Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE THIRTY-SEVENTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Cultural Perspectives, Values, and Meaning: Integrating Them Into Helping Interventions

It is well recognized that cultures differ in population groups—the military and veterans, LGBTQ, African-Americans, the disabled, street gangs, etc. These differences shape their mental health needs, presentations of disability, and responses to helping interventions. How do mental health clinicians, planners, and policy-makers incorporate these insights into action that benefit individuals, families, communities and the society as a whole? A panel of experts in specific populations, who can apply cultural perspectives, values, and meanings to maintain and regain mental health, will share their understanding and skills to enrich the capacities of practitioners active and interested in mental health.

Speakers

Natalie A. Cort, PhD, Core Faculty, Clinical Psychology Department, Massachusetts School of Professional Psychology; Adjunct Assistant Professor of Psychiatry, University of Rochester Medical Center; Consultant to the United States Departmet of Veterans Affairs' Interpersonal Psychotherapy for Depression Training Program

Sara Orozco, PhD, Counseling Psychology Program, Massachusetts School of Professional Psychology; specializing in individual, couples, and family therapy with diverse client populations

Susan Powell, PhD, Core Faculty, Counseling Psychology Program, Massachusetts School of Professional Psychology; special interest in diversity and difference, counseling theory, and clinical skill development

Moderator

David G. Satin, MD, DLFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School, Chairman, Erich Lindemann Memorial Lecture Committee

Friday, June 13, 2014, 2:30 – 5:00 pm

Massachusetts School of Professional Psychology
1 Wells Avenue, Newton, MA 02459

Introduction by David G. Satin, MD

Our topic for today is Cultural Perspectives, Values, and Meaning: Integrating Them Into Helping Interventions. We have three speakers who we will start with today; Dr. Natalie A. Cort, Dr. Sara Orozco, and Dr. Susan Powell. Afterwards we will have a round table discussion on applying cultural perspectives, values, and meaning to mental health practice, and we will hear comments and questions from you in the audience by written cards. In the last Lindemann lecture we presented insights into the sample cultures of Hispanic, Muslim, and Roman Catholic communities as they affect the understanding of and response to their mental health issues. Today we want to generalize from those particulars to the application of cultural understanding to mental health practice. This not only in mental health caregiving to individuals in families, but in the development of mental health programs and the education of mental health professionals, as well as Dr. Lindemann's perspective.

Susan Powell, PhD

Core Faculty, Counseling Psychology Program, Massachusetts School of Professional Psychology

Introduction by David G. Satin, MD

Our first speaker is Dr. Susan Powell who earned her Ph.D. in Counseling Psychology from Southern Illinois University- Carbondale. She is a Core Faculty member in the Counseling Psychology Program at the Massachusetts School of Professional Psychology and served as Associate Director from 2008-2010. Her interests and focus include diversity and difference, and the impact of diversity-related courses on students' personal and professional development and subjective experience of faculty who teach such courses. She has also consulted to a wide range of organizations throughout the U.S. on issues of diversity and difference, particularly as it relates to enhancing cultural competence.

Susan Powell, PhD

I will speak for Natalie and Sarah when I say that we are really honored to be invited here to be a part of this presentation today. I am going to take about 10-15 minutes to do a couple of things. First, I will talk about my interests, my experience, and my background and how that informed my interest in diversity and difference. Then I am going to do a brief lecture reviewing some important constructs that I think are really critical. When we talked about doing this presentation, we talked about how there is certainly an emphasis on skills with diverse populations: What skills work with African American populations? What skills are best when working with people living in poverty? While that is important, what I'm going to talk about is how awareness is a critical piece of cultural competence. I might even go out on a limb and say perhaps it is the most critical piece of cultural competence. We can read all the articles we want, go to as many continuing education events as we want, learn about different skills and so forth, but if we do not do the self-exploration piece and gain the awareness piece, we are going to be lacking in terms of what we can do clinically, in the classroom, with research, with our peers, and even interpersonally in our lives.

To share a bit about me, I grew up in southeastern Ohio. I grew up near West Virginia in a very impoverished area that is still impoverished today. I grew up in a working-class family and was born with a physical difference in my hands, so I grew up looking different from other people. In a family that was working class, that made a difference as well in terms of access to information and so forth. I share these things because I am also the first in my family to go to college, let alone go on for a graduate

degree, and I share these things because I think they really informed an early understanding, though I would not have articulated it this way, of how people get seen. What kinds of assumptions get made about people based on what we see when we look at them? The reality is, and it is ground-breaking in some ways and not so ground-breaking in other ways, is that really how I perceive somebody else says more about me than it does about them. That is where the awareness piece comes in. Hopefully this is something that you've thought about before.

That gives you just a bit of a background. I think that what happened was I got encouraged by some teachers to go to college. I went to college, and while there I took two courses that really changed my worldview. One of those was called Blacks in American History, and the other one was called Women in American History. In both of those courses, I suddenly realized, "Wow, my American history wasn't really American history." It was a very narrow definition of that, which further sparked my interest to learn more and to better serve different populations. That is what brings me here today. I think we will have an opportunity to talk amongst ourselves about that a bit more, as well. I am going to discuss a few lecture pieces here, and I am going to hand all this material over to Natalie.

As a reminder, when we talk about difference and diversity, we are broadly defining that. We are thinking about some of the traditional things we think about: gender and sex, race and ethnicity, sexual orientation, but also social class, including educational level, whether somebody is living in poverty, disability and physical difference, religion and spirituality, nationality, language, beliefs and values, age. All of these things impact all of us, but what we find is we tend to be more aware of aspects of our identity that result in us feeling stigmatized or oppressed in some way. We do not always think as much about aspects of our identity that afford us privilege. I think that is sometimes harder to look at. How am I privileged and what does that mean in terms of how clients interact with me, how I present myself, what opportunities I have had? This gives you a little overview, then, of diversity and difference.

In thinking about cultural competence, there are 3 main components if we look at how many diversity and difference scholars think about cultural competence. The first thing I want to say about this is it is an on-going process. When I do presentations or do consulting, I say to people, "You might leave with more questions than answers and that's okay." I think all of us want to say we cannot provide all of the answers, and in fact this is information that all of us continue to think about and hopefully learn about and grow related to. The other piece is it is important to keep in mind that this is important for both majority and "minority" populations. Again, a lot of times we think that race is important for people of color, and white people might not be as used to thinking, "My

race is really important as a white person. It's impacted my life experiences. It's impacted my opportunities."

