location where both felt participant could respond honestly and with confidentiality.

Consent and Data Collection Process

Data collection began in March of 2010 and stopped in April, 2010. Initial steps included completion of a Screening Questionnaire (Appendix C), a Demographic Questionnaire (Appendix D), a review of the Guided Interview Questions (Appendix E) and signing of the Consent Form (Appendix F). Following completion of these steps participant and I would record the interview.

Data Analysis Process

I completed analysis of all data collected from participants The interview responses were transcribed and coded for the purpose of eliciting applicable themes in the disclosures by the research participants. Once common themes were identified, they were then highlighted and reduced through multiple levels of coding.

.

CHAPTER IV

FINDINGS & DISCUSSION

Introduction

The majority of the themes showed up in the following areas: who guides the discussions; the importance and impact that "race talk" has on the clinical alliance; areas of anxiety regarding "race talk", specifically participants seemed to share similar practices of attendance to the presence of racial transference and counter-transference in the clinical relationship and how that informs both the client and the clinician's assumptions of similarity and over-identification. Participants also shared similarity of thinking about hindrances to "race talk" in the clinical dyad, particularly regarding their individual capacity to recognize micro-aggressions and the presence of internalized oppression. Lastly, the participants illustrated a collective desire for framework and education as to how to participate in "race talk" in the same-race clinical dyad. For instance, participants wanted to know how to talk about race as relevant to social construction or how to effectively make clinical use of racial transference and countertransference.

Client-driven discourse and the clinical alliance

The vast majority of participants (n=11) reported that they do in fact discuss racial micro-aggressions that occur both in and outside the clinical exchange with their same race clients. Those same participants reported that when they discuss racial micro-

aggressions, by and large, they follow the clients lead with regard to when and under what circumstance the topic will be discussed. A couple of the participants did also offer that they would themselves introduce "race talk" into the space. These same participants offered that they would wait for themes in the treatment before doing so but that they found it an important issue to address with their clients of color.

This seems a practice of benefit as often times there is a client-perceived power differential that is assumed in the clinical dyad. This client-perceive power differential could limit the clients level of interest and feelings of safety in order to introduce the topic of race. This could be due to fear that it may create conflict, make them seem non-compliant or that it could be perceived as provocative in a way that would jeopardize the treatment relationship. Conversely, the societally supported race-power differential can become mimicked in the cross racial therapeutic dyad if the client of color finds themselves in treatment with a non-color clinician. The likelihood of the client's transparency is, for some, perhaps not all clients, diminished due to aforementioned race/power differential. Although, the same-race dyad may tempt one to think that "race talk" is facilitated with more ease and to richer resolve, this is not true in all circumstances. There are intra-racial client-perceived power differentials that manifest in these clinical pairings as well. For instance issues of class, color-caste, education, competition and comparison, and race betrayal can become enlivened in the same race clinical dyad.

Two participants in particular offered specific dialogue on how they might broach the topic if they perceived it as an area of exploration that might benefit their client. For instance, participant #1 stated,

15

... since micro-aggressions can occur in all of these kinds of ways... I might have an African American client who will describe an interaction that he or she had with another individual regardless of the other individual's race... or it may happen in the work between us... the issue of class comes up as it relates to of race in the context of my work with African American clients ... in those cases they might bring it up but then I might address it...I will say that in my work with adult African American clients they usually introduce the topic because they will generate a scenario or they might say something and then I will follow up on it.

Participant #3 stated that although it is important to wait for the prompting of the client, it is also important to make use of the material they are presenting by saying something like "have you considered that there might be some issues here that may not be related to the issues perceived".

Nearly all participants (n=11) reported using the perceptions of their clients to guide the dialogue, so that it is in attendance to what the client thinks or feels about the experience they are sharing in the treatment arena. It seems that the clinician's capacity to recognize and attend to the ways that the client is bringing up their racial concerns is critical to being able to seize the opportunity to show the client that the clinician is open to, comfortable with and validating of "race talk" in the treatment.

Of the myriad of issues that can emerge when exploring the topic of race is the issue of microaggressions. Clinicians were asked share their clinical experiences as they pertain to talking to their same race clients about these subtle injustices. Participants reported on the various ways that the introduction of micro-aggression dialogue has looked for them in treatment. Some report that it has come up in the context of their client's experiences at work, at home, with family, members and in the context of their experience within the larger societal context. Participant #4 illustrated the impact of

societal implications and perpetuation of micro-aggressions by having the following

dialogue with her client:

> So, they (the client) may be trying to frame it in the "we are oppressed and this is
> why I sell drugs…" You know? Versus me bringing it back to, well what role do
> you play in it? Like if you know that we are oppressed and that things have been
> done to people of color, throughout the centuries, why do you 'buy into it'? You
> know, like yes, it happened but you are really buying into the system that is trying
> to oppress you. So, its more like I am trying to increase their awareness as
> opposed to we are just going to scapegoat it and not really look at their piece of it.
> Like how they are "buying to it" or how they are allowing themselves to become
> part of the problem through their own behaviors. *Parenthesis added.*

Participant #4 continued to talk about the benefit, complexity and impact that this

dialogue has on the relationship by saying:

