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Clinicians behind the curtain : are White Smith students addressing race and racism, why or why not? If so, how?

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Malcolm Russell Pradia
Clinician Behind The Curtain:
Are white Smith School for Social Work Students Addressing Race and Racism
Why or Why Not? If So How?

ABSTRACT

The literature confirms the importance of providing cross-cultural education and the development of cross-cultural skills for trainees entering clinical practice. In recognition of this, Smith College School for Social Work has a written commitment to anti-racism and as part of this commitment the college has developed a curriculum that addresses race and racism in clinical practice and the social work profession. Given this commitment, this study surveyed twelve white Smith College School for Social Work students to understand if white Smith students were addressing race and racism with clients of color in clinical practice, why or why not, and if so, how they were doing it. Results showed that the majority of white Smith students were addressing race and racism with clients of color, and while the majority surveyed could identify skills and techniques to address race, the majority were doing so inconsistently. Results further indicated that when race was addressed, it was the client's race and not the clinician's race. These findings are discussed and their educational implications raised.

Keywords: race, racism, multi-cultural competency, racial color-blindedness

Clinician Behind The Curtain: Are white Smith School for Social Work Students
Addressing Race and Racism, Why or Why Not? If So, How?

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

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	5
III METHODOLOGY.....	18
IV FINDINGS.....	22
V DISCUSSION.....	53
VI CONCLUSION.....	61
REFERENCES.....	63
APPENDICES	
Appendix A: HSR Approval Letter.....	65
Appendix B: Informed Consent Form.....	66
Appendix C: Recruitment Email.....	68
Appendix D: Follow-up Email to Participants.....	69
Appendix E: Interview Questions.....	70

CHAPTER I

Introduction

Since 1994, the School for Social Work at Smith College has operated with an explicit commitment toward anti-racism in all aspects of its policies, practices and teaching methods (Basham, 2004, p. 290). This research study will explore the practice of Smith College School for Social Work (SSW) students in addressing race and racism in therapy with clients of color. The purpose of this study is to identify and better understand both the motivations and apprehensions that white Smith (SSW) students may have in addressing race and racism, two topics often labeled as challenging or uncomfortable by the dominant society, with clients of color. The following is the research question that this study will seek to answer: Are white Smith SSW students addressing race and racism in therapy with clients of color? Why or why not, and if so, how? Smith SSW students remain a compelling population to examine given the institution's explicit commitment to recognizing the importance of race and racism, including in clinical practice. Investigating how this population navigates race and uncovering Smith's likely strengths and shortcomings can later serve to inform a larger population of clinicians.

Definitions

There are multiple terms that may be key in fully understanding the current literature and the research and subsequent findings of this study. With that in mind, this section will briefly define the following terms: White Supremacy, Whiteness, Racism, and Color-blind Racism.

White Supremacy

White Supremacy is a term that has been used in a multiple contexts and carried a variety of different meanings. For this reason a definition of this term is included in a context that is relevant to this research. The academic term used to capture the all-encompassing dimensions of

White privilege, dominance, and assumed superiority in mainstream society. These dimensions include: ideological, institutional, social, cultural, historical, political, and interpersonal (DiAngelo, 2012).

Whiteness

The aspects of racism that specifically elevate whites and their associations (DiAngelo, 2012).

Racism

Sometimes racism is understood as the result of individual acts of discrimination or oppression. However, it is necessary to also understand racism as a larger system in which these individual acts function. The United States and Canada, racism refers to White racial and cultural prejudice and discrimination, supported by institutional power and authority, used to the advantage of Whites and the disadvantage of people of Color. Racism encompasses economic, political, social, and institutional actions and beliefs that perpetuate an unequal distribution of privileges, resources, and power between Whites and people of Color (DiAngelo, 2012).

Color-blind Racism

Color-blind ideology protects “the belief that race should not and does not matter” (Burkard and Knox, 2004, p. 388). It is the ideology that pretending that we don’t notice race will end (or has already ended) racism (DiAngelo, 2012).

Conversations focused on race and racism can be challenging, especially if they are cross-racial conversations involving people from different races or ethnic backgrounds. In a therapeutic setting it can be even more difficult, compounded by a painful history that many people of color have experienced with mental health institutions. As Chang and Yoon (2011) acknowledge, “well-documented psychiatric abuses of Black Americans have caused many to be

mistrustful of the mental health care system which may complicate the rapport-building process with a therapist perceived to be an out group member” (p. 567). As a consequence, white therapists may avoid or neglect addressing race. “Research has documented the discomfort that white therapists display in cross-racial interactions and their subsequent avoidance of racial and cultural material in therapy” (Chang, 2011, p. 567).

The silence of white therapists working with clients of color is problematic, as a growing number of professionals are identifying race and racism as having a significant role in cultivating a therapeutic relationship that affects the overall treatment process. In fact, Chang and Yoon (2011) suggest that, “the past 20 years have seen a gradual shift towards recognizing race as having both an external reality as well as a psychic reality that affects unconscious and conscious ideas about the therapist and the therapy relationship” (p. 568). Chang and Yoon (2011) further highlight the extent to which race influences the therapeutic relationship and treatment process in explaining that, “there is growing consensus among multicultural counseling experts that explicit acknowledgement of therapist-client differences may help to facilitate the development of the therapeutic alliance and improve client satisfaction with treatment” (p. 567).

Understanding that white therapists often find it challenging to address race in practice with clients of color, while also recognizing the significance of the therapeutic alliance in relation to the treatment process; it might well serve the profession to begin to understand why some white therapists are indeed holding back or avoiding these conversations altogether, while others are more compelled to address race. Maxie, Arnold and Stephenson (2006) noted the importance of this type of research in suggesting that, “ethnic and racial differences between client and therapist affect therapy processes and outcomes, but little is known about the extent to which therapists have dialogues about their differences in therapy” (p. 85). Better understanding

what motivates or discourages white Smith SSW students to facilitate these dialogues, may inform how curriculum is developed or changed at the educational level. So too, at a higher level it could even serve to inspire possible professional development. Ultimately, exploring this topic further will serve to benefit people of color, as white clinicians will be more informed in supporting this community in treatment and during the healing process.

As a theoretical framework, Critical Race Theory will guide the research process in answering the research question. Ford and Airhihenbuwa (2010) explain that, “Critical Race Theory integrates transdisciplinary methodologies that draw on theory, experiential knowledge, and critical consciousness to illuminate and combat root causes of structural racism” (p. 31). Through this lens, the research will distinguish between the personal and individual and consider the macro level systems that may be influencing a white clinician in how to address race and racism or avoid it altogether. Furthermore, “Critical Race Theory challenges widely held but erroneous beliefs that “race consciousness” is synonymous with “racism” and that “colorblindness” is synonymous with the absence of racism” (Ford and Airhihenbuwa, 2010, p. 31). As Burkard and Knox (2004) further articulate, “Individuals who hold color-blind racial attitudes tend to deny the individual, institutional, and cultural manifestations of racism and believe that race has little meaning in people ’s lives” (p.388). This particular ideology would be problematic in a clinical setting as it ignores the fact that in the United States there is a continued rise in the formation of hate groups, unemployment rates among African Americans consistently remain double those of White Americans and annual incomes of people of color continue to be disproportionately lower compared to White Americans (Burkhard and Knox, 2004). The literature seems to conclude that understanding racism systemically is critical in clinical practice.

A colorblind ideology, “may unwittingly perpetuate racism in the psychotherapy process” (Burkhard and Knox, 2004, p. 388).

While there is an abundant amount of literature that suggests addressing race and racism in clinical practice is important and directly related to the success of developing a therapeutic relationship in cross racial dyads and sustaining treatment, there is limited amount of research that explains how white therapists are actually addressing race with clients of color and acknowledging this importance. This study then will serve to bolster the limited amount of research that has pursued uncovering what persuades white therapists to discuss race in practice. Further research may produce data and a better understanding as to what motivates white clinicians to discuss race in practice with clients of color and as a result, help shape educational institutions and clinical institutions in how they train staff, especially white staff, in addressing racism and adhering to culture competent practices.

Overall, this study will work to support educational institutions and clinical organizations in strengthening their training process and develop the social work profession and others like it, as well as continuing a pursuit that advances an agenda devoted to social justice. In that respect, this study’s intended audience is not limited to white clinicians working with people of color, but exists for all that recognize equality, including access to informed mental health services, cannot be achieved while systems of oppression such as racism continue to thrive.

CHAPTER II

Literature Review

There is an abundant amount of literature acknowledging the importance of cultural competency in clinical practice and the significance of race and racial identities in therapy,

particularly in cross-racial dyads. Much of the literature concludes that racial difference can serve as an initial barrier in building rapport between a white therapist and clients of color. The literature cites a swelling of mistrust from people of color, born out of a complicated and painful history with mental health services. Ultimately, the literature seems to be unanimously supportive of identifying and discussing cultural differences as the necessary method to beginning the therapeutic process.

Overwhelmingly the literature highlights the discussion of race as essential; however, it also suggests that cultural competency training is often limited, insignificant, and incomplete at the educational level. These two findings propose an incongruity that comes with likely consequences, especially among people of color seeking treatment. Basically, talking about race in cross-racial dyads is important, but white therapists may not be educated on how to successfully accomplish this. And while some studies have explored potential methods of acknowledging race, such as through therapist self-disclosure, this type of research has been almost absent. Indeed there is an inconsiderable amount of research that actually describes *how* white therapists may be addressing race with clients of color. The research has not yet fully examined the specific methods white therapists have engaged to address race and furthermore it has not explored what has compelled white therapists to do so with clients of color.

This research seeks to investigate this incongruity between the importance of discussing race in therapy and the possible lack of preparedness of white therapists after receiving education on race and cultural competency. In doing so, it is the hope that the data yielded may produce results that explain whether or not white therapists are addressing race with clients of color, how they are doing so, and what compels them to do so. Answering these questions will continue to support the professional field in developing new avenues to supporting people of color and

enhancing their experience in therapy while also informing how we can continue to construct appropriate curriculums.

Therapy begins like many relationships, by building an alliance and a sense of trust, and as literature suggests, race is not considered inconsequential nor is it seen as outside of the therapeutic relationship. Racial difference between the therapist and the client is widely considered as an important variable that affects the relationship (Chang and Yoon, 2011). Indeed race is an obvious player that can inform the treatment process. Many authors acknowledge the importance that race plays in this regard. As Cardmil and Battle (2003) support this notion by explaining that, “open discussions with clients regarding issues of race and ethnicity is one way to actively include a multicultural element into psychotherapy, as well as to strengthen the therapeutic alliance and promote better treatment outcome” (p. 278). Others have underscored these similar sentiments but with a greater sense of emergency, implying that it may be *critical* to clients of color that white therapists discuss racial and cultural similarities and differences in practice (Burkard, Knox, Groen, Perez, & Hess, 2006). Chang and Yoon (2011) pose that client-therapist differences in cultural values directly interfere with clients’ engagement in therapy and perceptions regarding the credibility of services. However, perhaps it is Gushue and Constantine (2007) that best frame the relationship between treatment success and discussing race in therapy by signifying that, “a psychologist who is cognizant of both the racial context and the impact of race on his or her own identity will have a better chance of creating a therapeutic alliance in which clients feel that their experiences are validated (p. 326). As the literature affirms, talking with clients about race benefits and contributes to a stronger therapeutic relationship. Addressing race creates an opportunity for healing a legacy of silence and shame in creating an environment of emotional safety within counseling relationship as a means of transitioning from a level of

superficiality toward a measure of intimacy that is crucial to embracing difference (Day-Vines, 2007). However, literature still provides little knowledge in the area of how white therapists consider and discuss race, and furthermore what serves as motivation. In fact, plenty of the literature implies that is difficult for white therapists to do and in some circumstances it is not being done at all, or very limitedly.

As suggested by Chang & Yoon (2011), “many white clinicians feel uncomfortable broaching the topic of race in therapy, whether directly or indirectly, due to their own cultural and racial socialization” (p. 580). This point is further recognized by Gushue & Constantine (2007) who facilitated a study with psychology trainees and found that white individuals are more likely to adhere to color-blind racial attitudes in comparison to trainees of color (Gushue & Constantine, 2007). D’Andrea (2005) makes a similar case, conveying that, “many White counseling psychologists and White students express heightened anxiety and anger when they are pressed to talk about the role that counseling psychologists should play in confronting the complex problem of racism” (p. 531). As D’Andrea (2005) further notes, white students often respond with apathy, withdrawal, or anger when presented with these issues in professional settings and do so as a way of minimizing race, experiencing likely uncomfortable feelings (p.533).

This reality can be challenging for people of color, especially in the context of counseling where past negative experiences may cause clients of color to approach white therapists with caution (Burkard, Knox, Groen, Perez, & Hess, 2006). Recognizing a history that has contributed to an unequal power dynamic and a lack of empowerment or sense of agency for clients of color, it is arguably the white therapist’s obligation, indeed an *ethical* obligation given the implied benefits of having these discussions with clients of color in cross-racial dyads, to bring up race.