Think about disability and physical difference. You might think if you do not have a disability or physical difference that it has not impacted your life. The reality is if you do not have a disability or physical difference, it tremendously impacts your life. Hopefully one of the things you can keep in mind today is thinking about: What are the aspects of my own identity? How does it impact me? How has it impacted my experiences? Awareness is the first component, and that's what we're talking more about today. This includes awareness of privilege, awareness of your own background, and awareness of biases and discomfort. I think all of us in this room have biases and discomfort. Perhaps some of us have thought more about that than others of us, but if you feel compelled to say, "Well, I don't have any prejudices. I don't have any biases. I treat everybody the same way," that is probably not true. I include myself in that.

It is an ongoing process, and we have to be thoughtful about it. It might even be easier to think about it as discomfort. I might think, "Oh, well, I'm comfortable with people with disabilities and physical differences," but the reality is maybe I have had more exposure to people who use wheelchairs, and I have had much less exposure to people with craniofacial differences. With some of these umbrella terms, we want to keep in mind that it is pretty hard to say, "Well, I'm okay with all people" and to not have any areas of discomfort that arise.

The second aspect of cultural competence is knowledge, and you can see here there is a range of different knowledge. If you pick up Sue and Sue's book, *Counseling the Culturally Diverse*, you will see different chapters on specific racial and ethnic groups, on working with women, working with people living in poverty, et cetera. Again, it is important to have information and knowledge about specific groups, but like we will talk about, the importance of awareness cannot be understated.

I am going to go ahead and move on to skills. I am going to include here, again, the importance of self-exploration as an important skill in terms of becoming culturally competent. Reading any kind of books like Sue and Sue's book you learn about skills. You learn about evidence-based practices, what kinds of practices work for different kinds of populations. Again, I always caution students to keep in mind that whenever we read about specific groups it is important to recognize that there are always individual differences. None of us want to be seen as just a member of a group. You want to have that knowledge but also recognize individuals within that group may not necessarily conform to what you expect them to value or behave or even expect in therapy.

How many of you have heard the term microaggressions? Some of you have. Microaggressions- in my opinion this is where it is at today. I am going to go out on a limb here and say there is probably nobody in this room who has overt bias. There are no

members of the KKK or Neo-Nazis in the room, I am guessing. The reality is that most of us, if not all of us, have unconscious bias and that is what microaggressions refer to. You might have heard the terms aversive racism, aversive disablism, or aversive sexism. What it essentially means is that we hold these unconscious biases even though we may abhor prejudice; we verbally and consciously abhor prejudice. We think everybody should be treated the same, but in reality we may have bias underlying that does impact how we interact with other people and the kinds of relationships we build clinically and so forth. I think it is important to note here that microaggressions can be enacted verbally, nonverbally, visually, and behaviorally. There are lots of ways in which microaggressions might manifest.

There are two specific kinds of microaggressions I want to note. One is micro-insult. This basically refers to a backhanded compliment where a person makes a comment or a behavior that in some way conveys some sort of insensitivity or bias, but they do not necessarily recognize it. I think about years ago when I was doing consulting in an organization. There was an African American man who was on the staff there, and he told me about how one of his White female coworkers had said to him, “You're not like the others. You’re one of the good ones,” We probably gasp at that and we think, “Oh, people don't say those things anymore.” Guess what? Yes, they do. All the time. I think that is a great example of how she in no way meant that in an offensive way, but in reality it communicates to him, “I see African American men in one way, and you don't fit that, so you are the exception to the rule.” I read an article recently about women with disabilities and physical differences, and one woman who used a wheelchair was talking about how she has children, and when people find out she has children she has frequently had people say, “Oh, that is so great. Good for you.” How many of you have children in here? How many of you have people ever said, “Well, that's so great. Good for you”? Anybody had that experience? So again the underlying message is, “We do not expect that of someone like you.” There is a great Ted Talk from Australia. I am forgetting her name- a woman who uses a wheelchair. It does a really nice job of looking at the lowered expectations that exist for people with disabilities that we do not even often recognize that we hold, but that impact them in some way.

A micro-invalidation is where if I experience a micro-insult, and I come to you and I say, “You know Ally, I really want to talk to you about something you said that felt really offensive to me,” and you say, “Oh, that's not what I meant. You misunderstood. I say that to everybody.” That's a micro-invalidation. It is when somebody comes to us with a concern about usually a micro-insult, and we invalidate that or try to explain it away. Many of us have probably had experiences like that at some point or another.

When we think about microaggressions and how they impact the therapy relationship, research shows us that 50% of people of color tend to prematurely

terminate therapy after one session. Now, there could be other reasons that play into that, but I am going to go out on a limb and say that I think a piece of that could be related to feeling like their therapist does not understand them.

Natalie is going to talk more specifically about some research that I think might exemplify some of this, as well. The importance then, again, is of all of us being able to think about our unconscious discomfort, areas where we might feel less comfortable with certain people than others. That is really important to be able to prevent microaggressions coming out in therapy. There is a growing body of research that looks at the long-term impact of microaggressions on people who experience them frequently, and it has a negative impact on psychological well-being. Again, if I do not take the time to self-reflect, then I am going to have a hard time recognizing how these things might come out in therapy. After Natalie and Sara present we have just two little vignettes that sort of exemplify how microaggressions might manifest in therapy and how we can challenge those in some way.

When Sara, Natalie, and I met, we talked about how the things we're talking about today we've learned from our personal experiences. We have learned from clinical work that we have done with clients. We have learned from teaching and what we hear from our students, and we also learned from research that we have done. I think that it is really important, though, to be able to challenge ourselves related to these kinds of things, that there might be times where we need to get genuine support, for example. Sometimes we tend to turn to people who we know will agree with us. It is always important, also, to have people in your life who will, in a supportive way, challenge you to think about things in a different way.

I like this last one: shifting your mindset from "That person needs to change" to "Is there something that I need to change? Is there something that I am missing that maybe I need to learn more about?" Finally, increasing your contact with people you are different from is critical. I think doing that on an equal plane so that you are not just seeing people in therapy or in situations where there is some sort of power imbalance, but having a chance- and some of you obviously may do this- but having a chance to really build equal relationships with people and get to know people. As we know, the one thing that really decreases bias is having contact with people who are different from us in some way.