> I think it strengthens it (the clinical alliance). Because I tend to be a very… I tend
> to look at things "micro" but we are gonna look at it on the "micro" and the
> "macro" level. You know, its like, if you know these things are in your
> community, to destroy your community but you are still part of the problem then
> you can't complain about it. And you should be taking that energy and instead of
> selling drugs you should be working to get your education and do all these things,
> like making sure you have a job. But yes, there may be hindrances but, you
> should be doing things that will put you in the position that you can fight these
> things as opposed to just complaining about it and doing nothing and being
> further disempowered. *Parenthesis added.*

In the previous illustration participant #4 attends to the societal implications of

race as well as offering opportunity for her client to acknowledge how she or he may be

contributing to their life's circumstance. Participant #4 remains accessible to the societal

implications of the client's race. Allowing for this dialogue also assists the client in

exploring his or her role, not only within the larger societal context, but also in relation to

the client's insight development. Acknowledging the clients experience of the world can

be validating as well as empowering. This attendance to the client's racial identity serves

to validate both the internal and external experience of the client. For the clinician it also

provides rich clinical material that can inform the treatment trajectory. To this end

participant #12 stated:

> I think that it ("race talk") impacts the alliance in a very positive way. In that the client may feel… that they could be open and that they wouldn't be judged. Um, and felt in some ways affirmed and um, you know there was some reality testing going on that they weren't just crazy. "You ain't crazy. Naw, it really happens". *Parenthesis added.*

By validating the client's racial experience of the world the clinician can begin got

develop a more holistic interpretation of the client. One that is embracing not just of the

clients peripheral contributions and interpretations but also of the systemic foundations

and structures that they are up against. Participant #6 shared:

> Typically, when it (the topic of race) comes in… it comes up in relation to interactions with the world. You know, how they perceived an environment, or our society so then we may discuss what it is like for them. But, what ends up happening, is there is the validity of racism but then there is also what they may perceive as racism and projections of their own life so that it may or may not be there. And so because they are in therapy, then we are kind of teasing out which way is which. *Parenthesis added.*

These findings illustrate previous research showing that when clinicians are direct

in attending to the race of their clients, clients perceive this racial responsiveness as

helpful in intimacy and alliance building (Chauhan, Fuertes, Ladany, Meuller, & Walker,

2002). Participants report that validation of the clients racial experience in the world

shows the client that the clinician is present and willing to have open dialogue about what

the client finds challenging- including the issue of race, which is a difficult one for so

many.

Clinicians reported that "race talk" is "critical", that it "deepens" the alliance; that

it "gives you a window into their own (the clients) dynamics", that it "shows you care

and understand", it "affirms them", and that it "validates them as you tease out the

18

meaning". Two participants in particular offer that "race talk" can also expose other

equally deep experiences of the client. In example of this point, participant #7 offered:

> … I think sometimes it has strengthened it (the alliance) by being able to talk
> about it and knowing and hearing that there is an interest on my part and that I am
> opening it up to talk about it. Um, but I also think it is something that also can be
> an avoidance for something perhaps deeper or deeper in a different way… I think
> sometimes it leads to something else that actually might not have to do with race
> but sometimes a client might put that forth as "this is because of race" and I think
> sometimes other things come up that are beyond that or are about vulnerabilities
> or have a broader kind of implication. *Parenthesis added.*

Participant #11 somewhat similarly offered that when working in a same race

clinical dyad with a client whom had specifically sought out an African American

clinician, they had found themselves at an impasse.

> … a client had specifically asked for an African American therapist and um, I
> think there was an impasse in the treatment, which had nothing to do with
> necessarily a racial micro-aggression but that question came up to her wanting an
> African American therapist when we reached another kind of an impasse that I
> was somehow letting her down. She had been with a white therapist and she
> basically came to the same impasse with me… I actually then had a conversation
> with her about her original request to try to point out to her that it really wasn't
> necessarily an issue of her having an African American therapist that would move
> her along in her issue that she was seeking treatment for… it was more about her
> and not about her therapist… I guess I am thinking about where there was an
> impasse in treatment and it wasn't about race but it was… that race issue to me
> was obscuring what the client's real problem was.

Both clients illustrate a similarity of impression with regard to feeling that race

was in some way eclipsing their clients underlying issues. These perceptions urge

inquisition as to whether the perceptions are the result of transference and counter

transference on the part of a co-created relationship. It seems that there is no shortage of

opportunities to talk about race and that if clinicians are present and attentive to the

multitude of entry points that clients are providing both participants will co-create an

exchange of validation and subsequent depth and meaning (Banks, 1985; Taylor, 1976; Gibbs, 1985; Hayes & Banks, 1972; Jackson, 1980; White, 1980 in Robinson, J.B.).

Eleven of the participants in the current study reported that that they talk about micro-aggressions. Six of the participants reported that they also talk about race and oppression and all of them felt that these conversations strengthened the therapeutic relationship. This finding is in stride with Ponterotto (2003) who wrote that when the client does not feel that the clinician is responsive toward addressing the race of the client, the clinical relationship is weak causing the clients to be less invested.

Racial Countertransference

When exploring the issue of anxiety in the clinical relationship, participants shared that their anxiety was minimal, but that they where certain to actively engage in what the majority of them felt to be an issues of "boundary management", "attendance to transference and "counter-transference", issues of "assumption" and concerns around "over-identification". Seven participants reported not feeling anxious, two reported that they have on occasion held some anxiety and two reported feeling anxiety.