Not addressing race in cross-racial dyads where the client is a person of color and the therapist is white, not only fails to serve the client effectively, but also “included in this stance is a denial that racism continues to benefit white individuals” (Gushue & Constantine, 2007, p.322). “These defensive reactions have been shown to adversely impact communication and the ability to collaborate effectively across racial lines” (Chang & Yoon p. 567). Studies that have explored cross-racial dyads in therapy with a white therapist and a client that is a person of color, have further provided evidence that support the above claims.

The Council on Social Work Education (CSWE) Educational Policy and Accreditation Standards and the National Association of Social Work (NASW) Code of Ethics both have a cultural competence mandate (Abrams & Moio, 2007). Some argue that current mental health disciplines lack comprehensive curriculums needed, related to race, cultural competency, or social justice. Lack of training may be one possible hypothesis that explains therapists’ inability or apprehension in addressing race with clients of color, a critical component of the therapy process. Chang and Yoon (2011) discussed one empirical study that was designed to “clarify the connotative meaning of race from the client’ s perspective and its perceived impact on the therapy relationship” (p. 569). This study found that the majority of participants, people of color, felt that they could not be understood on a deep, emotional level, if a white therapist was limited in his or her ability to appreciate how their minority status and identity as a racial and ethnic minority informed their lived experiences (Chang & Yoon, 2011, p. 573). The inability to foster a connection in the context of the client’s racial experience on the part of the therapist, led the client to be less likely to invite conversations of race. Indeed, these clients refrained from bringing up racial and cultural issues with their therapist, specifically because they found it difficult to discuss experiences of racial oppression, cultural practices, or community dynamics

due to concerns that their therapists would not respond with empathy, validation, or cultural sensitivity (Chang & Yoon, 2011, p. 573). Therefore, a white therapist's inability to address race with clients of color is not without consequence. Another hypothesis is that many curriculums are underdeveloped, but other literature suggests that it's more than a curriculum improvement that may be needed. Abrams and Moio (2007) make a case citing research that suggests "diversity content in social work education is often hindered by a lack of student readiness to deal with difficult or contentious discussions about race or other oppressions in the classroom setting" (p. 248). They further report that students resisted material, particularly when the conversation turned to issues white privilege in particular (Abrams & Moio, 2007). The study found that 71% of white students identified that their own privilege acted as a barrier to learning about or accepting the existence of oppression (Abrams & Moio, 2007, p. 248). However, Abrams and Moio (2007) are not challenging the student's character, in fact they make a case from reconsidering the format of many curriculums that have approached educating students with a cultural competence model, rather than a different model like a model based on Critical Race Theory. "The cultural competence model may not move students from these more primary defensive responses to a more refined critique of privilege and then to social action (Abrams & Moio, 2007, p. 248).

It becomes evident then, that white students in particular may not be able to develop the necessary tools to engage conversations around race and racism with clients of color without first addressing their own whiteness, and the privilege that comes with being a white person. Indeed, "recognizing White privilege is essential to achieving multicultural competence" (Ancis and Szymanski, 2001, p. 552). Ancis and Szymanski (2001) continue to explain that, "the privileges associated with whiteness are often unexamined and unarticulated by those who benefit; White

privilege is viewed as natural and maintained through the processes of denial, the belief in the superiority of Whites, and the notion of meritocracy” (p. 548). This function is representative of the larger racist society and the various systems produced within it; which includes helping professions such as, counseling, psychology and social work as Ancis & Szymanski (2001) suggest. Brown (1991) goes further in concluding that “almost all schools of psychotherapy are by virtue of their participation in the dominant culture, inherently racist” (p. 115). Despite this, the literature would suggest that not many people are talking or writing about this inequality. “The relationship between White privilege and unequal power relations has remained relatively unacknowledged in the counseling and psychology literature” (Ancis & Szymanski, 2001, p. 548). Many are alarmed, accepting the discussion of race and racism, particularly with clients of color, as an ethical obligation. Brown, (1991) theorizes that antiracism has been neglected as an ethical consideration, in part because this self-confrontation is a difficult one that yields an image at odds with the self-concept of many feminist therapists (p. 114). Some may extend that point of view to all progressive white therapists regardless of their varying theoretical modalities. Nevertheless, this reality can be problematic for in not discussing race and racism within the profession with clients of color; the profession continues to enact and perpetuate racism with its perceived silence. And the literature supports the notion that the power to ignore race or object to the system of privilege is in fact a function of a white privilege and therefore a function of racism (Ancis & Szymanski, 2001, p. 548). Furthermore, “the lack of significant focus on developing racial self-awareness in counseling and psychology training programs parallels the perpetuation of White culture as the norm in the psychology profession” (Ancis & Szymanski, 2001p. 549). To be specific, “self-awareness entails being cognizant of one’s attitudes, beliefs, and values regarding race, ethnicity, and culture, along with one’s awareness of the sociopolitical relevance

of cultural group membership” (Constantine, Hage, Kindaichi, and Bryant, 2007, p. 24).

Constantine, Hage, Kindaichi, and Bryant further contend that replicating experiences of injustice and oppression is avoided by maintaining an ongoing awareness of individual positions of power or privilege (p. 24).

Unfortunately there is a consensus in the literature that indeed suggests that there is a lack of attention being paid to fostering trainees’ racial, ethnic, and cultural self-awareness and understanding of race, racism, and white privilege (Ancis & Szymanski, 2001, p. 549). The literature is unanimous in recognizing this absence of discussion and the need for an immediate shift in practice, particularly citing the change in racial and ethnic demographics in the United States. “As the racial and ethnic diversity of the United States continues to increase, the need for mental health professionals to tailor their mental health services to the needs of various cultural populations has become more germane” (Constantine, Hage, Kindaichi, and Bryant, 2007, p. 24). Ancis and Szymanski (2001) too warrant this shift, highlighting that, “the majority of counseling, psychology graduate students, and mental health professionals are white (p. 549). Following suit, Pack-Brown (1999) also identifies that white people currently and in the future are projected to constitute a majority within the profession and thusly provides a context and a sense of urgency, noting “in a racist and culturally diverse society, White counseling students *need* to learn to effectively counsel racially diverse clients (p. 87). Moreover, as explained by Ancis and Szymanski (2001) the importance of cultivating self-awareness in white trainees regarding racial privilege is not *just* to serve as a function of deconstructing racism with acknowledgement of their own racist attitudes, beliefs, and understanding of how they have benefited from individual, institutional, and cultural racism”(p. 549). They argue, that it is also a necessity to the therapeutic process. “Self-awareness, or exploration of oneself, is often viewed as a prerequisite to achieving

accurate empathy with culturally diverse clients and developing a positive multicultural counseling relationship” (Ancis & Szymanski, 2001, p. 549). Pack-Brown (1999) likewise relates the importance of recognizing individual privileges in the therapeutic relationship, clarifying, “it is important that professional and ethical counselors learn how their racial identity influences their values and beliefs about the counseling process” (p. 89). Brown (1991) defends the case for talking about racism with clients of color and its ability to affect the positive development within the context of the therapeutic relationship, explaining that, “anti-racism has been addressed or framed by some white women as a political (as opposed to therapeutic) in such a way as to potentially minimize its core importance to feminist therapy theory and practice” (p. 114). Brown (1991) continues to defend the discussion of race, racism, and white privilege as more than political; in fact she defends it as an ethical obligation that conveys a commitment to anti-racism, with a proposition that, framing antiracism as ethical rather than as only a political consideration for feminist therapy, may make it easier to see how an antiracist attitude is an aspect of therapeutic dynamics” (p. 114). Pack-Brown (1999) is certainly sterner in underlining the ethical component of discussing race by emphasizing that, “counselors are professionally and ethically *bound* to actively attempt to understand the diverse cultural backgrounds of the clients with whom they work” (p. 89).

The literature lays the foundation for a more holistic and comprehensive approach that allow for “mental health professionals to understand individuals’ circumstances and concerns from a more ecological perspective” (Constantine, Hage, Kindaichi, and Bryant, 2007, p. 25). In educating students who are soon to enter a career in counseling and similar fields, the literature calls for more than just diversity or cultural competence training, but an education that includes a discussion of privilege based on race, specifically many students’ own white privilege, and

recognizes a more relational stance that implies that their race, privilege, and power is not independent from the therapeutic process. It is important that psychologists' develop awareness of personal biases that may adversely affect service delivery (Ancis & Szymanski, 2001, p. 549). "However, contemporary models of White racial identity do not specifically address counseling students' awareness of White privilege"(Ancis & Szymanski, 2001, p. 550). While most of the literature is vague in how it might address this issue, some solutions have been proposed.

Constantine, Hage, Kindaichi, and Bryant (2007) propose that, "some counselor and counseling psychology training programs also might consider including educational, legal, and public policy institutions as experiential or applied learning sites for the development of critical social justice competencies among their students (p. 25). Other authors are more vague about what specifically contemporary models that address racism, might look like for students. However, these authors are specific at least, in presenting a desired process and outcome. Pack-Brown (1999) indicates that, white counseling students must be challenged, within a safe environment, to question their potential influence with clients who live in a society that not only sees color but often judges, rewards, and punishes on the basis of color" (p. 88). Pack-Brown additionally calls for programs that, "provide increased opportunities for White students to comfortably identify their attitudes about racism, recognize their actions around racism, and develop skills in identifying institutional structures that may subordinate clients on the basis of racial characteristics" (p. 88).

There is a case being made for more than just a curriculum adjustment, update, or change. "Training teachers how to facilitate meaningful dialogues about race and racism is needed to effectively implement a diversity curriculum" (Abrams and Moio, 2007, p. 249). The argument being made is not merely to educate students on diversity, culture, race and racism, or privilege,

but to also anticipate the variety of ways in which students might respond, and how to approach each scenario. As D'Andrea (2005) explains, "faculty members in counseling psychology programs must become knowledgeable about the types of reactions that many White students may exhibit when presented with racial issues during their professional training and supervision experiences" (p. 532). By investing in the training of faculty members, D'Andrea (2005) hypothesizes that "faculty members will be better able to develop and implement strategies that are intentionally aimed at transforming how White students typically respond to racial issues before becoming professionals" (p. 532). It would seem that literature concludes that not only must information be exchanged as part of the learning process, but so too must counseling students be supported by teachers and instructors to navigate the complicated process and likely reactions that white students typically experience when discussing the complex issues of race, racism, white privilege, and how to support anti-racist efforts both personally and professionally as a white person. Perhaps this is the best beginning for reform. If not, then the consequence will likely be reflect data collected in one study that found the majority of the participants (people of color) viewed racial differences as an impediment to the therapy relationship and supported recommendations that therapists seriously consider how to assess and address these concerns with their clients of color (Chang & Yoon, 2011, p. 579).

Moreover, as a profession, race and cultural competence does seem to be considered, but may be poorly implemented. "APA mandates the inclusion of courses that focus on these multicultural issues for accreditation of doctoral clinical training programs; however, the most recent survey indicated that only 67.6% of the APA accredited programs surveyed required a multicultural course" (Sehgal, Saules, Young, Grey, Gillem, Nabors, Byrd and Jefferson, 2011, p. 2). This lack of training and preparedness may leave people of color with inadequate support. As

one study noted, “participants felt that their White therapists simply could not understand their experiences as people of color” (Chang & Yoon, 2011, p. 576).

There is indeed a fair amount of literature suggesting a need for improvement in regard to training students how to address race and racism and within that literature proposed efforts to facilitate that need. However, there is an inadequate amount of literature on how white therapists are actually addressing race and racism with clients of color. Nevertheless, there are a few studies that highlight how white therapists may be addressing race. One study in particular explores therapist self-disclosure as a possible avenue for doing so. “Cross-cultural counseling theorists have also suggested that therapist self-disclosure be used to convey the therapist’s sensitivity to cultural and racial issues, which may result in an increase of trust, greater perception of therapist credibility, and an improved therapeutic relationship with culturally diverse clients” (Burkard, Knox, Groen, Perez, & Hess, 2006, p. 15). By and large the results indicated that in the process of therapist self-disclosure in cross-racial dyads, clients of color felt more supported, noting that “clients of color who had therapists who were more responsive to cultural issues than not responsive were more likely themselves to self-disclose in therapy” (Burkard, Knox, Groen, Perez, & Hess, 2006, p. 16). The study highlights the self-disclosure of the therapist as a method to address race, where a therapist may acknowledge a personal experience to display sympathy and it also indicates possible motivations. When racial issues were addressed in therapy, therapists typically self-disclosed as a means to enhance and preserve the psychotherapy relationship and/or to acknowledge the role of racism and oppression in clients’ lives (Burkard, Knox, Groen, Perez, & Hess, 2006).