I will say something about emotion, as well. I think it can be very hard talking about difference and diversity and I mean *really* talking about it. I mean, really sort of exploring this in a way that is not comfortable to do, but I think it is useful to be able to learn to "sit in the fire" with these difficult emotions, being willing to recognize when you feel threatened, when you feel insecure, if you feel angry. Keeping track of what am I feeling, why am I feeling this way, how can I manage this? That can be really useful. I

think being an ally. You guys have all probably heard that term, ally, so that it is not always up to the person who is disenfranchised in some way to stand up and say something for themselves or for the group that they are seen as belonging to. Allies are important in terms of distributing that responsibility, and, also, for those of us who need allies, being appreciative of your allies. Those are just some things to keep in mind in terms of challenging yourself and continuing to grow. I am going to stop and turn it over to Natalie, and then we will come back and have an opportunity to have more discussion and look at a couple of brief clinical vignettes that will help you to think about this.

Natalie A. Cort, PhD

Core Faculty, Clinical Psychology Department, Massachusetts School of Professional Psychology; Adjunct Assistant Professor of Psychiatry, University of Rochester Medical Center; Consultant to the United States Department of Veterans Affairs' Interpersonal Psychotherapy for Depressing Training Program

Introduction by David G. Satin, MD

Our second speaker is Dr. Natalie Cort, who is a licensed clinical psychologist, Adjunct Assistant Professor of Psychiatry at the University of Rochester Medical Center and is Core Faculty of the MSPP Clinical Psychology Program. She provides consultation and training in the U.S. Department of Veterans Affairs IPT for Depression Training Program and practices psychiatric treatment of trauma-exposed adults. She also works with racial disparities in child abuse reporting, depression, and trauma-exposed African American women and children.

Natalie A. Cort, PhD

Hello. I am going to be presenting on the strong black woman in therapy. Just to share a little bit about myself, I am from South America. I am from Guyana, South America, and that is pretty meaningful just in terms of my own self-identity. Initially in graduate school, I really focused on doing trauma exposure work focusing on how trauma impacted women's experience of depression and how that impacted their treatment engagement and outcomes. There was a part of me that really, maybe unconsciously, avoided focusing on issues of race. During my internship year, I was approached by a fellowship director who asked me to apply for his two-year research fellowship and shared with me that the fellowship focused on examining racial disparities in the mental health system. I said I needed to think about that. His wife happened to be my research mentor at the time. I met with her and I shared that her husband had offered me this opportunity and, while I was really grateful for it, I was really uncomfortable with the idea of this fellowship. It was, in large part, because I did not want in any way to be seen as a cliché, to be the Black person in the department who did research on Black people.

There was a great deal of resistance in me for the possibility that I was going to be pigeonholed and seen in a really narrow way, in a way that I did not see myself in large part because of my own cultural background. I needed to do some self-exploration, and I was challenged by my mentor about whether or not I had anything to say. Was there anything unique that I could bring to this department that was primarily made up of White individuals? Really, primarily made up of White individuals. Was there anything

that I could say that was important and unique and different? I realized that I felt that I did- I did. Even though I was from South America, there were similarities. There were things that I could tap into that reflected the Black experience here in America, and since I am already in the system let me utilize that opportunity and that power to maybe make some changes while I was in the system. I said yes and pursued a two-year fellowship, and it was really a lovely experience.

I went on after that to be rewarded as a second fellowship from the National Institute of Mental Health which allowed me to further investigate race and trauma in mental health, and that is what I am going to be talking about today. The objectives of my talk today are really to enhance your knowledge about Black women's perceptions of psychotherapy and their thoughts about their providers and hopefully really promote the necessity for more culturally informed psychiatric treatment. There is obviously, as you may know, pretty significant persistent mental health disparities that exist in the U.S. Often times, we see that individuals who are racial ethnic minorities receive extremely poor, subpar psychiatric treatment. Given that this country is rapidly approaching being a majority-minority country, that is a huge problem. It is really important that we start to think and appreciate more the experiences of minorities in this country.

Before I move on, I really want to acknowledge the amazing women who participated in the study that I am going to be talking about, as well as my co-authors on this project and to disclaim that it was funded by the National Institute of Health. I am going to be sharing information about a group of people close to my heart for obvious reasons, Black women. My talk is going to be punctuated with research on the literature that exists out there about minority mental health, and I am also going to be sharing with you some results from a qualitative study that we did a few years ago. That study involved 25 Black women who had participated in Dr. Nancy Talbot's randomized clinical trial for depression. They had experienced that treatment at a community mental health center. Black women arrived for treatment with incredibly burdensome stressors that are disproportionately associated with psychiatric morbidity, and those stressors are shaped by a legacy of discrimination and racism. To survive the generational traumas and marginalization, Black women have faithfully relied on spirituality and religion to help them survive. We have also learned how to be self-reliant and silent in our pain, and for many Black women, the combination of powerlessness and strength really presents a pretty complex and problematic psychological paradox. I want to share with you an excerpt from a poem written by Laini Mataka. And I think this poem really elegantly encapsulates the enormity of the paradox that black women face.

On August 15, 1999 at 11:55 PM, while struggling with the reality of being a human instead of a myth, the strong black woman passed away. Medical sources say she died of natural causes but those who knew her know she died from being silent when she should

have been screaming, milling when she should have been raging, from being sick and not wanting anyone to know because her pain might inconvenience them. She died from loving men who didn't love themselves and could only offer her a crippled reflection. She died from raising children alone and from not being able to do a complete job. She died from asphyxiation, coughing up blood from secrets she kept trying to burn away instead of allowing herself the kind of nervous breakdown she was entitled to but only White girls could afford. She died from sacrificing herself for everybody and everything when what she really wanted to do was be a singer, a dancer, or some magnificent other. Sometimes, she was stomped to death while she carried the family in her belly, the community on her head, and the race on her back. The strong, silent, talking Black woman is dead or is she still alive and kicking?

Now this is a beautiful, poignant poem that really highlights the complex cultural context of psychiatric illnesses experienced by Black women. This is a complicated picture that is often absolutely unrecognized by most clinicians. It also highlights, I think, the incredible reservoir of strength and resilience that skilled, knowledgeable clinicians could really exploit in their attempt to improve the psychiatric lives of Black women.