All of the participants who reported feeling some anxiety (n=5) shared that this anxiety was related to the issue of boundary management. These five participants reported that they although anxious they remained attentive to "staying conscious of making their clients time about them", and "not wanting to bring too much of myself into it", because they "want to be helpful to the client". Specifically participant #3 had this to say about boundary management:

Well, as an African American I certainly have my own issues. So, the anxiety is… okay, I need to have a boundary here with what I am being presented with as opposed to what my own issues are. And not wanting to color their um, the sharing of their experience with um, what I might be saying from my experience or from my own issues. I am just really conscious of making when they com to see about their issues and not mine. You know, I can't have them come in and be like 'Let me tell you about what happen to me'.

Participant #7 offered that her anxiety is slightly different but still in attendance to boundaries. She shared,

I have had times of anxiety. I don't that as a rule but I have had times of that and most of those times for me are when I think that the client has an assumption about how I will feel. Whether the client is saying something about race or connects something to race and is assuming "well of course you feel the same way because you are black or you are African American". Then there have been times that I have felt anxious. Like the whole thing of, "Are you black enough'? Or that kind of thing, sort of putting it on that level which sometimes feels like it can get in the way of being able to talk person to person because there is an assumption of what we should or I should believe... in those cases I have gotten anxiety because I don't know if this person is going to allow me to get to know them based on their experience. Or is it going to get in the way because there is the assumption of "well I should feel the same way" … can I be free to ask the client to tell me what their experience is like without necessarily having the same agreement.

This illustration underscores the issues of colorism and racial transference or counter-transference as well as the issue of internalized racism. Half of the participants talked about what impact their race has on the clinical dyad. Of those six, two Biracial, African American Identified participants shared that they each felt that their biracial presentation, regardless of their personal racial identification seemed to produce anxiety for both themselves and their clients in the clinical dyad. They reported they have been let wondering, "Am I Black enough?" Participant #6 offered deeper reflection stating:

I am biracial… I identify as African American, culturally… there are some times that people want to discount, you know like, "Oh well, you are mixed so you

21

don't understand", or you know, "You are light skinned so you people don't get it" and so what I find myself often doing is, um, using slang or verbiage that is kind of like, "I get you"… balancing the two types of vocabulary so that we can talk… but I can also talk you as your therapist who does have, you know, this additional insight and education into what is going on.

Participant #10 offered:

…I think as far as African Americans working with African Americans we have to understand that depending on how light your skin is or how dark your skin is informs of how people are going to relate you. And that it can be very, very different especially since lighter skinned African Americans don't experience it as much as dark skinned African Americans …

Participant #3 reported:

… there are also African Americans who have negative perceptions of African Americans um, that maybe the quality of service may not be as good from another African American. That is something that is real and to be aware of that and to be aware of their issues around the subject as opposed to … you know, I was talking about the boundaries and not to go in their like "I know exactly how you feel, here is what it is like for me" because the clients issues become overcome with that.

These illustrations accentuate the experience of being a person of color in a same race dyad. As discussed earlier, similarity of race breeds intraracial politics that if explored can provide context for better understanding the experience of the client and the clients interpretations of the world. The participants stated that they brought their personal stories or philosophies into the clinical space "only to the extent that it is useful to client". In those times the clinician remained attentive to doing so in an effort to "normalize", and "explore meaning behind client's assumptions" by asking questions like, "is it important we feel the same way"?

An interesting similarity that was illuminated was the lack of exposure to intra-racial micro-aggression in the dyad. Participants offered that they would discuss them if

they arose but that they rarely, if at all do arise. One participant offered a possible lens for understanding this lack of exposure by saying that:

> I would discuss them if they had happen. So, far they haven't happen with African American clients. I try to create space to talk about race with all clients to talk about issues around race, experiences of micro aggressions. Um, I probably have discussed it indirectly in terms of... well, no, I don't think I have. We have certainly talked about issues of race and how they have impacted the client but not how it has impacted conversations between us.

Further on in the interview she harkens back to the issue of same race micro-aggressions in the clinical dyad, and said:

> It's kind of interesting that I vividly can remember experiences where it's with a white client or a client who is not similar to myself, versus it goes in to the unconscious with clients who are similar to myself… that instance happen in the last month… you know for her to come in like "where is the therapist" … you know she has never had an African American therapist. So, I mean, that's a whole of unpacking of so much… it wouldn't be in her reality that I could be the therapist. So, that says a lot on many levels.

In this illustration we are exposed to the clinician's unconscious process regarding what clinicians of color might do when faced with same race microaggressions. Because microaggression are, by their nature, latent, it is easy to see how they may be missed particularly when it is in the cross racial dyad that individuals are most aware of its occurrence.

It is worthy of note that the majority of the participants (n=8) reported that they felt that their African American racial presentation and identification was catalyst for making discussions about race possible in their same race dyads. This could be due to the perceived similarity of race on both the part of the clinician, as well as the client. However, whatever the catalyst or comfort level the occurrence of countertransference, with regard to the issue of race, is incalculable. However, as stated above, a number of

the participants felt that being of similar race aided in introduction an exploration of issues around race. This commonality of perspective is illustrated by participant #11, participant #3, participant #12, participant # 8, and participant #1.