Literature supports that addressing race in therapy proves to be fundamentally important to the success of clients of color seeking mental health treatments. The literature also makes a

claim that counseling education must be continually developed in such a way that goes beyond platforms that focus merely on diversity awareness, or cultural competence, but also reflect the privileges that each therapist may hold within the therapeutic alliance and in the larger society, specifically white privilege. While the literature was largely vague in providing suggestion regarding how to accomplish this awareness, a few propositions have been made. Indeed further research is in order. It is critical for the profession to recognize the importance of research as the life source for the ongoing evolution and development of our profession D'Andrea (2005).

D'Andrea (2005) further calls attention to the disapproval expressed by “multicultural and social justice advocates have repeatedly criticized the lack of attention that social scientists have directed to issues related to race, ethnicity, and culture” (p. 525). Additionally, the profession will benefit from research that explores how white therapists are *actually* addressing race, why are they are compelled to do so, will ultimately continue to foster a greater sense of equality for people of color pursuing mental health support. Additionally it will continue to foster a professional development geared towards accommodating and considering the needs of all populations and demographics. If not, then likely consequences will emerge as D'Andrea (2005) foreshadows, explaining, “failure to clearly define, control for, and report on the impact of race and ethnicity in psychological research leads many counseling psychologists to overgeneralize the results of such studies to persons in racial-ethnic groups that are not included in such research”(p. 526). “In a society that is replete with racism and racist attitudes it becomes critically important that the majority of counseling professionals (Whites) are trained to be ethical and culturally competent”(Pack-Brown, 1999, p. 92). It would seem based on the literature that the field must first acknowledge the need to address race and racism as a critical part to developing and sustaining the therapeutic relationship. Brown (1991) notes “our failures

to acknowledge racism become barriers to mutuality and respect” (p. 115). Secondly, we must broaden criteria of curriculums to encompass concepts around racial privilege and to do so in a way that anticipates typical responses that white students likely may experience, including feelings of guilt, shame, confusion, or denial.

CHAPTER III

Methodology

Recognizing the emphasis and importance that the literature has placed in regard to acknowledging race and racism in clinical practice, the hope of this study is to answer the following question: Are white Smith College School for Social Work students addressing race and racism with clients of color; why or why not, and if so how?

Research Design

Considering the research question, an explorative approach was adopted, utilizing qualitative methods, specifically through issuing a survey via Survey Monkey. The survey was comprised of ten open-ended questions that participants were asked to reflect on before submitting their individual responses, based on their independent experiences. This method of issuing a survey via Survey Monkey with open-ended questions was determined in order to allow each participant to express their experience with more description, explanation, and opportunity for reflection that may also produce more meaningful responses; as well as capturing more subtle feelings or nuances related to the participant’s experiences. Furthermore, employing this approach also allowed for participant anonymity. While an interview may be considered to be a more thorough approach, an anonymous survey may yield more honest, less biased data, which does not produce responses influenced by social desirability. Responses influenced by social

desirability can often occur with another individual present, especially considering race, as awareness of the race and other social locations of the interviewer has the capacity to impact the data. A University of Massachusetts study argues that, “an anonymous survey was used to optimize representative sampling, honest reporting, and generalizability” (Maxie, Arnold and Stephenson, 2006, p. 88). Therefore this approach was chosen given the broader support and effectiveness it has generated in other studies, including the aforementioned.

Sample

The study population of interest is white therapists that practice therapy with people of color. The sample of this study is made up of 12 white Smith College School for Social Work students who are currently enrolled and have practiced therapy with people of color. This particular sample is desired given the perceived attention that Smith College School for Social Work as an institution places on the importance addressing of race and racism. The college has developed a written commitment to anti-racism and explains that it “has operated with an explicit commitment toward anti-racism in all aspects of its policies, practices and teaching methods” (Basham, 2004, p. 290). Furthermore the school’s mission statement is “...to advance the aims of the profession through education in excellence in clinical social work practice, through the development of knowledge and work toward becoming an anti-racism institution” (Basham, 2004, p. 290). A sample from an institution that has sought to prioritize a curriculum, highlighting the importance of race and racism in clinical practice will likely include individuals that have worked with people of color in therapy and furthermore, likely include individuals that are able to reflect upon their experiences with race and racism as white therapists in practice with clients of color. This is a reasonable hypothesis given that Smith mandates that all second-year Masters students to conduct an anti-racism field project (Basham, 2004.). Finally, the data may

help to understand what is working in the curriculum that may help other institutions improve their approaches regarding race and clinical practice with clients of color, as well as discover what might be improved in Smith College's School for Social Work curriculum.

The sample will be generated through outreach via the social media using the social network site *facebook.com*. Posted to the "The Unofficial Smith College School for Social Work" group, will be a note that describes the study briefly, outlines the criteria of desired participants, and provides contact information for those wishing to volunteer as part of the study. In addition to this approach, Robin DiAngelo will contact students via email who have formerly participated in a course she instructed at the Smith College School for Social Work titled, "Racism in the United States." In her email she will briefly describe the study and the criteria for desired participants, as well as provide contact information for those interested in participating. This method of recruitment is consistent with other studies. An Eastern Michigan University study reports that, "participants were recruited by email requests to listservs and email lists of APA-accredited internship sites, graduate school programs, college counseling centers" (Sehgal, Saules, Young, Grey, Gillem, Nabors, Byrd and Jefferson, 2011, p. 4). Utilizing technology such as email and social media is seemingly a growing recruitment method among similar studies and research methods in general.

Bias

The design and method of this study has been constructed with the intention to limit personal bias in all respects. Recognizing the impossibility of eliminating all bias, the study has included potential biases that may occur and will be considered as part of the final data and results. First, I, the researcher, will likely know many of the participants, as I am currently a full time Masters student in the Smith College School for Social Work. As a student there, I have

established a friendly rapport with other students and in some cases, a friendship has emerged. This friendship may come with consequences that could skew data, and other studies have taken precautions to safeguard against this. One study that used snowballing as a participant recruitment strategy and found that, members of the research team knew three participants and as a result opted to utilize a member of the research team not known to the participant to conduct interviews with these participants (Burkard, Knox, Groen, Perez, & Hess, 2006). I recognize that there is the potential for participants to be influenced by our positive relationship. I understand that in some cases, individuals may volunteer as a favor to me, in solidarity of this friendship, and with the wish to support me as part of this friendship. For those participants that I am not acquainted with, they will likely have some connection to individuals I may know, and their volunteering may exist as an extension of a friendship between a participant or friend and myself. Secondly, The same possibility exists in those that volunteer after being contacted by Robin DiAngelo. These individuals may participate out of an allegiance to Robin DiAngelo or perhaps feel obligated to say, “yes” given an actual or perceived power dynamic between professor and student. Finally, my racial identity is Black. Participants who are aware of my race, and for whom it is challenging or uncomfortable to deny participation based on their perception of what it may mean for them as white people or for me as a person of color, may be influenced to agree to participate in this study. With all these familiar interpersonal connections, feelings related to guilt, obligation, and friendship may exist as governing forces that compel participation. While this is a reality, the anonymous nature of a survey may help ameliorate this influence in terms of the actual data generated.

CHAPTER IV

Findings

The intention of this research study was to gain further insight, information, and perspective in regard to how white Smith College School for Social Work students address race and racism in clinical practice with people of color. An anonymous survey composed of seven questions related to the topic of race and racism and three demographic questions was developed and issued to twelve volunteer participants from Smith's School for Social Work. All of the participants were white as part of the research criteria and design. The survey included an open response question, "How do you identify your gender," and four participants identified their gender as "male," while eight participants identified as "female." The median age of the participants was 31, with the youngest participant reporting an age of 23 years old and the oldest participant reporting an age of 44 years old.

As mentioned, seven questions were asked related to race and racism in a clinical practice in a cross-racial dyad (a white clinician and client that identifies as a person of color). Each question was an open-ended question in which the participant could generate a unique response. Nevertheless, in reviewing the survey, it is clear that many of the participants responded similarly to questions, but especially to one in particular, the fifth question of the survey.

Survey Question Five: Has there been a time when you considered race unimportant in practice with a client of color. If so, why did you feel it was unimportant at that time?

While some responses were more explicit, detailed, and with a more obvious tone of certainty than others, nine of the twelve participants responded in a way that indicated that they had never experienced a moment in practice with a person of color in which they felt race was unimportant. Some responses are included in the following: "I don't know if I would ever say

‘unimportant,’” and “I wouldn't say I've ever felt that it wasn't important.” Still, others communicated this theme more directly explaining, “No. Race is always important and is just as important to discuss with whites,” “I don't think it's ever unimportant,” and “No, I've never thought it was unimportant, though there are some clients for whom it seems more pressing to discuss than for others. “ One response simply included in capital letters, “NO,” with no further explanation. Despite the majority, communicating the importance of race in clinical practice many went on to elaborate and a trend emerged in which some participants discussed that regardless of the recognition and emphasis they have placed on the importance of addressing race in clinical practice with people of color, they have not always engaged in conversation that would address race with a client of color. Some cited a lack of preparedness, fear of compromising the potential to continue to develop rapport and build a therapeutic alliance and timing, while others referenced a need to prioritize symptomatic behaviors or another perceived immediate need expressed by the client. A participant explained feeling “inadequately prepared” as a barrier for addressing race.

“No. I have never considered it to be unimportant. However, I feel that there have been times, especially in my first year internship when I felt inadequately prepared to address race in a way I felt confident would be appropriate and advance our working alliance. As a result, I did not address race with some clients of color, when had I been working with them now, I would seek to do so. The absence of my acknowledgement of this aspect of my clients' social identity may very well have led them to feel that I thought race was unimportant to our work.”

Another participant expressed a similar sentiment about the importance of discussing race in clinical practice, but an uncertainty about when to engage in that discussion. This participant responded:

“I wouldn't say I've ever felt that it wasn't important, but I recently (in the last few weeks) became aware that I had not discussed race with one of my clients of color and wasn't sure exactly why it had been neglected. I reverted back to the thinking that I don't feel I have to bring it up in the first session, but should bring it into the work (if the client hasn't already) within the first few sessions. Thinking back on the case now, I feel like that in this case, bringing up race prematurely may not have been advantageous to the work. Interestingly enough, it became a large part of our closing session.”

While many responses communicated that race was never unimportant in their practice with clients of color, two participants suggested another perspective. While these participants did not explicitly deny the importance of race, each of these two responses did indicate an importance in exploring “the client’s own presentation of their sense of the problem.” One participant explained:

“I think it’s when the client seems to think another factor of their identity subsumes that of race and is more alienating or challenging than that, e.g. their national/cultural origin, their sexual orientation, their physical appearance, their sense of personal value and self-worth, their identification with a mental illness, etc. While race of course can still be a

factor, and should be explored, it is wrong I feel to ignore the client’s own presentation of their sense of the problem.”

The other participant that seemed to share this similar view explained:

“Yes, when clients are significantly concerned with other material or other conflicts and do not have the time/energy/emotional readiness to discuss race with me in therapy at that time. It does not mean that it isn't important or might not become important. But it just is not the most important at that time.”

The participant’s response indicates a feeling that race is important and can become important, but that there are times in her clinical practice when this participant perceives that it may not be as important to other issues being expressed by the client.