Some of this research here was discussed by Susan, but Black individuals enter treatment with much, much more severe chronic and debilitating psychiatric conditions and pretty depleted familial resources. The research suggests that for many Black women, the time between the onset of a psychiatric condition and when they seek treatment can be as much as 20 to 30 years. For the general population, that timeframe is about 7 years, so that is pretty meaningful. Often times, when we see Black individuals for therapy the situations that they are in tend to be a lot more severe. As was mentioned, Blacks also significantly underutilized outpatient psychiatric services, as well as psychotropic medication, and due to the limited multicultural competence as well as a pretty mono-culturalistic diagnostic system, it will not be a surprise to any of you I am sure that minority patients tend to be disproportionately misdiagnosed with psychiatric conditions. When that happens, it is typically that they are diagnosed with very, very severe psychiatric conditions. Instead of panic disorder, you are getting a diagnosis of schizophrenia. That is a big difference in terms of treatment, and it is really quite meaningful. For Black women, we see these misdiagnoses leading to disproportionate involuntary psychiatric hospitalizations as much as 3 times the rate at which White women are hospitalized. These synergistic disparities that come together maintain a psychological isolation that is often times experienced by many people of color.

I am sure most of you are aware that there is a pretty significant legacy of medical exploitation in this country of minorities, and that has led to significant mistrust of the health care system of which we are a part. That mistrust is extremely problematic

because it shows in research that it decreases disclosure of personal experiences and information and, therefore, it reduces the ability to form therapeutic alliance, and that obviously is pretty critical to positive treatment outcomes. There is also a fear of stigma when we think of barriers to treatment, and that stigma relates to a fear of being considered unstable or crazy, and those are labels that black women work really, really hard to avoid. For many Blacks, admitting that they are living with a psychiatric condition is an admission of their inability to function, to manage their lives. Maintaining a self-reliant, in-control image is quite important.

I wanted to share with you some thoughts from our qualitative study. I asked the 25 Black women in our study about their thoughts about why it was so difficult to participate in treatment. What barriers existed for them? One of them said, "People may think that something is wrong with me. For me, it was denial, not knowing how to label depression. This is my messed up life, and this is how it's supposed to be." Her sentiment really highlights a finding that has been shown in other qualitative studies with Black individuals where there is the feeling as though being Black means that life is going to be hard. Your life is going to be difficult, so the fact that I am depressed should not be a surprise to me. If you are thinking in that way, that this is all there is, you are less likely to be motivated to go to treatment to try to fix it. One woman shared, "Black women just eat and eat and eat until they feel the stress is gone." Not surprisingly, there are pretty high rates of diabetes among Black women. One woman also said that, "We Black women really don't come to therapy until we are at our wits end. We hold it in and we bury it. We drown in it. We're taught to do that. My mother did it. My mother, she would go so far and then break down and cry like she is so full of it and hurt and tired." That goes back to the statistics I was sharing with you that often times Black women do not show up to therapy until decades after the onset of a condition.

When we have asked about Black individual's perceptions about psychiatric treatment in general, this is what we typically see being reported: The feeling as though psychiatric treatment is warranted but only in certain circumstances. It is warranted, and it should be reserved for individuals with very severe mental illness, like schizophrenia or for individuals who have been exposed to trauma. They highlight across research that the simple word psychotherapy, in and of itself, is associated with the label "crazy" and one of our participants said, "A lot of Black people, they don't look at coming to therapy, you know, as realistic for them because they look at it as taboo. A lot of us think you go to see a therapist, you crazy." In addition, there are lots of negative thoughts and resistance to feeling as though medication could have some utility.

In terms of perceptions of providers, it is not uncommon that when we talk about racial disparities, often times the question about racial-ethnic matching between provider and patient comes up. I just want to share with you what we know about that.

Most patients will report having a moderate desire to be paired with a clinician who looks like them. However, there is not a consensus in terms of whether or not that is actually helpful to treatment outcomes, and there is some suggestion that it really does not have much of an impact on improving treatment outcomes if you are working with a clinician who looks like you. Where the difference is, is that it might help to increase your initial engagement in treatment but, again, not necessarily predictive of more positive outcomes. For Black individuals who want to work with a clinician who looks like them, as you can see, the availability of clinicians who are black and psychologists and psychiatrists who are Black is significantly, significantly low, so there is an incredible paucity and these numbers are pretty similar for Hispanic clinicians, too, and even worse for Native American clinicians. I think in 1994, there were maybe 29 Native American psychologists across the country.

Let me share a little bit about what our participants had to say about their providers. In our study, the 25 women that we worked with had seen providers who were all White. One woman said, “She listened, but I don't think she understands. I've been sexually assaulted, abused as a child, stressed out from my husband, so no, I don't think she understands because I don't think she's been through what I've been through, and I've been through a lot.” Another woman says our clinic needs more Black female therapists “so Black females can feel like they got somebody that understands them because you can't sit across from a rich White lady that’s never had any type of problems ever. Or their problem was they couldn't get into the college they wanted to. Those are not real problems to the Black people.” A third woman said, “There were some things that confused him,” her White therapist, “because I'm a woman of color and so some of my language may be different, how I interpret or how I express myself, but the fact that he went and came back and got the clarity, you know, was appreciated.”

These women were really highlighting the fact that, for many of them, they did not feel as though their therapists really understood the deep complexity of their lives, the environmental context of their depression, and their coping capacities. They felt as though there were pretty significant socioeconomic, educational, and cultural differences between themselves and their clinicians, and as a result of those differences they were concerned about whether or not their clinicians could really fully appreciate their daily challenges and, therefore, would be able to actually give them advice that would be suitable, that would be appropriate, and that they could actually use. For some women, it meant that they worried about not experiencing a sense of mutuality, and that made it really challenging for them to feel emotionally safe and be willing to disclose some of their experiences.

I was also really interested in having the women in our study share with me their thoughts about their lives and White women's lives. The reason was because our

previous clinical trial had demonstrated that Black women did not do as well in depression treatment as White women had done. This was interesting because they came to treatment at the same rates, so it was not a matter of not being engaged in treatment. They came at the same rates, they saw the same therapists, it was at the same hospital, and they had similar initial rates of depression, but they did not improve as well as White women. I wanted to hear their thoughts about why that might be, and this is what they had to say. “We struggle more. White women have a lot of support from their families. If I wanted something I would rather go to a stranger than to my own family. A White woman’s going to be privileged. They come into therapy with an understanding and a language to express themselves. African-American families perish from a lack of knowledge. Families don't stick together. White families learn how to keep the family together. They don't keep a secret; they talk about it amongst themselves. African Americans keep a secret and it creates problems.”