Participant #11 reflected:

I do think it's the shared experience of being part or a member of a racially oppressed group um, and I do want to say that I really do try to approach the clinical work without the assumptions that every one has had the same experience, and even if we have had the same experience, the way that you interpret it, internalized it and all of those things still may not be the same as for myself… I think there is some shared understanding between my self and African Americans client. And I think in my work with African American clients I think that sometimes there is a sense of relief having an African American therapist.

Participant #3 reported:

… seeing them as being important enough to be heard. Um, I think in some cases I have used the term "marked", I am marked by the color of my skin. What that means is there could be positive racial prejudice because I am also Black and that they can just come to me and I will just understand everything. And I actually get some of that here. People will just come to me or want to talk to me and they are not even my clients, but because there are no other African American clinical staff. So, my plate gets full, so I call that 'positive racial prejudice'.

Participant #12 stated:

… I identify myself as African American. I am very much proud of my culture and my um, heritage and so I think that comes across um, in a way that is very authentic… and so I think that my approach in general makes it easy for my African American and my non-African American clients to talk openly about these issues.

Participant #8 offered:

… going through my own professional growth and development… know it (racism) exists, I know that its there, I know the subtleties of it, um, I know how it can present itself and so it makes the dialogue with my clients easier because they don't have to explain um, all the pieces to me and help me to understand when someone says "So, you *where* did you go to school?" and they don't ask anyone else where they went to school. So, I think it helps … because they have been looking for a therapist, they specifically want an African American therapist who

24

understands what it means to work in these environments and how to balance all this out. So…um, that is what I think allows the conversation to occur.

Participant # 1 shared:

… I am interested in my clients. So, it is just another area of discovery and questioning. As a Black person, growing up in America, as a Black person period the issue of race is very much part of my life, very much part of my existence. I don't feel like it is something that can be put on a shelf and not come back to. It flavors everything in all kinds of different ways. It is just necessary. I don't think there is a choice.

Most of the participants (n=8) talked about the impact that being African American has on the same race dyad. The phrase "positive racial prejudice" that participant #3 used could also be seen a form of positive transference and counter-transference with regard to race, because he is perceived to be a member of the same group. It is important for clinicians to be aware that this could be a potential "blind spot" (Holmes, 1999). The clinician must attend to the role his or her own intrapsychic structure plays in the development of the clinical relationship. If not, it could "the ego resourcefulness" of the therapist could limit the overall efficacy of the treatment relationship (Holmes, p. 319).

The remaining participants (n=4) reported that "confidentiality", "addressing treatment stigma in the Black community", clinical transparency" and "clinical responsibility" as their driving forces for engaging in "race talk" with their clients. Participant #7 expands on this notion of clinical responsibility by saying:

… It is important to be able to open dialogue and conversation because that is why people are in the room ... And particularly in our culture when it comes to race and the whole history of race and what that means. Especially when it connected to how people see themselves or how it affects the two people in the room. I think it is fundamental. How can we do this work? I am not trying to say that I don't mess up or that I do it perfectly but more that it is my goal to try and do it and to struggle with it sometimes. But wanting to and having it as a goal, an

important one to incorporate that- I think, is important. How can you not, in a sense, is how I feel. How can you not address things that come up?

Perceived benefits

Participants collectively (n=11) agreed that White clinicians could benefit from the exposure to the principals and practices of African American clinicians who are working with African American clients. They offered a variety of ways that this information might be of support White clinician's work with African American clients. Participant #1 stated:

> …I think that white clinical social workers do benefit from it (material on micro-aggression). I think that it makes the work that they do richer. I think that it also requires a certain degree of vulnerability because they have to acknowledge a certain power dynamic that is evident, by the very definition of race. Prejudice is one thing, racism is another thing. That fact that one group has more power than another group historically and how do you mange that so being able to talk about it is important and I am not going to say that it is easy for White clinicians to necessarily do so, unless they are educated in a certain way, unless they are open in a certain way.

Participant #5 states, "I think that it could help to at least keep talking about it. It can help bridge some of the racial divide. Normalize. You know, make people understand that it is still going on." A way for white clinicians to do this is to develop a greater awareness of their own attitudes about race and how said attitudes impact the interracial dyad (Todisco, et. al., 1991).

Participant #6 offered,

> … I think it would help them understand the experience of the African American. Especially in today's times where racism is not always as blatant as it used to be. There is no sign that says "Whites Only", but there are a lot of subtle cultural innuendos and I think that if you are not of African American or Hispanic or of minority culture you know, or in intimate relationship with someone, then you don't understand how things can be perceived by others.

Participant#8 shares this philosophy and adds,

I have to learn two languages. I have to learn two sets of behaviors and how to observe those behaviors and um, assess what it not being said. And so, unfortunately, um, I think that my white colleagues, white clinicians still have a lot of growth in this area. I think a lot of things are missed in session because one, what they think they know culturally about the African American client and what they have read but they also don't know that where, I know, you know that, while no matter how sophisticated you are and no matter how much education you have there is a stigma about being in therapy and you don't go and tell someone your business and especially not someone White.

And to this end Participant #11 continues by saying,

African American clinicians, a lot of clinicians regardless of their race or ethnic backgrounds sometimes discount race and even if you are not addressing it but if you are aware of how it impacts or understand the role it may or may not have in treatment. I think that it could be beneficial in that way, just bringing awareness of these issues as clinical material, not necessarily as a problem. It just stems as part of what their experiences is, not as their totality. I mean we live in a society where race is very much an issue and it's only fair and then when we go into the clinical setting which is personal. So, if it not being discussed there, there is something wrong with that.