Figure 1

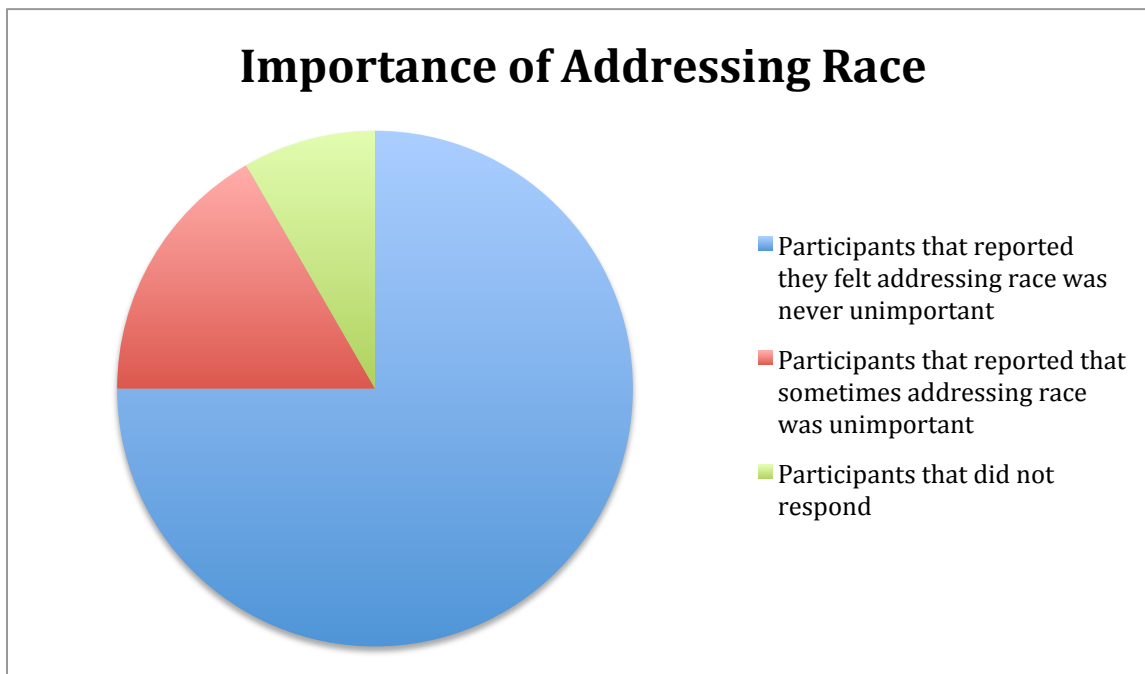
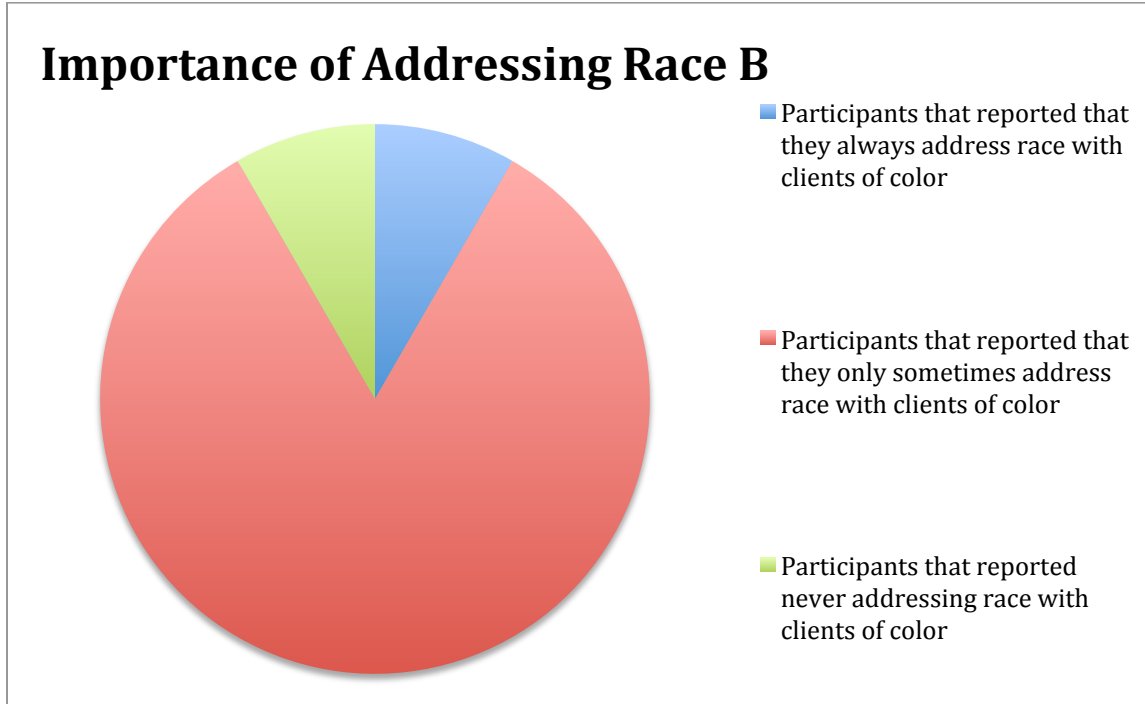
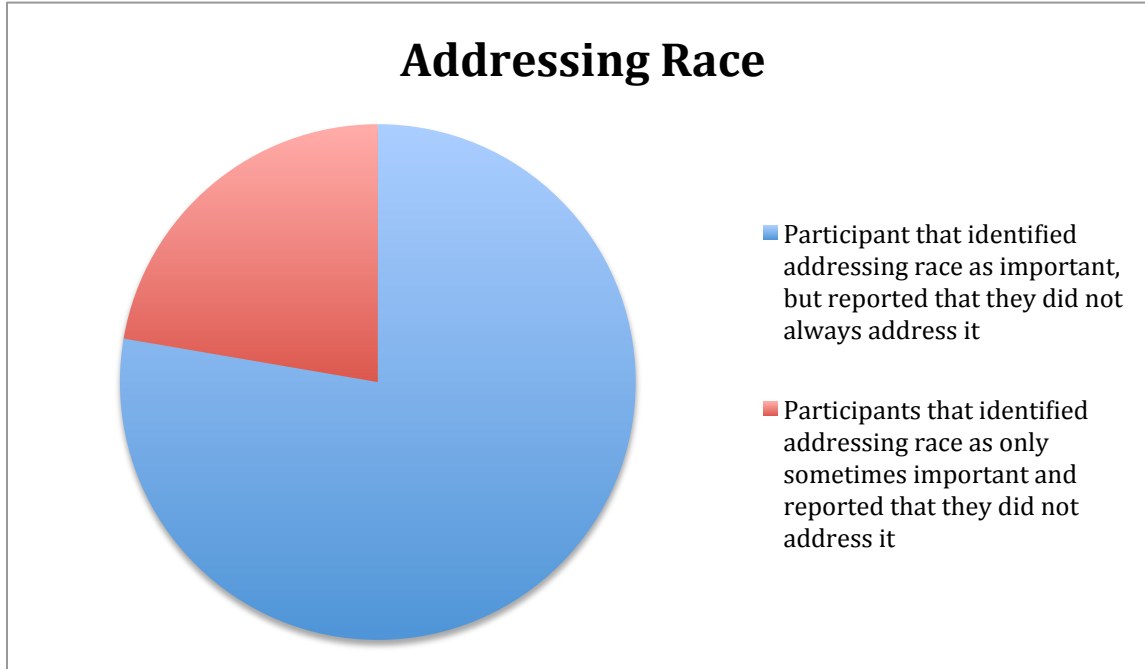


Figure 1B



It would appear from the responses to the survey question, that a majority (75%) never found race to be unimportant in clinical practice with people of color. The remaining participants seemed to express a similar understanding as the majority but also considered circumstances in which race was perceived by them, the clinician, to be a less important discussion to have in one particular moment. And while the majority seemed to place importance on conversations of race and racism, seven of the nine responses that indicated an importance of addressing race (77.7%) suggested that these conversations were not always had, and sometimes even avoided.

Figure 2



Survey Question One: Can you recall a time when you addressed race with a client of color? If so, why did you feel it was necessary to do so at that time

Nevertheless, eleven out of twelve participants (91.6%) were able to detail a situation when they believed that they addressed race with a client of color. This finding is consistent with other studies including the Maxie, Arnold and Stephenson (2006) study that surveyed 808 APA licensed mostly white psychologists and found that a majority (84.5%) reported ethnic/racial differences had been discussed with at least one client during the previous two years (Maxie, Arnold and Stephenson, 2006, p.89).

As part of this study, one participant indicated that they had never addressed race with a client of color. Five out of the twelve responses (41.6%) seemed to suggest that as the white clinician they initiated the conversation, implying a majority experienced the client initiating the conversation. The Maxie, Arnold, and Stephenson (2006) study found that “many therapists described client initiated discussions in which conversations about racism, social and

professional isolation, or the therapist's ability to understand were frequently mentioned by clients" (Maxie, Arnold, Stephenson, 2006, p.92). One interesting trend discovered in this study, however, is only three responses (25%) seemed to explicitly acknowledge their own race or whiteness while eight out of the twelve participants (66.6%) seemed to discuss the client's race without acknowledging their own race.

Figure 3

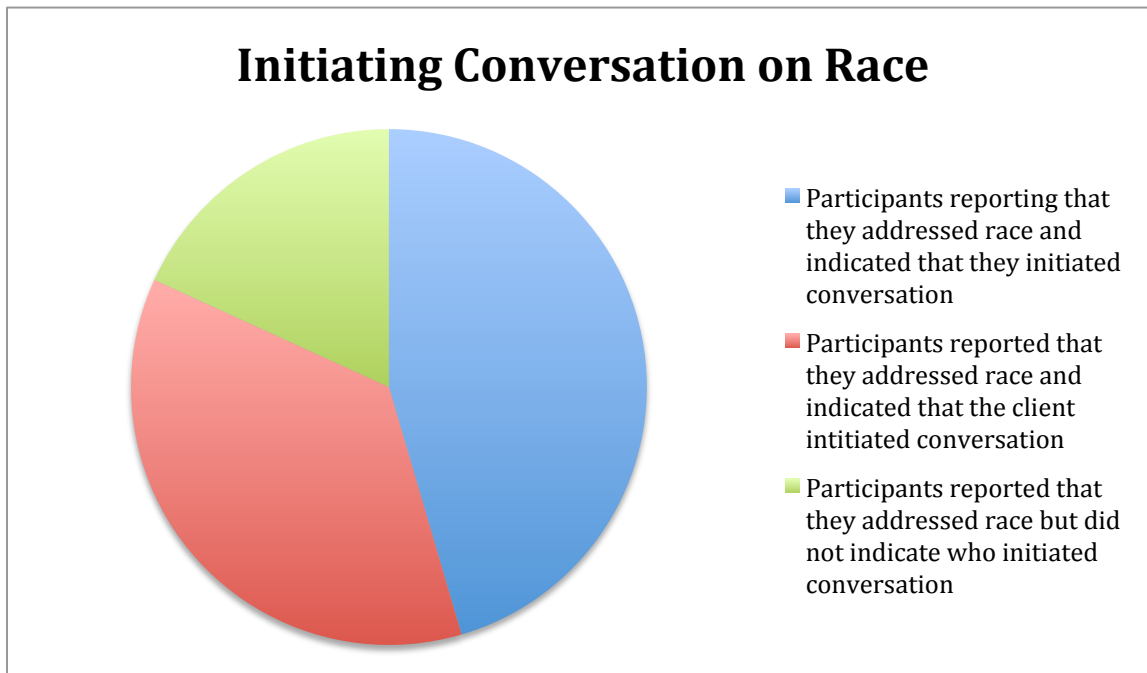
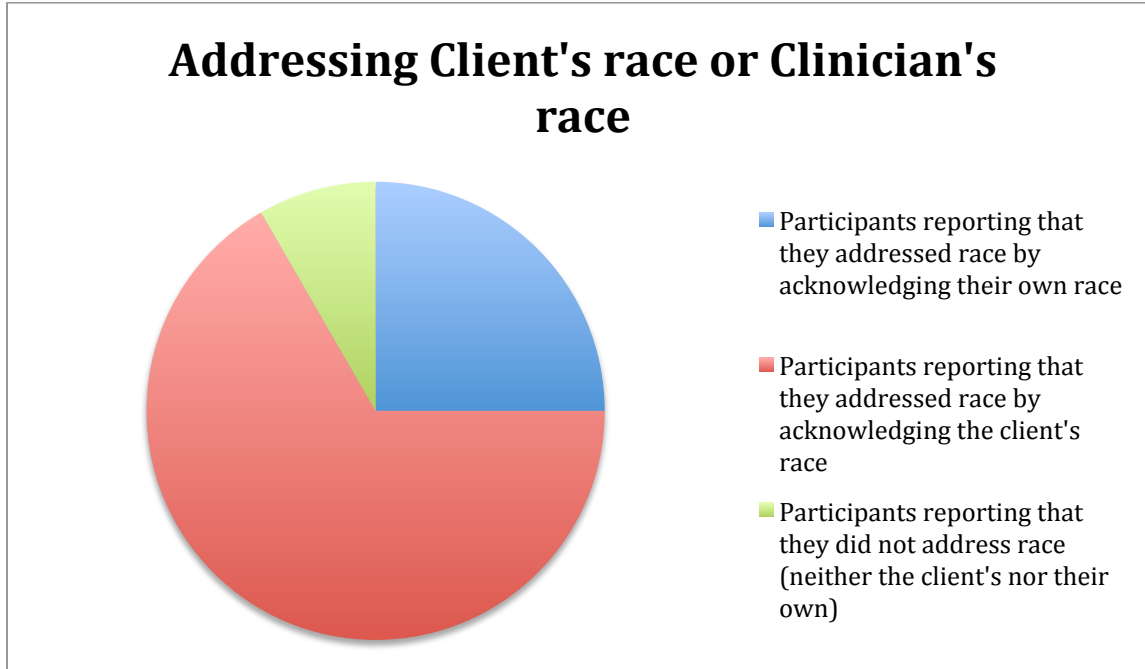


Figure 4



One participant, as mentioned denied a moment in which they had addressed race. One participant answered:

Yes. There have been many occasions when I have addressed race with clients of color. I felt it was necessary for me to respond to what a client was bringing in to the room. My clients have brought up their race as a significant component of their life experiences and I encouraged them to explore the topic as it related to our work together.”

Overall the responses indicated that it is often the client’s race that is addressed and not race or racism as a generality, or the clinician’s white race. One participant responded:

“Yes. I did this several times. One Hispanic client was discussing how she often felt different, isolated or not good enough with others at her prestigious institution. I asked her if she ever felt that way with me. I thought this was a good opportunity to discuss the differences between us

and to discuss the client's experience of that to see if it would help the client gain insight into her experience in other relationships.”