They shared their feelings that, compared to White patients, many Black females are overwhelmed with multiple stressors and a great deal of relational discord, and as a result those family resources were frequently unavailable to them as buffers against depression. Instead, they suggested that for many Black families crises were managed internally and attempts to seek external support and guidance were often times strongly discouraged. Their words really underscore the enormous courage it takes and strength it takes when Black women show up to therapy.

As I wrap up, one of our participants suggested how we as therapists can start to address some of these issues. This is what she had to say. “Let Black women know”- this is what she thinks a therapist should say- “I don't have no experience in your shoes but if you feel that you trust me enough to share, if it's just a little bit, you know. Start off with just a little bit until you can feel a little bit more confident in me.” From her perspective, she felt that we as clinicians, including White clinicians, should directly address issues of cultural differences because they are in the room. Whether or not you address it, it's in the room, and she felt that that was preferable to ignoring the potential barriers that existed. She felt that therapists should really acknowledge their limited understanding of certain aspects of their patients’ lives. We are not always going to share every single experience, and we are not expected to, but acknowledge that there are some differences that might create distance. Also share with your patient that you are really interested and desirous of learning more about their unique experiences.

In closing, we know that there is an incredible crisis in the provision of psychiatric care to racial ethnic minorities in this country, and it is incredibly emotionally costly, but it is also incredibly economically costly to this country, to each of us as taxpayers. Given this country's changing demographics, I think it is really important that we recognize

that these issues really should be at the forefront of our clinical training and our clinical work and not be relegated to the background. Thank you.

Sara Orozco, PhD

Counseling Psychology Program, Massachusetts School of Professional Psychology

Introduction by David G. Satin, MD

Our last speaker is Dr. Sara Orozco who earned her Ph.D. in Psychology with a specialty in neuroscience from Georgia State University. She completed a clinical post-doctoral fellowship in the Department of Neuropharmacology at The Scripps Research Institute and completed a clinical re-specialization program at the Massachusetts School of Professional Psychology. She is a full-time Core Faculty member of the MSPP Counseling Psychology Program and specializes in anxiety and mood disorders, grief and loss, adjustment disorders, medical and health concerns, and relationship issues. She is involved in numerous civic organizations, maintains active interest in policy advocacy, and has campaigned for the Massachusetts State Senate.

Sara Orozco, PhD

Buenas tarde. Mi nombre es Sara Orozco. Good afternoon, my name is Sara Orozco, and I am a faculty member here at MSPP and the Chair of the Diversity Committee. I am also Co-Chair of the Rainbow Alliance. It is an honor to be here today, so thank you and thank you for having Natalie, Susan, and I work together- it has been really fun. In addition to being a faculty at MSPP, I have a private practice where I treat a diverse range of individuals: adults, families, couples, and adolescents.

I am a Latina professional. I am a lesbian professional. What I am not, however, is a professional lesbian, and I am not a professional Latina. I feel that it is important to make that distinction because the fact I am a Latina and a lesbian does not automatically make me an expert in treating people from those populations. I am sure that I am not the only minority person who has had this experience. In my 20-plus year career and more, I have often found myself the go-to person for all things having to do with people of color and gays. This extends to serving on insurance panels or getting referrals from school systems or from other referral systems simply because I am Spanish-speaking. This obvious advantage that my native language may give me when it comes to business and my privilege that comes with having a Ph.D. in academic institutions shapes this part of my experience at this time, but this is not all of my experience. Those same advantages of race can fall away quickly when I am away from MSPP or when I am not sitting at my therapist chair.

I will give you a very brief example. I live in the same town that I practice in. I have two sons, and my partner carried our sons and they look very all American. When it was time to send them to school, we decided each one of us would take turns walking our

sons to school. On the days my partner would walk them, she would come back and she says, “Oh, my gosh! I met so many people.” She said, “Oh, it was so nice. It was wonderful. There are so many nice people.” Then, the next day, eager to meet all these wonderful people, I would walk my sons to school, and I would come back and I would say to my partner, “It must have been an odd day. I didn't meet anybody.” The next time she would go, she would walk off to school. She would come back and said, “There's even more new people.” And so the next day I would go, and then she asked, “Did you meet anybody?” Well, I did not meet anybody.

This went on for a period of time and finally there was somebody who invited our kids to a play date, and my partner was going to drop them off and I was going to pick them up. Then it hit me and I said to my partner, “I think I know what's going on.” She said, “What's going on?” I said, “I think they think I'm the nanny.” She said, “There's no way they think you're the nanny.” I said, “No, I do. I think *they* think I'm the nanny.” So I go, “What I need you to do is when you drop off the kids, I need you to tell her that I'm not the nanny, that I'm actually the other mother.” She was sure that I was wrong. Anyway, my partner goes. She drops off the kids, and she comes back with a t-shirt, and on it she wrote “I'm not the nanny.” She says, “I think you need to wear this when you walk to school.” It was true. The woman had really thought that I was the nanny. It is not that I felt bad at all about being a nanny. What I felt was this tremendous level of shame. I felt incredibly disconnected from my children and from my family. I felt isolated. I felt alone in my own community, and I think what I felt was what other people might feel like in my own community- in the same place that I treat clients.

When I was thinking about doing this lecture and what I would talk about, I felt like I wanted to talk about self-disclosure. How do we self-disclose when we are minority therapists working with minority clients and majority clients? I was taught that we do not self-disclose, but I was also taught that if we do self-disclose we must do no harm and always take into consideration the best interest of the client. Are we doing this for the client?

I will start with types of disclosures. I am going to talk a little bit about different types of disclosures, and they are the types that are self-revealing. We intentionally self-reveal to clients. We reveal by the clothes that we wear. We reveal by what we actually tell a client. We reveal by if they come to our house. They come to your house, and they see your car, the pictures on your walls, stickers. They see a lot of things that are deliberately a self-disclosure. Then, there are things that are observed by the client. They may see that we are pregnant. They may see our skin color. They may be able to see our age. They may be able to see that we have a wedding ring or that we do not have a wedding ring. There are a lot of things that are visible and observed by the client that we

don't even know. They may be able to see a disability. They see a lot of things, clients, and they make assumptions.