Participants #6, #8 and #11offered insight into how race is a complicated facet of

the clinical relationship. They each also offered how important it is to address it directly.

Constantine (2007) wrote about clients of colors perceptions of their white therapists,

capacity and interest in talking about race. Constantine also discussed the impact of client

perceived hostility on the part of the clinician and the impact that has on the therapeutic

working alliance. The participants of this study highlighted that if a helping professional

enacts a form of racial aggression upon a client of color that effect of this can be more

detrimental than had that aggression been enacted by a laymen. As research has shown

us, such enactments can result in early termination (Constantine, 2007) which is a

common occurrence, in the case of the African American client.

Participant #7 specifically stated that it would,

> … I think that in our country most African Americans have an awareness of race living in our own skins… it gives African American clinicians strength to go on with these discussions. It is not always easy and um, sometimes there might be a desire to just, because of some of the pain and struggle to just say 'okay I don't want to deal with that'. I have had that, 'hindrance' where if I am completely honest, I feel like 'I don't feel like it', 'do I really need to bring this up', I am tired of it', 'I have spent all these years with it, can't we just get past this?' … so in that sense I think too it can be another reminder, just having things more open that this is important there are things that we miss or things we have not thought about in the same way that again, by having more dialogue, we can have more opinions, more experience…

Participants felt there was limited information regarding how to facilitate healthy dialogue when racial transgressions occur in the context of a clinical relationship. They perceived this as a gap in the training that they received. Participants felt that more information would have multiple benefits. They felt that it would illuminate challenges such as "class and racial completion in the dyad", they felt that it would "be validating for us (African American clinicians) to have language", it would "give permission and strength", it would help "to develop comfort and give a framework",   and that it would be good to "get away from cultural competency" because, in agreement with what Stuart (2004) stated, cultural competency efforts minimize opportunity to explore individual experiences which in effect is one of the ways that breed stereotype.

CHAPTER V

IMPLICATIONS

Based on the findings of this research study African American clinicians may be interested in becoming better equipped to effectively respond to the racial experiences of their same or other raced clients. Through exploration of race and attendance to the ways that race manifests in the daily lives of clients of color clinicians in this sample were able to get a holistic look at their client's intrapsychic experience of the world. Multicultural competency trainings tend to graze that surface of what is an exquisitely deep relationship between one's race and their experience of the world. Cultural competency may be a satisfactory macro practice but fail to provide the depth of attendance that therapeutic work requires.

The implications of the participant's responses, although limited by sample size, may indicate that one of the ways that clinicians can remain in attendance to their client's racial experiences is to address microaggressions that occur both in and outside the clinical setting.   By being open to attending to issues of race that arise in the therapeutic dyad the clinician shows the clients that they are interested in hearing about the clients whole story, including the parts of their story that are scary and difficult for both the clinician and client to discuss. In order for the client to take the risks necessary to expose themselves to and explore themselves with the therapist, it is important for the client to feel that the clinician is safe enough for exploration of their deepest hurts. This safety builds clinical alliance between client and clinician and offers a depth of experience that

the client might otherwise not experience if they are guarded and uncertain that their clinician can stay present and explore the deepest most difficult parts of racial experience. Participant's responses agreed with Holmes (1991) that clinicians need not only attend to their client's racial experience, but also to their own. Continuing research and exploration on the ways that African American clinician use themselves either through transference, counter transference or treatment appropriate disclosure, would serve to benefit the field of social work.

The participants confirmed that, at least for them, cultural competency fell short, and that clinicians must pick up and continue forward. More specifically, the participants of the study felt that cultural competency fell short of adequately exploring the intrapsychic experience of their clients and in turn they felt that "race talk" was an important way of showing the client that their experience if both important and of interest to them, as clinicians and African Americans themselves.

Strengths and Limitations

The sample size for this is study was too small to be at all generalizable to others and to do so would be to perpetuate yet another stereotype- that of the African American clinician. Any future exploration or research on this topic should aim for a larger population pool and should aim to control variables including but not limited to, the geography of the participant, participant's number of years in practice, the participants self-identified class, their political viewpoint, the generational contributions of the participant, the sex of or gender preference of the participant, the clinicians personal exposure to psychotherapeutic treatment around their own race, and the racial self-

identification of the participants with regard to being single, bi or multiracial in their personal identification.

This study was drawn and based upon a small convenience non-representative sample of African American clinicians. Nonetheless, perhaps these findings may hold validity for some African Americans. Further exploration of these issues is warranted and indeed clearly needed. Due to the unique relationship between African American and White communities this research focused solely on this racial pairing. This study therefore falls short of exploring the equally important racial experience of any other race. It does not explore the racial experience of another marginalized group and it should not be assumed that all racial groups would share the same understanding and or experience or interpretation of their race or the racially based microaggressions that they experience.