This response does not directly suggest that race was a discussion addressed as a difference in identity between the clinician and the client with privileges and disadvantages that one may have over the other, but the word “differences” is used, which may have included racial differences.

This participant also notes “others at her prestigious institution,” and it could be that ‘prestigious’ is synonymous with “white” for this participant and would imply racial difference, but it is unclear. What is clear, however, is that this particular participant initiated the conversation with a question related to “differences” that prompted further discussion.

Another response indicated that race had been explored previously in the treatment and this participant used that previous conversation to initiate another conversation about race:

“She said that the first time she remembered feeling "real despair" was at age 7, when she was in the shower combing the tangles from her hair. I asked S if she had any associations or feelings arise when she thought about her hair, remembering an earlier session where we had talked about the constant racial microaggressions and overtly racist comments she endured in her mostly-White elementary school - some of which related to her hair.”

The client's concerns, as expressed by the participant's response, did not seem to be previously framed as racism by the client. The participant's survey response, however, suggests that as a white clinician they were able to take a situation that seemed to be causing the client, a person of color, some discomfort and name that situation as racism for the client. Other

responses seemed to respond with situations that were even more direct in addressing racism, noting:

“I have addressed the existence of the interracial dyad between me and my clients of color on a few occasions. I have felt it was necessary to do this because of the already skewed power dynamic that I believe therapy sets up. I think it is important to not reiterate that dynamic racially or at least to bring a conversation about it to the fore. For instance, a client of color frequently agrees with me or affirms me by saying things such as "That's a great idea!" or "I never thought of that!" and I wonder if she feels she has to say these things because she has been socialized not to disagree with white people.”

By discussing the “interracial dyad” this participant seems to address both the race of the client and the participant’s own race. In doing so, the participant seems to express an ability to also talk about inherent power dynamics, both as a therapist and client, but also racially, with the intention to not re-create this dynamic as part of treatment for the client. From the participant’s response alone, it seems that this participant is aware not only of the client’s race, but how the client’s race and their own race are continually influencing the therapeutic relationship and subsequently the treatment. One other participant seemed to also address their own race and how it was influencing the relationship in treatment with clients of color. The participant wrote:

“Yes. My client is a refugee from Somalia and was fired in an unjust way from his job. I worried that he wouldn't want to raise the issue of discrimination or racism with me because I'm white and he might feel unsafe doing so. So I raised the issue to make it clear to him that it was

okay to talk about racism with me, even though I'm white, and that he didn't have to feel worried that he'd offend me or hurt my feelings or deny the existence of racial discrimination.”

This participant’s approach seemed to illuminate a conversation on race that existed both at a very personal level within the immediate therapeutic alliance, but also at the macro-level in acknowledging “the existence of racial discrimination,” and the role and impact it has on the client’s lived experience. One other response seemed to equally demonstrate a direct approach that highlighted race (both the client’s race and the participant’s race) and racism:

“Yes. With one particular client (an adolescent multiracial female), we talked about race and racism during our second session. I felt that it was necessary because I felt a responsibility to name the racial privilege I carry and the impact that might have on our relationship. The client appeared surprised.... she eventually broke down crying and stated that, after seeing 5 different counselors, I was the first to discuss race. Our work since that time has often been about her experiences of racism and how she has come to feel that she is "different" and "weird" because of her racial identity.”

This participant reports addressing race and does so by identifying their own “racial privilege.” The participant acknowledges that their own race, as a white person, has an “impact” on the therapeutic relationship with clients of color. This was not the majority understanding reflected in the overall survey responses as many first discussed the client’s race as a way to open conversation about race and racism.

While all participants responded in the affirmative, supporting the notion that they had addressed race with a client of color before, three responses were particularly vague, with little description about the role they had played with the client of color in addressing race and racism. These three responses often talked about a client's "background" or "difference" but never explicitly used the term race. Thus, it is difficult to tell if a discussion about race was raised and if race or racism was addressed. From the responses alone, it would appear that a client, a person of color presented an issue related to race and racism, but it is unclear how these three participants specifically addressed race. One participant explained:

"Yes, I can, more than once. The most memorable was because the client herself had mentioned the contrast between her own background and the majority of other students on the campus, which caused her to feel alienated from them. Also, she mentioned feeling somewhat ashamed and embarrassed of certain details of her background: growing up economically disadvantaged in a large urban area, her mother addicted to cocaine, her father in prison, raised by her grandmother and the victim of routine physical abuse."

It is uncertain if the participant is using the term "background" to identify race. It is further ambiguous how the participant addressed race specifically. It seems that a space was afforded for this client to express discomfort based on a feeling of difference among her peers, but nothing further is identifiable. The participant makes mention of addiction, incarceration, and physical violence, but does not suggest that they highlighted these issues as structural and disproportionately affecting people of color.

A different participant also conveyed a moment in which they addressed race with a person of color in treatment. However, this participant too seems to describe a moment in which the person of color presents an issue related to race, but does not plainly identify *how* race was addressed in this situation:

“Yes, in one case in particular because we were speaking to the different "selves" that my client felt like she had to embody in order to navigate the world. Being a mixed-race person, my client had four separate identities that she felt she had to switch between depending on how she was feeling and the situation she was in. As a white clinician, I felt it important to recognize and validate the impact that race has in her life.”

One participant, detailed a moment when a client, a person of color, had discussed race. The participant did not elaborate further beyond what the client had to say. The participant answered, “Recently a client of color made it clear he was bothered by the fact that he was the only person of color in the program.” It is uncertain if this participant actually addressed race or racism despite the participant affirming that it had been addressed.

Overall, in gathering each individual response, many themes emerged. In particular this question revealed that eleven of the twelve participants felt that they had experienced a moment when they had addressed race with a person of color in clinical practice. While three of the twelve participants (25%) surveyed did address their own race and racism at a macro or systemic level the majority of responses illustrated a pattern that indicated that most participants seemed to address the client’s race without any explicit reflection or consideration of their own race as a white person. Furthermore, while all of the participants affirmed that they had experienced a moment of addressing race in practice with clients of color, three of the twelve

(25%) participants were vague in describing their exact role or involvement in the process, simply describing an issue related to race raised by a person of color without indicating a response on their part or how they specifically addressed it. Two of the participants that reported that they could recall addressing race with a client of color never used the term “race” or “racism” in their survey responses, but rather spoke of “differences,” “contrast,” or “background.” Finally, the survey question directly asked participants to suggest why they felt it was necessary at the time to address race. Two of the participants surveyed did not specifically answer this part of the question, however the remaining seven spoke of building client insight and exploration of self, recognition and validation of the client, and a perceived impact on the therapeutic alliance, or to acknowledge racism and the dynamics that may emerge in the client/clinician relationship as a result.

As mentioned, two participants talked about the potential for the client to develop further insight into their sense of self through discussing the client’s race and experiences of racism. One participant noted,

“S showed so much insight into her depression in that session, connecting it to her experiences of internalized oppression and racism. I think I felt it necessary to address race in this session because it seemed incredibly relevant to S's exploration of her past and her presenting problem.”

Another participant also reported that they felt it necessary given the potential for the client to gain further insight during treatment. The participant wrote:

“I thought this was a good opportunity to discuss the differences between us and to discuss the clients experience of that to see if it would help the client gain insight into her experience in other relationships.”

Additionally, three different participants reported that they felt a need to address race and racism in effort to validate the client's lived experience of experiences oppression or discrimination routinely as a function of a system that privileges white people and whiteness. One participant suggested:

“I raised the issue to make it clear to him that it was okay to talk about racism with me, even though I'm white, and that he didn't have to feel worried that he'd offend me or hurt my feelings or deny the existence of racial discrimination.”

Another participant spoke in similar terms,

“I felt that it was necessary because I felt a responsibility to name the racial privilege I carry and the impact that might have on our relationship.”

Another reason suggested by a participant for addressing race, was to validate their client's experience by suggesting that each issue they present or face is in fact connected to their racial identity and should be explored as such. The participant wrote:

“I have felt this was necessary because I think that their general life experiences cannot be separated from their experiences as a person of color.”

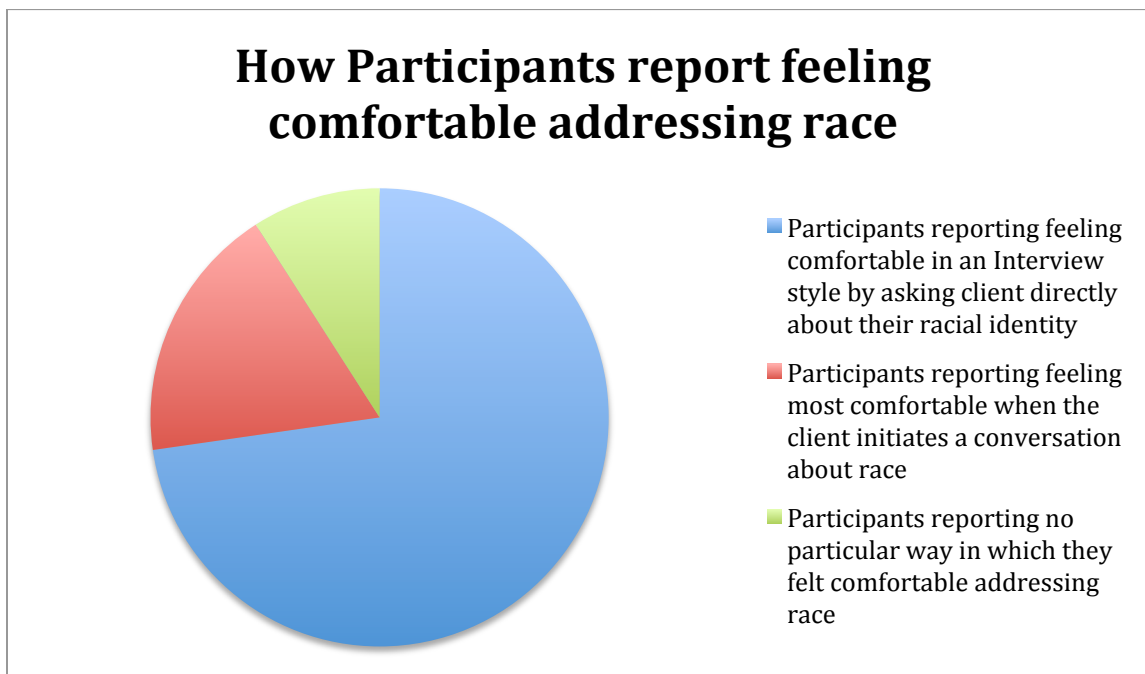
These responses reveal that almost all participants, with the exception of one, felt as if there had been a moment that race and racism were addressed with clients of color. More often than not the participant addressed race through a discussion about the client's race instead of their own. Three of the twelve participants expressed a sentiment that they had addressed race, but had not specifically included how in their response. Instead, their response described only how the client, a person of color, had raised an issue related to race or included it in the

treatment. Finally, many found it important to address race in an effort to help the client gain insight into their sense of self or to avoid racist dynamics being played out between them within the therapy. Other reasons explored in survey expressed interests in validating and supporting the client and maintaining a therapeutic alliance.

Survey Question Three: Describe how you feel most comfortable addressing race with a person of color in clinical practice

Equally important in understanding why participants chose to address racism is *how* they are doing so, if they are doing so. Eight out of the twelve (66.6%) surveyed reported that they felt most comfortable addressing race as an interview style, with a question directed towards the client’s racial identity, although one participant did describe a question that could likely lead to a conversation about racism as well.

Figure 5



Furthermore, one of these twelve did indicate in their response that they were comfortable addressing race by not only acknowledging the client’s race but also through

acknowledging their own race. Four of twelve (33.3%) participants explained that they prefer to ask this question early on in treatment.

“In the initial session when I am asking different questions about their lives like "who's in your family," "where did you grow up," "what has been important to your experience..." In this session I often will find a place to say, "how do you identify?" or "are there ways that race or being_____ have influenced your experience?”

This participant is able to address race initially in a way that may lead beyond racial identity to a conversation into how that client experiences that racial identity in a world that privileges white people and whiteness. This response is unique in comparison to other responses because it has the potential to lend itself to a conversation about racism and not merely racial identity. A similar response explains,

“I usually just go right at it: It’s a very white campus in a very white part of the country. It must be alienating to be a person of color in it. What must that be like? What would/could I not understand? What’s it like working with me, a white therapist?”

Continuing with this trend of addressing race early on, a different participant reported that they too felt comfortable addressing race in an initial session and provided insight as to why this could be problematic for them and their clients.

“I make efforts to inquire about racial identity and the salience of racial identity from the very beginning of therapy (i.e. during the intake), and I'm sure that has something to do with my comfort... It is my hope that this line of inquiry serves to communicate a willingness and openness to discuss

issues of race and racism with clients of color, particularly as a method of directly acknowledging the power imbalance between myself (as a White clinician) and the client. I try to bring awareness to the possibility that I may be privileging my own comfort and needs by addressing race in this way, i.e., as a part of my clinical agenda, rather than the client's.”