Then there is the unplanned. We are at the grocery store. We run into our clients. We are at the medical office or the oncologist's office, and we run into the client. We are at our place of worship and we run into our clients. That reveals our beliefs, and there are other places we could run into our clients that can say a lot about who we are. Then the most dreaded- there is the Google search. Then there is the type of self-disclosure that is initiated by the client. There is so much available to the client now where they can look at our public records. They can look at our resume. They can do a Google search and know more about us than we probably know about ourselves. These are different ways that there is this level of self-disclosure that are all over the place.

I also want to talk a little bit about what we do know or what we have been taught about our rationale. We have been told that if you are going to self-disclose, there has to be a rationale. One thing that Susan was talking about and is true is that we all have baggage. When we are doing self-disclosure, we just have to make sure that we check in with it, so one of the stories I'm going to be talking about a little bit is always being self-aware and the difference sometimes between a therapist who is minority who is self-disclosing, and a therapist who is not a minority population who is working with minority clients or not working with the majority clients.

Some of the rationales that did come up was there are times when people work with AA groups or different types of groups and disclosing your abuse history might be important for those types of groups. There is a rationale when working with either abuse groups or working with a military group or working with adolescents with whom sometimes you want to establish trust, when you do not want to patronize or maybe you want to establish a different type of relationship, you do not want to be an authority figure, and you might reveal more information because they ask very direct questions. Sometimes, if you do religious or spiritual counseling you might want to self-disclose. I know that the literature says that you might want to reveal your sexual orientation in particular because there are clients who look for people who are out. If you are not, you may have clients who are looking for people who are or practice in different styles, and they might ask you directly so you might have to have a rationale for self-disclosing. There are minorities who look for people who may be bilingual. These are different rationales where people might self-disclose. My purpose for trying to have this discussion today was to have an open discussion about what are some of the things that might come up around self-disclosure that make it difficult.

Then I draw that line on the sand, and I have to determine or you have to determine if you are going to self-disclose, that are you going to reveal something. For me, that line in the sand changes all the time, and it changes based on the client and the situation and,

it has to do a lot with how I am feeling. It has a lot to do with the situation and how close to my heart that situation is. It is constantly changing.

I wanted to share with you three very brief samples of some of my experiences working with clients and leave you with that so we can open up a conversation. I work with this Latino family, and I work with the whole family. At different times, I am working with the whole family and sometimes I am working with the mother and the adolescent daughter. When I am working with the mother and the adolescent daughter, the daughter talks to me in English and the mother talks to me in Spanish. The mother does not speak English. She understands it, but it is faster for the daughter to speak English because she was raised here, but the mother has a really difficult time communicating so it is back-and-forth continuously.

It reminds me a lot of my own childhood. It goes really quick back-and-forth and, sometimes, when the daughter talks to the mother she quickly says it in Spanish and I understand it. There's no need to translate because I am right there. It is just a lot of fun. It is a lot of mental gymnastics back-and-forth. Sometimes I am sitting with the mother because I do a lot of work with the mother, and one day she was telling me about how late her daughter came home one night and how angry she was and we were talking in Spanish. She was telling me how upset and how sad and afraid and scared she was about how late her daughter had gone out and now that she is starting to go out with her peers, this really terrifies her. When she was telling me the story, she said, in that moment, she was so angry at her daughter that she took off her sandal and she threw it at her daughter. In that moment, I started laughing. I started laughing and she started laughing, and we were both laughing because it so reminded me of my mother throwing her sandals at me. I don't know if it is a Spanish thing. I know that a lot of my friends have sandals thrown at them. After we laughed, I just stared at her and then she started to cry.

I have a couple, a brand-new heterosexual White couple. They come in, the woman sits down, and she says, “I researched you. I specifically wanted to come see you. I thought you would really be able to help us.” You can tell he is in for the ride. He is in. He is willing to do whatever it takes. As they are talking, about halfway through while we are discussing goals she says, “Well, one thing that I really want to talk about is he's controlling everything that we do inside the house. He controls everything, but in particular he controls what we watch on TV. And he controls what we can and what we cannot watch, and I don't want our children to grow up this way. And one of the things in particular that he won't allow us to do is he won't allow us to watch any shows where they show gay people and particularly gay men.” He jumps in and he says, “Because it is disgusting. Because we’re not going to show homosexuality in our house and my children are not going to see this.”

This one has many faces. This one has been around as long as I have been practicing, but this one in particular I will just put him as a White man at middle-age. Second session he comes in to talk about his wife, relationship issues, some depression. We hit it off right away- just fantastic person, a great therapeutic relationship. Second session he gets up. He is getting ready to leave, and he looks up and he says, “Where are you from?” And I cannot help it. It is just this moment in which I pause. It is just a slight pause. I cannot even remember if I looked down. He says, “Because I noticed a slight accent.” And I looked up and with a smile confidently I said, “I'm from Miami, but my parents immigrated shortly before that from Cuba.” Thank you. I look forward to our conversation.

Discussion

David Satin:

I want to thank all 3 of our speakers for giving us an introduction to the meat of the lecture, which is using these ideas. Dr. Powell gave us a broad perspective on dealing with culture as a subject and cultures as they vary. Dr. Cort gives us the example of the Afro-American woman and how culture affects her within her population and from outside of her population. Dr. Orozco gives an interesting perspective on the caregiver's culture and how the caregiver deals with that in the helping relationship. It is a wonderful start to the flowering of these seeds. Go to it.

Susan Powell:

I am going to put up 2 examples, and these are actually examples that students recently shared with me of experiences they had in therapy. I am going to read the first one and I would like you to be thinking about how might microaggressions be present in this example. These are very recent examples, by the way.

The first one, she is an African American woman who shares with her therapist that recently she was in a class with a White male professor who asked her to "share the African American perspective" on whatever topic was being discussed in class. The student was, not surprisingly, upset by this and went to therapy to talk to her therapist who was also a White male. When she disclosed about this, the therapist said, "Well, maybe when he said that, he was trying to help you understand blah blah blah." I am curious. What kinds of reactions do you have to that?

Audience Member:

Ouch.

Susan Powell:

We have got an "ouch." Other reactions? Why is this a microaggression? What might be happening here?

Audience Member:

She is completely marginalized.

Dr. Powell:

She is completely marginalized. Okay. She is seen as being just a member of her group.

Audience Member:

She is seen that way by both of them, so it is a double ouch.