Conclusions

Regardless of its blatant manifestations having been diminished, racism is still very much an issue in this country (Miller & Garran, 2008). The fact that our society has slowed its more visible and direct demonstrations of racism does not take away from the fact that this country's heritage of slavery against African American's continues to impact and impair their development (Wilson & Stith, 1991), opportunities and overall trajectory of wellness both in and outside this country. The legacy of slavery continues its multi-generational exploit of the wellness and opportunity for African Americans and can have a profound impact on their mental health and treatment longevity (Hollar, 2001). Because of this fact it is important to explore the unique and very individual experience

31

of African American clients and not simply rest upon attendance to cultural norms (Rogers-Sinn; 2008), gestures and holidays.

These topical attempts at acknowledgment of African American culture may support, versus diminish stereotypes (Ridley, 2005; Stuart, 2004; Pennington, 2008; Wilson& Stith, 1991;), facilitate an air of "othering" and stymie the progress that could be made manifest if richer and more individual attendances cultural differences were facilitated. African American clients deserve and require interventions that are unique and related to their individual experience (Delphin & Rowe, 2008) and not a series of loose attendances to simple presumed overarching cultural norms that were in place for white clients who do not have a similar history (Chung & Bemack; 2002).

Furthermore, for clinicians not to attend to the nuanced ways in which racial slights can manifest in the treatment relationship is not only poor practice but also unethical. Racial microaggressions create race-laden inferences that are unconsciously ingested by the recipient and eventually become wed and embedded into the psyche-thereby proving to be the antithesis of treatment and healthy therapeutic alliance between clinician and client. Clinicians would do well to think about the ways that they can explore their client in a fashion that is inclusive of every facet of the client. Race is one of the primary defining characteristics for people of color. As such it should be held, acknowledged and explored as one of the primary facets not to be neglected forgotten or presumed to be handled without any spoken effort being given to the matter. African American clinicians hold a valuable voice with regard to development of racially astute and emotionally validating treatment. Through acknowledgment of both their own unique experience as well as through exploration of the individual experiences of their clients,

32

they are providing a vehicle for a revolutionary treatment paradigm that could have immeasurable implications for success and treatment longevity for African American clients.

REFERENCES

American Counseling Association, (1999). In Sue, D. W., Nadal. K.L.; Capodilupo, C.M.; Lin, A.I.; Torino, G.C.; & Rivera, D.P. (2008). *Racial micro-aggressions against black americans: Implications for counseling.* Journal of Counseling & Development, (86) 330-338.

Banks (1985); Taylor (1976); Gibbs (1985); Hayes & Banks (1972); Jackson, (1980); White (1980).   In Robinson, J. B. (1989). Clinical treatment of black families: Issues and strategies. Social Work. 323-329.

Buckard & Knox (2004). In Sue, D. W.; Nadal. K.L.; Capodilupo, C.M.; Lin, A.I;Torino, G.C., & Rivera, D.P. (2008). Racial micro-aggressions against black American :Implications for counseling. Journal of Counseling & Development, (86) 330-338.

Constantine, M. G. (2007). Racial micro-aggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology*, 54(1), 1-16.

Constantine, M. G. & Sue, D.W. (2007). Perceptions of Racial Micro-aggressions among Black Supervisees in Cross Racial Dyads. *Journal of Counseling Psychology*. 54(2), pp. 143-153.

Chung, R.C. & Bemak, F. (2002). The relationship of culture and empathy in cross-cultural counseling. *Journal of Counseling and Development*., (80) 154-159

Delphin, M.E. & Rowe, M. (2008). Continuing education in cultural competence for community mental health practitioners. *Professional Psychology: Research and Practice*. 39 (2), 182-191.

Dovidio & Gaertner, (2004) & Gaertner & Dovidio, (1986). In Penner, L.A.; Dovidio, J.F.; West, T.V.; Gaertner, S.L.; Albrecht, T.L.; Dailey, R.K. & Markova, T. (2009). Aversive racism and medical interactions with black patients: A field study. American Psychological Society (pp.25- 30)

Franklin, A. J. (1999). Invisibility and racial identity development in psychotherapy and counseling African American men. The counseling Psychologist, (27) 761-793.

Fuertes, J.N.; Mueller, L.N.; Chauhan, R.V.; Walker, J.A. & Ladany, N. (2002). An investigation of European American therapists approach to counseling African American clients. The Counseling Psychologist (30), 763-788.

Goodstein, R. (2008). What's Missing From the Dialogue on Racial Micro-aggressions in Counseling and Therapy. *American Psychologist,* 276-277.

Hansen, N.D.; Randazzo, K.V.; Schwartz, A. Marshall; M., Kalis, D.; Frazier, R.; Burke, C.; Kershner- Rice, K., & Norvig, G. (2006). Do we Practice what we preach? An exploratory Survey of Multicultural Psychotherapy Competencies. *Professional Psychology: Research and Practice*. 37 (1), 66-74.

Hollar, M.C. (2001). The Impact of Racism on the Delivery of Health Care and Mental Health. Services. *Psychiatric Quarterly,* 72(4), 337-345.

Holmes, D.E. (1999). Race and countertransference: Two "blind spots" in the psychoanalytic perception. *Journal of Applied Psychoanalytic Studies,* 1(4), 319-332.

Holmes & Rahe (1967). In Sue, D. W.; Nadal. K.L.; Capodilupo, C.M.; Lin, A.I.; Torino, G.C., & Rivera, D.P. (2008). Racial micro-aggressions against black americans: Implications for counseling. Journal of Counseling & Development, (86) 330-338.