Another participant indicated feeling comfortable addressing race earlier on explaining,

“I would say that when the assessment form asks for the client to identify their race, this allows me the opportunity to bring it up just as I would do with any other question on the assessment form.”

While others did not indicate when exactly they felt comfortable addressing race, as these three expressed their comfort in doing so early on, others did continue to indicate that they experienced comfort in asking interview style question about the client’s racial identity including: “How do you identify racially or ethnically?” One participant expressed comfort not only in asking about the client’s race but also exploring their own race, explaining:

“I usually feel comfortable asking about how race impacts the clients... I try and ask this to all white folks as well as people of color. I also think that naming my own whiteness can be a launching point for explaining why I think it's important to talk about.”

Not all participants however felt most comfortable addressing race with interview style questions. Two participants of the twelve (16.6%) explicitly reported that they felt more comfortable addressing race when the client is the initiator of the conversation, answering the question with:

“I feel most comfortable addressing race when my client has addressed it themselves, however indirectly. When I get the sense a client feels race is a significant component of what we are currently discussing I will name it directly and ask them to elaborate on their feelings about it.”

The other participant to report that they felt more comfortable addressing race after a client had brought it up was more concise identifying that they “...feel[s] most comfortable when the client brings up the topic for discussion.” Another participant, in addition to these two participants reported that they would ask a question about race, but also reported the they felt comfortable when the person of color, the client, began the conversation explaining,

“I also feel most comfortable talking about race with a person of color when they bring it up. Often, I am actually relieved/excited when the client brings up something about their race/ethnicity/identity because it helps me to hear what language they use and how they feel about this first, so I can gauge how I will respond or ask questions based on the tone they have set.”

One response suggested that they do not have a regular method or particular style that they feel comfortable using. The participant explained, “...it is totally dependent on the situation.”

From these twelve responses, it is clear that the majority, nine participants, (75%) identified asking questions about the client’s race as most comfortable. Among these nine participants, four shared the notion that inquiring about the client’s race early on in the treatment was most comfortable. Overall nine participants that felt comfortable asking interview style questions about race with the client, and one of these nine suggested that they might use their own race to initiate that conversation. Other participants, specifically two individuals felt most

comfortable when the client brought up race, and finally, one participant expressed not having a particular way that felt comfortable.

The above responses provided insight as to what is the most comfortable way in which these twelve white participants felt addressing race and racism with a client of color. The survey further revealed that nine out of twelve (75%) participants felt race was never unimportant in a cross racial dyad and that all participants have experienced a moment in which they have felt that they addressed race and yet, as question five uncovered, addressing race has not always been common practice among those surveyed.

Survey Question Four: If you routinely address race with clients of color, how do you address it, and what motivates you to consistently do so?

As part of this survey, and with anticipation of these results, participants were also asked about their motivation. It is clear from some participant's responses to other questions that they do not routinely address race and racism with clients of color. However, many answered this question as if they routinely addressed race and racism. In answering the above question participants identified their motivation and three consistent reasons seem to be recognized. The results signified that often participants were motivated to address race and racism because it was directly related to informing the client's treatment and presenting problem, to build a therapeutic alliance, or to avoid enacting racism within the treatment. Three participants (25%) noted the importance race plays specifically in relation to the client's presenting problem and communicated that a discussion would continue to inform treatment. One participant answered:

“I am motivated to address race with my clients of color because I seek to understand each aspect of their identity as completely as possible in the context of their presenting concern.”

Another participant echoed a similar point of view explaining,

“Discussing race and racism in the therapy provides crucial information I could have otherwise missed regarding a range of issues, like the impact of cultural trauma, power dynamics, issues related to self-esteem, issues in the therapeutic relationship, how these issues play out in enactments.”

Additionally, one participant explained, “I have been exposed to, and have learned a lot about possible implications of racial oppression, and I try to be curious about how it's impacted each client in particular.” This however, is inconsistent with the Maxie, Arnold and Stephenson (2006) study that found that in regard to motivation related to addressing differences, including racial or ethnic differences. “...fewer therapists cited “presenting problem” (3.9%)” (Maxie, Arnold, Stephenson, 2006, p.89). Rather that study concluded, “The most frequent primary reasons were “a cultural component to the client’s presentation” (39.8%), and “something the client said” (35.9%)” (Maxie, Arnold, Stephenson, 2006, p.89).

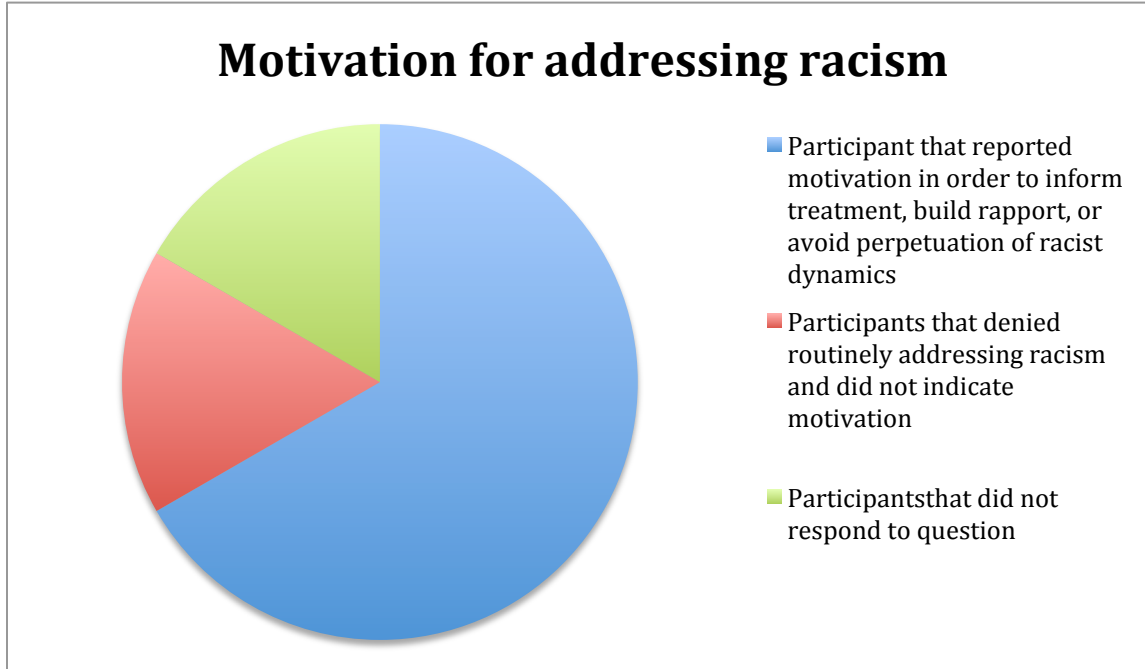
Still, this study found that others spoke about the importance of building a therapeutic alliance and how discussing racism is part of this process, “I am motivated to do so each time because it is so important to developing a trusting therapeutic alliance with the client,” and this is consistent with other research. In the Maxie, Arnold, Stephenson (2006) study 4.6% respondents listed “other” as a reason for addressing difference, including an ethnic or racial difference. When further investigating this selection, the study found that nine respondents had listed reasons related to trust and rapport building, relationship, and helping the therapeutic process (Maxie, Arnold, Stephenson ,2006, p. 89).

Moreover, in this study, two participants identified their motivation as the intention of avoiding oppressive dynamics based on race. One participant suggested that the motivation was to address race was in an effort to “not to reinforce the unequal power dynamic,” and because the participant believes that “race is an integral part of their human experience.” Another participant, though not explicitly, suggested that silence on race might be related to oppression and cause a negative impact on treatment. The participant reported, “The absence of addressing issues of race acts as a painful communication of silence to clients of color.”

While each participant was asked this question two of the participants did not answer the question. One participant placed a period in the answer box, while the other wrote “N/A” which may mean that this participant does not routinely address race but further clarity would be needed. Two of the twelve participants (16.6%) explained that they did not routinely address race with clients of color. One of these participants explained, “I don’t routinely address race. I decide whether, when and how to address it based on the situation.” This participant did not include a circumstance in which they might address race with a client of color and what her motivation might be.

Overall eight out of the twelve participants (66.6%) conveyed that their motivation in discussing race with a client of color was related to informing treatment and gaining insight that would also address the client’s presenting problem, to build a therapeutic relationship and establish trust, or to avoid enacting racist dynamics with the treatment. Two participants (16.6%) did not answer the question and two participants (16.6%) denied routinely addressing race.

Figure 6



Survey Question Two: Have there been times when you have felt race could have been addressed with a client of color but you didn't address it? If so, why do you choose not address it at those times?

In a full attempt to understand how Smith students may be addressing racism, this study not only considered asking each participant about their motivation to do so, but also to consider moments when they had not addressed race, but might of thought it appropriate to do so. Eleven out of the twelve participants (91.6%) indicated that there has been a time when they felt race could have been addressed but they did not address race. In exploring this question participants generated a variety of reasons for which they had not addressed race with a client of color, even if the participant thought that race could have been addressed. Multiple participants discussed their own uncertainty about the impact that a conversation may have had on the treatment, therapeutic alliance, or timing and many alluded to perceived negative impact if they were to have done so.

“I felt there was not enough rapport created between us for me to bring it up...and I also got too caught up in my own head and with fear in trying to figure out how to bring it up”

This is inconsistent with other studies including the Maxie, Arnold, Stephenson (2006) study that found almost all therapists acknowledged that addressing ethnic/racial differences never or only occasionally hindered their work (Maxie, Arnold, Stephenson, 2006, p.90). Other studies too seem to suggest similar findings, reporting that European American therapists address race with clients of color less frequently than African American therapists, however among both European American and African American therapists they found that there was a perception these discussions had positive effects on the therapy (Day-Vines et. al 2007).

Other participants too shared an inner process outlining why they had not addressed race:

“I rationalized this to myself that it must not have been a salient issue to them if they did not bring it up. However, I recognize that it is also possible that they did not feel comfortable or ready to bring it up to me, as a white clinician. I chose not to address it in some instances because I was playing it safe and uncertain at times.”

A participant also spoke about their hesitation and uncertainty that resulted in not addressing race. However, this particular participant seemed to negate their own reason for not addressing race with a client of color:

“Generally these instances have been with clients with whom I don't feel I have a strong therapeutic alliance with yet. I guess I may have been

concerned that if I addressed race at the "wrong time" it would be detrimental to the therapy but I know logically that can't be true.”

Others did not address race as they felt that it was not salient for the client in that moment. For example, one participant suggests, “It depends on what else the client is discussing that is relevant to race, and if it seems like they would be willing to hear, begin, or even think about the conversation of race.” One other participant also spoke about salience of race as a moment for addressing or not addressing race. The participant explained, “What discriminates between bringing it up and not bringing it up is how present it is for the client as a factor, or at least the presence of clues supporting the therapist’s belief that it could be a factor.”

A different participant explained that race was not addressed, citing the client’s own discomfort discussing race, “K’s rejection of her father and subsequently of her racial and national identities seems to make directly speaking to issues of race particularly uncomfortable and painful for K.” One participant spoke of not speaking about race as a means to possibly protect their self. The participant acknowledged that at times they felt intimidated by certain clients and did not address the issue of race.

“I feel as though I also have not addressed race when I’ve felt somewhat intimidated by a client too. For instance I recognize that I am inherently less comfortable working with men from the get-go, so I know that I would be less likely to address race with a man of color than with a woman of color.”

Out of the twelve surveyed, one participant did not express a similar response. This participant noted the following, “Each time the need or perceived need has come up I have

addressed it with the client, regardless of whether it is to educate whites about their use of "offensive" language or if it is to address the topic, name or label it so to speak.”

Survey Question Seven: In moments where you may not have addressed race with a client of color, did you feel that there were any consequences as a result?

Beyond exploring why each participant thought that they might not have addressed race with a client of color, this study sought to additionally understand if each participant had perceived any consequences as a result of not addressing race in a cross racial dyad with a client of color. Six of the twelve participants (50%) indicated that they could identify consequences. These six participants talked in particular about enacting racist or oppressive dynamics and often considered their actions either a micro-aggression towards their client, a person of color, or a result of their own white privilege. One participant explained the following:

“Yes, I wonder if I am not giving clients the space or the chance to discuss this important part of their identity and experience. It is very possible that I am sending the message that I don't want to talk about or can't talk about race. To some folks it could be felt like a micro-aggression or erasure of identity, sort of "if we don't talk about it, it isn't there." That's not fair.”