Susan Powell:

Exactly. The problem is that her therapist is probably unintentionally communicating that, as well. Any other reactions of why this might be an example of a microaggression?

Audience Member:

He completely invalidated her experience. He was not empathic as a therapist to her in the moment.

Susan Powell:

Right, the therapist was not empathic to the client's experience.

Audience Member:

Specifically, he was not empathic. You have 2 White men discounting what a Black woman says about or feels about whether something is insulting or not, and it is really not up to them to do that. It is more an invalidation than just about where a White person invalidates another White person.

Susan Powell:

Right. I think some of the White men in the audience go, "Oh man, we always get targeted as being the people who say the wrong things," but this could also be a White woman who would say this. It could even be a person of color who would say it. One thing I wanted to say is about something Natalie had said when she talked about the issue of how racial matching between the therapist and client is not always something that makes a difference in treatment outcomes; I might offer that that might be partly because what is more important than race is racial and cultural identity development, and that that holds true for people of color, but also White people. White people go through their own process of racial and cultural identity development. You have probably studied those theories and know something about that.

Audience Member:

What if it was a female and I wanted the female perspective? I am getting that we are all going to say it is the same thing, but is that really valid?

Susan Powell:

He is asking, what if I want the female perspective? I think that it is a fair question, and I think it is something people struggle with but the reality is that if somebody says to me, "Tell me what people with disabilities or with physical differences think about that." It is like well, I can't. I can tell you what I think. I can tell you what as a woman that I

think, but there is no one given perspective for every group, so it is hard. When people feel like they get thrown on the spot like that, it is objectification. Intentionally or not, it ends up being objectification.

Natalie Cort:

I get what you are saying in that. That it is a challenging thing to figure out. As I was sharing with you, I understand this experience because of being asked to do this research on racial disparities and not wanting to be the cliché token Black person and having to come to a place where I felt comfortable with not being used by the system to educate everybody, because that is not my job. For me to actually actively and in a powerful way bring my own voice to this process that, I think, for many of us it is a really challenging place to be in.

Sara Orozco:

Yes, and I think at one point we were talking about how do we handle people who we know are well intentioned. In a situation like the one described here, how do we facilitate a discussion that is helpful and not damaging? How do we intervene in that moment without this person feeling like they have to educate. How do we create safe teaching moments?

Susan Powell:

I think the other thing I was going to say, too, is that there is this way in which, from the therapist's perspective, he may have consciously or unconsciously been reacting to she is upset with a White male therapist. He may have felt some sort of relating to the professor. I think the other issue is- and I say this from years, more than 20 years now of teaching in this area and consulting in this area- is that a lot of times White people have a really hard time talking about race issues, and especially if it is with people of color. I think when it is African American, in particular, I have seen a lot of White people really struggle with that, so it is quite possible too that her therapist, the minute this race-related issue gets brought up does not quite know how to deal with that.

I think that gets back to the importance of self-awareness and to Natalie's example, too, of some of the feedback from some of the African American clients talking about their experience sort of assuming that the therapist will not understand. We and people who are White in particular have to be really thoughtful about how race comes into the therapy session. How do I feel? I can't tell you how many times I have heard people in things when I have been teaching or doing training, where they struggle with even saying race. They struggle to say Black or African American. They stammer, and I find that to be particularly true when it is a racially mixed group. People really struggle with that. That

is part of the self-awareness piece. If we can get more comfortable talking about those things, then when our clients bring them up it is not as scary or uncomfortable.

Audience Member:

What I want to say is that it seems to be that there are more groups and roles involved in that particular vignette. I think that it does seem like the White male therapist was identifying with the professor, a White male, but I think that a female therapist might have found herself aligning with the professor and making a clinical error in being kind of parental and, in a way, discounting the feelings of this young woman, whether she is African American or not. I think that really that is the most offensive part of that interchange. If the person, whether male or female, African American or White or some other parts of other group had just kind of been open to listening to the way the woman felt in being categorized, it might have been the starting point for a different discussion.

Susan Powell:

I think that is a great point. It is a really great point. Really fitting.

Audience Member:

It seems to me an absurd question. Could anyone speak for their people? It could have been sex or color or just about anything. It was a very poor question in the first place, and that the therapist didn't recognize that is a problem.

Susan Powell:

It is a problematic question to begin with, right, and I think that that is very true.

Audience Member:

I think one of the problems is sort of a tension. We have all these courses to talk about women's studies, Black studies, culture- Spanish culture, this culture, whatever. I think there is kind of this interesting point here that fails all these things on culture that we learn. What I think happens is when they get an individual they are taught in a way to take what you are learning about this culture because it is supposed to help you understand someone a little bit better. Then when you are faced with that individual, they are always so much more than that. The problem is that cognitive filter, what supposedly you are learning if you are sensitive, learning all these things in terms of that individual who is in front of you. I think that it is a very complex thing because the individual in front of you, of course, does represents themselves but in essence do they represent nothing? Are they coming as a tabula rasa or is there some impact upon what you learn? I think it is pretty complex.

Susan Powell:

Yes, I think it is complex, and I think the point she is making is that, based on having learning about X, Y, or Z group, people may have a tendency to then objectify. I think the difference is if I have a white client come to my office, I am very unlikely to say, "What's the White perspective on this?" It is something that happens more to people of color.

Audience Member:

In the professor part of the scenario, what if the professor said to this young woman, "Mary what do you think? Let's hear your thoughts on this topic." And she answers the question. Then the professor says, "Do you think your experience as an African American woman in this society informs your answer?" Is that okay?

Susan Powell:

Anyone want to respond to that?

Audience Member:

I would not ask it. I would not do it.

Susan Powell:

Yeah, you would not ask it. I think that if you would not ask the same thing of a White student, I would not ask it of a student of color.

Audience Member:

You might want to consider asking exactly that kind of question also of a White student. It is also an opportunity to talk about different forms of and types of privilege. I think where the challenge is here is make sure it is an inquiry that crosses all of the different domains in which people build their identities so it does not get targeted to one or two or three domains of experience. Just sharing 2 moments. At one point, I was in a group where we were discussing race and class, and as we were introducing ourselves we were asked where we were from, and I shared that I was born south of the Mason Dixon line. At one point, I was asked if I could give the Southern perspective on 450 years. Because I have a somewhat religiously ambiguous last name, on more than one occasion I have been asked what this experience would be like as a Jew, although I was raised a Catholic.