Kearney, L.K.; Draper, M., & Baron, A. (2005). Counseling utilization by ethnic minority college students. Cultural Diversity and Ethnic Minority Psychology, (11) 272-285.

Loury, G. (2001). *The anatomy of racial inequality*. Cambridge. MA: Harvard University Press. (p. 96)

Miller, J. & Garran, A.M. (2008). *Racism in the United States: Implications for the helping professions* (p. 25)*.* Belmont CA. Thompson Brook/Cole.

Mueser, K.; Bond, G.; Drake, R., & Resnick, S., (1998). *Models of Community Care for Severe Mental Illness: A Review of Research on Case Management*. Retrieved October 31, 2009, from http://schizophreniabulletin.oxfordjournals.org/cgi/reprint/24/1/37

Pedersen, P. & Marsella, A.,(1982). *The Ethical Crisis for Cross-Cultural Counseling and Therapy*. Professional Psychology, 33 (4), 492-500.

Pedersen, A.; Walker, I., & Wise, M.(1991). "Talk does not cook rice": Beyond anti-racism rhetoric to strategies for social action. *Australian Psychologist*. 40 (1), 20-31.

Pennington, G.; Cooper, S.; Wilson-Stark, K.; Peterson, D.B., & O'Roark, A.M. (2008). Counseling competently in multicultural contexts*. Consulting Psychology Journal: Practice and Research*. 60 (2), 186-202.

Ponterotto, J.G. (2003). African American and European American therapists' experiences of addressing race in cross cultural psychotherapy dyads. *Journal of Counseling Psychology*. 50 (4), 466-481

Ridely, C. (2005). *Overcoming unintentional racism in counseling and therapy: A practitioners guide to intentional intervention.* (pp. 15-27). Thousand Oaks, CA: Sage.

Rogers-Sirin, L. (2008). Approaches to multicultural training for professional: A guide for choosing an appropriate program. *Professional Psychology: Research and Practice*. 39(3), 313-319.

Solorzano, D.; Ceja, M., & Yosso. T (2000). Critical race theory, racial micro-aggressions, and campus racial climate: The experience of AfricanAmerican college students. The Journal of Negro Education*, (69), 60-73.*

Strong, B. & De Vault, C. (1995). The Marriage and family experience (p. 28). In Bell-Tolliver, L.; Burgess, R., & Brock, L.J. (2009). African American therapists working with African American families: An exploration of the strengths perspective in treatment. *Journal of Marital and Family Therapy*. 35(3), 293-307.

Stuart, R. B. (2004). Twelve practical suggestions for achieving multicultural competence. *Professional Psychology: Research and Practice.* 35 (1), 3-9.

Sue, D.W. (1978). Eliminating cultural oppression in counseling: Toward a general theory. *Journal of Counseling Psychology*. 25(5), 419-428

Sue, D. W., & Sue, D. (2003). *Counseling the Culturally Diverse: Theory and Practice* (4th ed.).(pp.477-486) New York. Wiley.

Sue, D.W. et.al (2007). Racial Micro-aggressions in everyday life: Implications for clinical practice. *American Psychologist Association*. 62 (4), 271-286.

Sue, D. W.; Nadal. K.L.; Capodilupo, C.M.; Lin, A.I.; Torino, G.C., & Rivera, D.P. (2008). Racial micro-aggressions against black americans: Implications for counseling. *Journal of Counseling & Development*, (86) 330-338.

Sue, D. W.: Capodilupo, C.M., & Holder, A.M.B. (2008*).* Racial micro-aggressions in the life experience of black americans. *Professional Psychology: Research and Practice.* 30(3), 329-336.

Terrell & Terrell (1991). In Wilson, L. & Stith, S.M. (1991). Culturally sensitive therapy with black clients. *Journal of Multicultural Counseling & Development.* 19 (1), 457-486

Todisco, M., Salomone, P. R. (1991). Facilitating effective cross cultural relationships: The white counselor and the black client. *Journal of Multicultural Counseling & Development*. (19)4, 146-157.

Wilson, L. & Stith, S.M. (1991). Culturally sensitive therapy with black clients *.Journalof Multicultural Counseling & Development.* 19(1), 477-486.

APPENDIX A
HUMAN SUBJECT REVIEW LETTER OF APPROVAL

SMITH COLLEGE
School for
Social Work

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

March 4, 2010

Illana Jordan

Dear Illana,

Your revisions have been reviewed and they are approved. We are happy to give final approval to your study. I do have to say that I am concerned about all the mailing back and forth you plan to do because you're making demands on very busy people. You don't really have to require them to fill out a screening questionnaire. You can just ask them the screening questions over the phone and if they pass and they are interested, go ahead and set up the interview time and place. And of course, if it is going to be a phone interview, you will have to send them the Consent to be returned to you, as you say. The in-person interview people should also get a Consent to read, but they can sign it when they see you.

The way you have set it up is in compliance as far as Human Subjects Review goes, but we know how hard it is to recruit people and the simpler and more direct and less demanding the process, the more likely you are to be successful in your efforts.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. If you decide you want to simplify your recruitment process, you can always send in an amendment request.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: David Burton, Research Advisor

APPENDIX B
LETTER OF RECRUITMENT

Hello,

My name is Illana Jordan. I am a graduate student at Smith College School for Social Work. I am conducting an exploratory study seeks to understand how African American clinicians facilitate dialogue with regard to racial micro-aggressions in the therapeutic exchange. Additionally, the exploratory study seeks to understand any benefits or implications this facilitation has had on their interracial therapeutic alliances. I am seeking clinicians to participant in this study. By participating in this study you will be adding breadth to the field of social work with regard to working with clients from typically oppressed and marginalized communities. Additionally, you will be giving voice to what is also a minimally explored voice - that of African American clinicians.