Another participant was particularly detailed in their response. This participant was explicit in acknowledging their silence as a function of oppression and white privilege suggesting,

“I've found that not addressing race can result in a number of problems, notably the reproduction of racist power dynamics, and therapeutic ruptures. For instance, during first year field placement, I found that issues related to race and racism often went unaddressed or were

minimized by White staff, namely through a failure to recognize the existence of issues related to race (i.e., silencing; colorblindness), and I attribute attrition rates of clients of color in the program to these dynamics. Disturbingly, I notice that the covert racism/micro-aggressions perpetrated by White clinicians in a team/staff meeting setting, or during moments of "clinical gossip," inevitably impacts treatment in an incredibly harmful way. I know that I have perpetrated silencing and left issues related to race and racism unaddressed numerous times, in part as a result of my choice to exploit my White privilege rather than challenge my White colleagues or myself, and continue to commit myself to making changes in this regard. I also notice that there are probably many other examples I could give here re: not addressing race and noticing the consequences of it, but that I have more trouble remembering those instances, likely indicating an unconscious defensive move (i.e. wanting to be the "good White therapist").

Additionally, three participants identified that they had missed an opportunity to fully understand the client as a whole person and saw this as a consequence. One participant explained, "I think that the biggest consequence was that we didn't get to have a more full discussion," while another acknowledged they felt that,

"The consequences have been that I haven't had the chance to truly get to know a client of color when I haven't addressed race or that the trust level hasn't been as strong, but I can't be certain that these were direct

consequences of not addressing race, I just imagine that they may have been.”

Another continued to suggest that not fully understanding the client was a consequence of having not addressed race. This participant wrote:

“Yes, it always feels like I missed something, because I did. I can't understand someone if I don't understand how their race has impacted their life, and how they identify racially.”

With consideration of current research, these participant's concerns may be legitimate as Chang and Yoon (2011) found in their study that:

“The majority of participants felt that they could not be understood on a deep, emotional level because their therapists were limited in their ability to appreciate how their minority status and identity as a racial and ethnic minority shaped their lives” (p. 573).

Two participants were still uncertain if there were any consequences as a result of not addressing race suggesting that they were, “still on the fence about whether I should have handled it differently with the client I mentioned above who often remarked on our difference but never the difference of our racial identity.” One participant seemed to imply consequences but still with a sense of uncertainty explaining, “I'm not sure. Likely there was. Unfortunately, I am not aware of it.” Other participant denied that there were any consequences and responded,

“Consequences that wouldn't have happened had I mentioned race overtly? I don't think so. Race matters have their consequences in the therapy, whether the therapist brings it up or not. However, with clients of color, I believe I usually tend to bring it up eventually. Or, if they're

foreign students, we bring up the experience of being foreign in the country.”

One participant denied any perceived consequences of not addressing race with a client of color, but also suggested that there may have been benefits, if in fact, race had been addressed. The participant wrote, “No, I never felt like there were any immediate consequences. However, I did leave wondering if there would have been positive consequences if I had brought it up.”

Another participant noted a consequence of not addressing race, but provided an example with a white client, not a client of color as the question had asked each participant to consider. Ultimately, six participants (50%) were able to identify consequences of not addressing race. The consequences most often reported were in relation recreating racist dynamics within the treatment or not fully understanding all parts of the client’s identity.

Survey Question Six: Has your formal education informed how you approach race as a subject matter with clients of color?

The final question that participants were asked to answer as part of the survey was in regard to their formal education. All participants agreed that their formal education had in fact informed how they approach race in clinical practice with clients of color. This finding is consistent with other research including Theresa McDowell (2004) study that explored the racial experience of therapist in training who were part of a Marriage and Family Therapy graduate level program and found that “...most participants were challenged in their graduate programs to gain deeper racial awareness through at least some course readings, class discussions, and supervision” (McDowell, 2004, p.308). Each participant acknowledged Smith College School for Social Work as a positive influence. Some participants reported support from professors

“Yes. During my second summer at Smith I spoke directly with the professors who taught my Racism in the United States class about the specific concerns I had in my first internship in relation to race. Race has also been addressed in other classes that I have taken at Smith.”

Others spoke directly about Smith’s commitment to anti-racism and the anti-racism course offered as part of the curriculum.

“My program offered an anti-racism course that had a profound impact on my understanding of how to approach race as a subject matter with clients of color. In addition, my supervisor often encourages me to discuss my own missteps and successes. These training opportunities have allowed me to integrate anti-racism work into my professional and personal life in very meaningful ways.”

Still others attributed their ability almost entirely to Smith as institution expressing, “Yes, absolutely. Without Smith's training I don't believe I would address race at all,” and “Not until Smith and they seem to be trying and offer the subject up for keen conversation.”

However perhaps the following response is most representative of the overall data collected from this survey in suggesting the following,

“Yes. I feel as though I have been prepared by Smith to approach race as a subject matter with clients of color. I cognitively know what I "should" do and feel like I have a strong intellectual understanding of the different dynamics happening as a white clinician working with a client of color. I just feel as though I need more experience building my confidence and ease in this area.”

And while all the participants credited their formal education as a tool to help them advance in understanding and being aware of race and racism in clinical practice, few still seemed uncertain how to address race, despite understanding an importance to do so. One participant wrote:

“Yes. I now realize that race is an important factor whether the client brings up or I sense it as such with any particular client. I'm still not sure if I should bring it up as something to discuss, or provide the opportunity to discuss with every client of color I deal with; but at the very least, I do know I need to be much more aware of it being an important dynamic, whether it is being spoken, unspoken, felt or not. I need to be aware that power differentials, unconscious influences, internalized racism discrimination, societal oppression, and even my own racism (conscious or unconscious) are always at play.”

The survey responses seemed to indicate that the majority recognize race as an important part of clinical practice with people of color and can recall a moment in which they felt they had addressed race with a client of color. In addressing race with a client of color, the majority seemed to address the client's race without acknowledgement of their own race or whiteness. Half of those surveyed were able to recognize possible consequences of not addressing race and many seemed to be informed with ways in which they begin to address race...and yet they do not always address race. This notion is reflected in the Sehgal, Saules, Young, Grey, Gillem, Nabors, Byrd and Jefferson (2011) study that found “...that both psychologists and students were not consistent in endorsing what they would do if they were to actually see these clients in therapy” (p. 6). There is indeed a disconnect, which many have attributed to feelings of uncertainty related to the impact doing so would have on the therapeutic alliance, or a perceived understanding that

race was not a salient issue at the time.

CHAPTER V

Discussion

The results from the study suggest that the majority of white Smith SSW students recognize race and racism as topics that are necessary to address with people of color. Furthermore, the majority of the white Smith students surveyed reported that not doing so has potential consequences for the client, the client-therapist relationship, and the overall treatment. They have unanimously credited their Smith education as a framework for the development of skills needed to engage in conversations about race and racism that may inform treatment with people of color. Study participants have described different ways in which they feel most comfortable addressing race with people of color. However, despite these encouraging results, the data shows that white Smith SSW students inconsistently address race with people of color. This is perhaps one of the clearest themes that emerged from the study. It is, therefore important to explore this incongruity between theory and practice, wherein white Smith students seem to emphasize the importance of addressing race, but nevertheless, do not routinely address race with people of color. For example, one participant explained a particular moment when they had wanted to address race, but didn't. The participant reported, "...my co-worker suggested we move on to the "important" part of the intake. I felt really confused and angry and yet I moved on." This is a critical moment to highlight given the frequency of similar instances that emerged in participant responses. It is also important given that the Smith School for Social Work defines "anti-racism work in terms of dismantling unjust policies and practices within the organization" (Basham, 2004, p. 290). In this scenario, the participant's action did not reflect the Smith SSW commitment and their frustration was informed by a sense that they had responded in a way that

did not reflect their values or Smith SSW training.

Another theme that developed seemed to indicate that more often than not, it was only the client's race—when it was not white—that was being addressed. A majority of responses—nearly all in fact, suggested that participants did not include their own race as part of a discussion with clients of color. Additionally, none of the responses seemed to indicate that this seemingly common practice of only addressing a client's race could be problematic. In the following section, I will explore these two themes in depth.

Addressing Race Inconsistently

Participants that acknowledged an inconsistency in addressing race with a person of color reported a variety of reasons for why they made a decision not to address race. Some of these reasons included a feeling that race was not a salient issue for the client, that the participant had a perceived fear that bringing up a conversation about race would negatively impact their relationship with the client, or that they felt unprepared to engage a conversation about race. In each instance, however, a participant made an independent decision not to address race; these decisions were not discussed with either the client or with other colleagues or mentors. This is problematic because the anti-racist literature is clear that whites must not think in isolation about anti-racist practice but be accountable to people of color and other whites engaged in anti-racism (Raible, 2008; Kivel, XX). Given white socialization to avoid explicit discussion of race, coupled with psycho-social investments in racism, independent decision-making on whether or not to address race with clients of color is problematic (DiAngelo, 2012). Some participants justified this decision as an effort to protect the client. However, there could be further explanation beyond what participants most commonly reported.

While each participant response for why they may have made the choice not to address

race is likely rational for them, it is also clear from each situation identified above that there is a perceived risk for the participant. Where there is a perceived risk, more often than not individuals will proceed with caution or avoid the risk altogether in order to protect their own self-interests. Yet this approach could stifle an opportunity for a genuine conversation around race. For instance, if they address race and the client feels it is not salient, the risk could be an experience of pushback from the client, which could be uncomfortable for the white clinician. Similarly if the participant felt unprepared and addressed race anyway, the perceived risk could be the potential for racial embarrassment or worse--offending the client in a way in which they would have to be accountable. Given the tensions around race, this accountability could be uncomfortable for the white clinician. Further, this accountability could challenge the self-image of whites as good people, "innocent" of race and racial investments. The motive implicitly embedded in each rationale for not addressing race, seems to be to avoid a sense of vulnerability. One participant explained their reluctance quite candidly, reporting "I chose not to address it in some instances because I was playing it safe and uncertain at times." "Playing it safe," implies a sense of risk to self, which drives the behavior to avoid risk.

Talking about race and racism for whites arguably requires a sense of vulnerability and risk taking; ultimately it requires not not playing it safe, given both the history of racial oppression in this country and the ongoing racism today. Yet waiting for the situation to "feel right" will likely ensure that race is not addressed. Race is a challenging conversation to engage, particularly cross racially. It can evoke feelings of guilt, shame, anger, confusion, and frustration for all racial parties, but especially white individuals. The discussion can be additionally complicated in a cross racial therapeutic setting, because the white therapist is expected to be supportive, helpful, good, just, and compassionate and yet, as white individuals they benefit from

a larger racially oppressive system which does not embody or produce these same qualities. It can therefore be challenging for white clinicians as well as people of color to reconcile this reality. For a white clinician, addressing race comprehensively would mean naming an unfair system in which they experience unearned benefits, while at the same time accepting accountability and responsibility to change that system. No doubt, this a daunting process for the clinician. Additionally, participants may not have not admitted their own discomfort in addressing race, because this would be a socially undesirable response for not addressing race; and so alternative notions are created, perhaps even unconsciously.

White clinicians are able to protect their own comfortable level by not addressing race, likely because there is no immediate professional or legal consequence. If a white clinician *does* address race there may be a sense of pride, courage, and thoroughness in their decision to do so. However, this may not work the same way when that same white clinician makes the choice to *not* address race, citing any number of reasons, for there is almost no instantaneous consequence present for the white clinician. Many of the participants were aware of this on some level as their responses seemed to indicate relationship consequences that only emerge after termination. No immediate consequences seemed to be named by participants. For example, one participant reported, “I feel like the consequences have been that I haven't had the chance to truly get to know a client of color when I haven't addressed race.” It is worthy of note that participants named no immediate consequences.

Other topics that may be uncomfortable to address certainly have the potential to impact or strain the therapeutic relationship and yet are still addressed, even if the clinician does it reluctantly. As an example addressing suicide, child neglect and abuse, or risky sexual behaviors are routinely addressed because these particular situations present explicitly immediate

consequences not only for the patient but also for the clinician. Not addressing race has not been considered in the same way among the profession and so the choice to protect from feelings of discomfort exists more readily for the white clinician.

Addressing Only the Client's Race

Participants however, did describe moments in which they felt confident in their decision to address race with a client of color. A significant amount of responses indicated that participants felt most comfortable addressing race by asking their client's interview style questions, often early on in the treatment process. Similar to the inconsistent pattern of addressing race discussed above, this finding could also be directly related to the participant's comfort level. It could be more comfortable to ask a question about racial identity while also asking about other social identities, say during an intake session. This would give the white clinician an opportunity to discuss race but in a less overt way. It could very well exist as a moment to open the door, but in perhaps a "safe," contained, or less "risky" way for the white clinician and one that does not inherently seek or require further discussion. It could also be more comfortable addressing race as part of a routine or as part of an intuitional practice that may have the potential to minimize a sense of personal discomfort on the part of the white clinician. Day-Vines (2007) describes these types of approaches as "isolating, explaining, "the isolating counselor does broach issues of race and representation, albeit in a simplistic and superficial manner" (Day Vines, 2007, p. 404). Addressing race in this way may operate merely as a single statement or question that counselors feel obligated to administer at least once. However, after this the initial broaching, they may assume that this activity can be removed from a prescribed list of counseling responsibilities (Day-Vines, 2007).