If you are interested in participating in this study, you: identify as African American, have an MSW/CSW, hold the appropriate clinical licensure, have worked in a fulltime position as clinician with primarily (at least 50%)African American clients for at least a year, and speak fluent English. Due of the nature of the research study, diversity of race and ethnicity are isolated. However, I will strive for diversity of gender, sex, sexual orientation, gender presentation, identification or expression, religion, socioeconomic status and physical capability.

Please contact me by phone at xxx-xxx-xxx or by email: xxx@smith.edu to learn more about the study or to arrange for an interview. I will interview the first fifteen African American clinicians who fit the aforementioned criteria.

Sincerely,

Illana C. Jordan

APPENDIX C
SCREENING QUESTIONAIRE

1. Do you identify as African American?

2. Do you have a Master's in Social Work?

3. Do you currently hold appropriate licensure to practice clinical social work?

4. Have you worked fill-time as a clinician with at least a 50% African American client population for at least a year?

5. Do you speak fluent English?

APPENDIX D
DEMOGRAPHIC QUESTIONAIRE

1. What is your name?

2. What is the best way to reach you?

   a. What is your phone number?

   b. What is your email address?

3. What is your current age?

4. With what ethnicity or culture do you identify?

5. How do you describe your gender?

6. What is your sexual orientation?

7. If applicable, what is your religious or spiritual affiliation?

8. What is the highest level of education you have completed?

9. What is your current job title?

10. How do you describe the environment in which you were raised?

    a. Was it racially homogenous?

    b. Was it racially diverse?

APPENDIX E
GUIDED INTERVIEW QUESTIONS

Frame and Definition: This study will define micro-aggressions as "Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color (Sue, D.W. et.al, 2007). I will then share a written definition of micro-aggressions with the participants and answer any question they may have regarding said definition.

The participants will then be asked the following guided interview questions:

1) Do you discuss racial micro-aggressions in treatment with your adult African American clients?
   a.) If so, who typically introduces the topic or issue?
2) If not, do you discuss race and oppression with your adult African American clients?
   a.) If so, what does that discussion look like?
   b.) If so, how would you say that these conversations impact the therapeutic alliance with your clients?
3) Do you experience anxiety with regard to discussing issues of race/micro-aggression/ oppression with your African American clients?
   a.) If so, do you articulate your anxiety to you clients?
   b.) If not, what impact would you say your anxiety has on your capacity to be present with your clients?
4) Do you discuss racial micro-aggressions that occur between yourself and your clients?
   a) If so, what has been the impact of these conversations?
5) What, if anything, do you perceive as a hindrance to your ability to talk about racial micro-aggressions with your African American clients?
6) What, if anything, makes these conversations with your African American clients, possible for you?
7) Would you please share with me how you think white clinical social workers might benefit from this material as they continue to work with African American clients? and
8) Would you please share with me how you think African American clinical social workers might benefit from this material as they continue to work with African American clients?

APPENDIX F
CONSENT FORM

Dear Participant,

My name is Illana C. Jordan. I am a Master's candidate at the Smith College School for Social Work in Northampton, Ma. I am conducting a research project on how clinicians handle racial micro-aggressions that occur between client and clinician and if clinicians discuss racial micro-aggressions that occur outside of the dyad. The project will serve as my Master's level thesis, as well as for public presentations and possible publication.

Your involvement in this study will involve an hour long interview. I will be taking field notes and, with your permission, audio taping the interview. I will be doing all of the transcriptions myself or hiring a transcriptionist who will have to sign an agreement of confidentiality.

There are few perceived risks with regard to participating in this research study. However, the questions in this study have the potential to bring up emotional issues related to your connection to race and work with or experiences with racial oppression. You may find the subject matter a source of internal conflict that could result in feelings of guilt, shame, frustration and anxiety because of the sensitivity of the topic. My hope is that through participating in this study, you will be contributing to the body of knowledge about race in the clinical setting in addition to providing an opportunity for you to reflect on the work you have done. No monetary compensation will be provided for your time.

Please know your identity and demographic information will be kept confidential. Your name and identifying information will be removed from all of the statements you make. Any statements you make that I use in quotes or vignettes will be carefully disguised in all publications and presentations. All data will be kept in a secure location for a period of three years, as required by Federal guidelines, and all electronic data will be password protected. Should I need the material for longer than three years, they will continue to be kept in a secure location and will be destroyed when no longer needed.

This study is entirely voluntary. You may contact me at any point prior to April 1st, the end of data collection, to remove your data from the study prior to data analysis. If you do choose to withdraw from the study, all of the data pertaining to your interview will be destroyed immediately. During the interview, you have full right to skip interview questions or to stop in the process. If you have any additional questions or do decide to withdraw, please feel free to contact me at XXX@smith.edu or XXX-XXX-XXXX. If you have any concerns about your rights or any aspect of the study, I encourage you to contact me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____   _____
Researcher signature   date
_____   _____
Participant signature
        date