Some participants reported that they sometimes addressed race after a client had initiated

a conversation. In either instance however, it was the client's race that was addressed. Participants often inquired about a client's personal racial experience, racial identity, or experience of racial discrimination. The majority of participants did not discuss their own sense of their race, whiteness, racial privilege, and racial experience in relation to their client's. Almost unanimously participants report addressing race through a conversation about the client's race, both strictly and exclusively.

This is both a surprising and yet not so surprising outcome. On the one hand it is surprising given that many of the participant responses regarding their decision not to address race, place a strong emphasis on the therapeutic relationship. Relationship often implies a shared experience or connection, and therefore my expectation would be that a greater awareness of the clinician's sense of self in relation to the client would be present, and this would include racial identity awareness. And yet it's not so surprising given the inherent function of racism as a system. This finding illustrates the denial of white privilege that often manifests itself in color-blind attitudes. "Many individuals promote "color-blind" counseling as a means of appearing bias free, but, in reality, an orientation that ignores the salience of race may operate as a shield for concealing hidden biases" (Day-Vines, 2007, p. 402). Furthermore as McIntosh (1998) explains, "As a white person, I realized I had been taught about racism as something that puts others at a disadvantage, but had been taught not to see one of its corollary aspects, white privilege, which puts me at an advantage" (p.31). Likely for many of the participants surveyed, race is often seen as something that others have as people of color, but not something that they possess as white people. This is in fact a direct function of white privilege in which, "whites are carefully taught not to recognize white privilege" (p. 31). If white clinicians acknowledged their own race juxtapositioned with that of their clients (people of color), this may be more obvious

and potentially uncomfortable for the white clinician.

Yet not engaging with the dynamics *between* client and therapist as *racialized* actors—however comfortable it may be to avoid—has this response, however difficult, is not without consequences for “Failure to consider race and representation may prevent a counselor from recognizing the inevitable encounters with racism that minority group members experience” (Day-Vines, 2007, p. 402). It may also prevent white counselors from realizing the inevitable encounters with racism that minority group members experience *in the therapeutic session itself*. Racial dynamics are at play during the therapeutic encounter, as they are in all encounters. In other words, not naming race does not render it inoperative, it merely reinforces the problematic racial dynamics in the society at large. This may be the greatest irony in these findings; white clinicians often avoided race in order to “save” the relationship, yet white avoidance of race does not generally engender trust in people of color. This avoidance merely reinforces the evidence that this white person is like most others and therefore unaware of or invested in white privilege and unable to build an authentic cross-racial relationship (DiAngelo, 2012). Avoiding race actually reinforces racist norms and thus, the trust and relationship can only go so far.

Implications

As the survey responses suggest, the decision to not address race with clients of color is often made in isolation without outside consultation, recommendation, or supervision. Additionally, embedded in this independent decision to not address race are themes of white privilege that represent the inherent power dynamic that exists in clinical practice. Therefore there is the potential to enact racially oppressive dynamics, however unintentionally, within the therapy that can be harmful to the client. Studies have found that clients of color often feel, minimized, marginalized, and misunderstood when a white therapist has not addressed race and

racism as part of the treatment process. Chang and Yoon (2011) identified that clients of color:

“...found it difficult to discuss experiences of racial oppression, specific cultural practices, and family or community dynamics due to concerns that their therapists would not respond with empathy, validation, or cultural sensitivity” (p.573).

The consequences go beyond the client’s marginalization as studies indicate that perceived insensitivity to the personal and cultural meaning of clients’ experiences can lead to and contribute to the underutilization of and premature departure from counseling services (Day-Vines, 2007). Given the consequences of this decision, it is imperative that white clinicians maintain outside support in order to guarantee that an informed decision is being made. These supports could include the identification of supervisors with an anti-racist analysis, racial affinity groups, clinicians of color or other people of color who are willing to serve as mentors, and continual education that keeps race and racism salient for clinicians.

Furthermore, participants often spoke about their reluctance to address race with clients of color out of a fear that it could negatively impact the relationship or that race was not particularly salient for a client. This understanding may distract from Smith SSW’s commitment to anti-racism, because race is being conceptualized only on an individual level which does not lend itself to the opportunity to see racism as a systemic issue and as a collaborative effort within the profession. The supports identified above would also help address this misunderstanding.

Moving forward it may be important to investigate further how white clinicians are continuing to educate, inform, and prepare themselves to address race and racism with people of color. Specifically, Smith SSW may continue its mission toward anti-racism efforts by mandating not only a 2nd year anti-racism project for it’s students, but offering anti-racism

training or courses for supervisors at respected field placements that may continue to inform the student in both the clinical and learning process during the year. Continued research may ask white clinicians directly about their race and what their sense of their own whiteness is as this study did not.

Smith SSW identifies its commitment to anti-racism through the curriculum it has created and part of this curriculum is a five week anti-racism course offered to students. Smith may consider extending this program to ten weeks (both semesters) to place a greater emphasis on themes relating to white privilege and color-blindness that may support white students in acknowledging their discomfort in addressing race, while also understanding more deeply their own race and the benefits that come to white people in a racially oppressive society. Finally, Smith SSW may continue to develop programming that educates students about racism as a systemic issue that is not confined to the therapeutic relationship using theory such as Critical Race Theory. Critical Race Theory may inform students practice both with white and non white clients.

Chapter VI

Conclusion

This study surveyed twelve white Smith SSW students regarding how they address race and racism with clients of color. The questions were designed to gain further insight into whether or not race was being addressed with people of color, how Smith SSW students were doing so, what motivated them to do so, and when, if ever, have they not addressed race and why. The results showed that the majority of white Smith SSW students surveyed were in fact addressing race. Many suggested an ideology that respects the importance of race and racism and addressing these topics in practice with clients of color. However, the results also indicated that the majority

of white Smith SSW students were doing so inconsistently. Many of the participants expressed regret or shortcoming for the moments in which they had not addressed race. Common explanations revolved around the fear of a possible negative impact on the relationship or that race did not appear to the white clinician as relevant as expressed by the client. However, this study has also suggested that perhaps at the core of the hesitation for not addressing race is the participant's own discomfort related to the topic of race and the potentially complicated feelings it may bring up for the participant, specifically as a white person who benefits from unearned privileges. Furthermore, when they did address race, it was almost always with recognition of the client's race and not their own race. This study has hypothesized that this outcome may be a direct product of color-blind attitudes as related to a function to perpetuate a racist system that benefits white people. Nevertheless, the research has provided insight into how further research could serve to continue to effect change that would move Social Work as a profession in a direction towards equality. Suggestions have been made specifically in regard to the Smith SSW that may advance their mission towards anti-racist efforts overall.

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Appendix A

HSR Approval Letter

February 23, 2013

Malcolm Pradia

Dear Malcolm,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

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 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.

Sincerely,

Marsha Kline Pruett M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: Robin DiAngelo, Research Advisor

Appendix B

Informed Consent

Greetings,

My name is Malcolm Pradia and I am a second year Masters student enrolled in Smith College's Social Work program. I am conducting a study that focuses on race and racism in the context of clinical practice. In particular, I am exploring how white Smith students in practice are addressing race and racism with clients of color and what motivates these students to do so, specifically. I'm also exploring the cases in which race and racism is not addressed and why that might be. There is growing amount of evidence in literature that suggests that addressing race in practice with clients of color in particular, is important and can have a significant impact on the therapeutic alliance, the treatment process, and the treatment outcome. I've chosen to explore students at Smith College in the School for Social Work because of the school's written commitment to anti-racism and the emphasis that the school has placed on the importance race in the context of clinical practice.

Nature of Participation

The purpose of this study is to 1) present literature that supports the importance of addressing race and racism in practice in cross racial dyads with white therapists and people of color, 2) determine whether or not white Smith Students are addressing race and racism with clients of color, 3) identify what motivates or discourages these students from addressing race and racism with clients of color, 4) compare the data collected to the values of the Smith School for Social Work's commitment to anti-racism statement 5) consider the strengths and limitations of the social work curriculum related to preparing white students to address race and racism with clients of color, and 6) develop a deeper understanding on addressing race and racism in clinical practice which may be a valuable contribution to the Social Work profession in serving and supporting all communities, including people of color. Finally, this data may strengthen the ability of white social workers to apply clinical skills with people of color seeking mental health treatment.

You are being asked to respond to a survey comprised of six open-ended questions related to addressing race and racism in practice with clients of color, based on your own individual experience. The survey will be electronic via Survey Monkey. Participants will be white Smith Social Work students that have worked in a clinical setting with people of color.

Risks of Participation

This study has been designed to protect participants and produce a limited amount of risk. It is possible that you may experience discomfort when reflecting on your unique experiences. It is also possible, that you may feel uncomfortable disclosing or sharing your experiences in regards to race, racism, and clients of color, as you may find them private and personal. All members that are part of this study will sign a confidentiality agreement prior to viewing any submission from you. Identifying information will be excluded from the data.

Benefits of Participation

The opportunity to reflect on clinical and personal choices that you have made, might provide you with new or greater insight in how you may approach and address the topics of race and racism with clients of color in the future. Such reflection may encourage you to continue to cultivate a deeper understanding of race and racism in an effort to develop strong clinical skills and seek additional support from peers, colleagues, and relevant literature. Additionally, the data collected may provide insight that could serve to improve or build upon trainings on social justice and cultural competency. Curriculum may be built upon in a way that will continue to prepare white social work students for working with people of color in therapy.

Confidentiality

Utilizing an electronic survey via Survey Monkey will not require you to reveal any identifying information such as your name. Any identifying information related to you will be removed. You are cautioned to not reveal any identifying information that may be associated with a client or individual you have worked with as a means to protect the third parties identity. Non participants that are involved in reviewing surveys or other information associated with the study will sign and adhere to a confidentiality agreement prior to conducting work related to the study. This agreement will be written as a contract. Research advisors will have access to data from the study only after it is clear that all identifying information has been removed and excluded from this data. In publishing or presenting the data publically, identifying information will be removed. In the case of quotations that may reveal identifying information, they will be paraphrased and changed to preserve confidentiality. All data will be secured and stored safely. Electronic data will be protected for three years as required by Federal regulations. The data will then be destroyed when no longer needed. If the data is needed after three years, it will continue to be safely and securely stored.

The Voluntary Nature of Participation

Your participation in this study is voluntary. You can decline to answer any of the survey questions. If you at any point no longer wish to be a part of the study, you can withdraw from the study by emailing me without any explanation included. Should you withdraw, there is no penalty. Your Information will be destroyed immediately and not included in the study's findings. Participants can withdraw any time before March 1, 2013, the anticipated end of research.

Investigator's Signature: _____ Date: _____

Advisor's Signature (if applicable): _____ Date: _____

(Required for all students)

Appendix C

Recruitment Email

Hi,

My name is Malcolm Pradia and I'm a second year SSW Masters student. I'm hoping to find volunteers to participate in my thesis. I am looking to learn more about how white Smith students are addressing race and racism in practice with clients of color. If you are interested, identify racially as white, are enrolled or have been enrolled in the Smith School for Social Work, and have had the opportunity to work with clients of color for the purpose of therapy please email me at ____ Or! Please share this information with individuals who may not see this message but would be interested and meet the inclusion criteria. Thanks!

Appendix D

Follow-up Email to Participants

Greetings!

Thanks for your expressed interest in my study. Thank you for reading the two documents attached in the previous email in regard to the voluntary nature of this study and informed consent. If for some reason you did not receive this information please contact me via email me before you click the attached link.

I've included in this email a link to SurveyMonkey where you can take the survey. It is about 10 questions. I estimate that most folks can complete it in 30 to 60 minutes. As you respond to each question please conceal any information that may identify yourself, agencies, and of course patients/clients/people you've worked with. There is no option to leave a question blank. If you choose not to answer a particular question you can merely answer by placing a period in the text box. If you do not understand a question please do not contact me for clarification or interpretation, instead, attempt to answer it as best you know how. Thank you so very much for your participation!

Best,
Malcolm

HERE IS THE LINK: <http://www.surveymonkey.com/s/MYZLHLT>

Appendix E

Survey Questions

1. Can you recall a time when you addressed race with a client of color? If so, why did you feel it was necessary to do so at that time
2. Have there been times when you have felt race could have been addressed with a client of color but you didn't address it? If so, why do you choose not address it at those times?
3. Describe how you feel most comfortable addressing race with a person of color in clinical practice
4. If you routinely address race with clients of color, how do you address it, and what motivates you to consistently do so?
5. Has there been a time when you considered race unimportant in practice with a client of color. If so, why did you feel it was unimportant at that time?
6. Has your formal education informed how you approach race as a subject matter with clients of color?
7. In moments where you may not have addressed race with a client of color, did you feel that there were any consequences as a result?
8. How do you identify your gender?
9. How do you identify your race?
10. What is your age?