Susan Powell:

Well, it is an interesting point too. There is this notion of a common microaggression. It is what is called the perpetual foreigner. A lot of times, people of

color, and in our culture in particular I think Latinos and Asians today, even if they are born and raised here. I have had several students talk about this. A young man who is from New Jersey born and raised but his parents are from India. This student said that people, usually White people, will ask him, "Where are you from?" He will say New Jersey, and they will say, "No, where are you really from?" As a White person, I can say I have never been asked that. I have been asked where are you from, but nobody pushes it further if I say southeastern Ohio. I suggested to the student, next time someone asks you that ask them where they are from, and when they say southeastern Ohio say, "No, where are you really from?" Because we are all really from somewhere else. Should we switch to the next vignette and then open it up for general questions?

A young White woman with a diagnosis of multiple sclerosis arrives at a therapy appointment using a cane and her therapist, who she has been working with for nearly a year, gasps and says with pity in her voice, "Oh, Mary." How might microaggressions be playing a role here?

Audience Member:

Personally, I think I would feel that was okay. They were feeling empathy, they were sad for me, and that gave me permission to feel sympathy and sadness for myself. Sometimes, you cannot. It is not allowed. For me, that is not an issue but maybe someone else would see it a different way.

Sara Orozco:

Thank you.

Audience Member:

Just approaching this strictly therapeutically, the question should be, "How is that for you?" It was being projective of the therapist's experience of what it was like for her, so it is an empathic failure.

Audience Member:

But on the other hand, I think if they knew the kind of unplanned disclosure that you had mentioned. It is funny when I think about it. I guess part of what I was thinking was maybe the therapist herself was somebody who also had multiple sclerosis. It is certainly not in the vignette. I think that whatever the person might have expected, if they have a relationship that can be the opening to a conversation. I will just share a little bit of a story. I know a person who was dealing with a diagnosis of leukemia and she had a therapist she had seen for quite a while, and the therapist was very personally involved in her getting the diagnosis and actually had her come into the office to make a phone call that she was going to find out whatever. On several occasions when the woman who

was the patient was not doing well, the therapist who was maybe young, maybe a somewhat inexperienced person was obviously distraught, even tearful, at some of the kind of things that went on. When the patient terminated her therapy with the therapist, she said to the therapist, but it was a conversation, she said, "I need a therapist who is going to be strong for me in this situation." She went and sought a therapist who I think she has been happy with, who is a person more connected with the hospital and more connected with people who had this kind of illness. In some ways, the therapist was reflecting a piece of the woman's feelings that she was not comfortable with. I think that one of the things that is a problem in this discussion is maybe it's the elephant in the room for people who did not know what some of these difficulties or differences are like. I just have one last thing to say. I once had a person who was teaching a couple's therapy course, and I always thought this man was a really bad teacher, but one thing that I just found really memorable that he said was, "If you don't know what to do, just draw your chair up really close"- he had a rolling chair- "just draw your chair up really close to the person and be very curious, and think of it as kind of like an anthropology experiment. It's sort of like these two people are like two worlds, and we don't know their culture until we ask them and find out."

Audience Member:

It is hard to know what else went on there, but I was thinking that reaction is kind of like the sandals, and I would hope that maybe in the session I would ask, "What was it like for you that I gasped? What did you make of that? How did that make you feel?" It is an opportunity to hopefully correct or work that through.

Sara Orozco:

That is a great point and something I would love to incorporate in some of those moments. My sandal reaction came out so quickly, and I was very fortunate that the client had the same reaction. It would have been great to explore why she laughed because I assumed, perhaps incorrectly, that we were laughing for the same reason—something we both understood the same way culturally. However, if we had explored it at the time, I would have interrupted the progression of her discussion, which was the emotional state of her daughter and her concerns regarding her behavior. If I had discussed why we both laughed together, it might have been more my curiosity.

I think of the many times a client asks me where I am from and I did not know, honestly, if it is a microaggression or not. I am still trying to figure out what are microaggressions when they happen. I have usually interpreted those comments to be a form of curiosity. People are curious. They want to know things about you. However,

sometimes it has been very clear when the question has an aggressive tone to it and the message I get is that my accent is not okay.

In those moments I get a quick flashback of growing up in a neighborhood where we were not wanted and people screaming at us to go back to our country. I think in that moment with those clients I have to take a deep breath. Not so much because I'm feeling it as a microaggression, but because I know that's my work. That is really my work. I got to get past those flashbacks in that moment and hear what the client is really asking me. In most cases, the client is simply asking, "Where are you from because I hear something different." It seems like a simple question but I think it is much more difficult than it sounds for a minority therapist.

Audience Member:

In this example, I am just struck by the fact that they have been working together for a year. I do not know what the relationship has been and what has transpired before this, so I do not want to jump to something but my first feeling was, "Oh, now she has to take care of her therapist, and that's an issue."

Audience Member:

I agree with the person who just spoke. I think she really does a disservice to this young woman because the attention is more on her as the therapist to find something open-ended to say, like "Oh, that's new. When did you get it?" Then if the person is ready to go into "this is just devastating" they will, and if they're not, they're not. It just seems like maybe that is somebody who doe snot have a lot of experience dealing with people with degenerative illnesses.

Audience Member:

One thing that I could offer here is, the therapist is making an assumption that the cane represents a decline in functioning whereas she may have just sprained her ankle.

Audience Member:

It seems like what we are discussing is more like a subset of the subject of countertransference. Therapists always bring baggage, not only in these areas but what your relationships were or what your likes and dislikes are. You're always going to have things like that. I have, for example, a couple very young patients who have their issues and some of it brings out things in mine, parallel things. It is something I have to address in terms of how I handle that.

Audience Member:

I can agree on awareness of countertransference, but in this particular vignette there is a stereotype here, and that's that someone with a degenerative illness is pitiable. It is health. It needs a lot of a certain kind of empathy. You feel sorry for them. It is also interesting. I think this was a harder vignette to really think about for me, and I think it is because I am not as aware of the stereotypes I hold, but I think there are stereotypes here, too, which distinguishes it a little bit from sheer countertransference.

Susan Powell:

I appreciate all the comments about that, and I would agree that it is more complex. I think that people struggle with this one more. But I would also add that I think you're right. It sort of gets at there is this often unexamined assumption that disability is tragic, that it is bad and that it is awful, and the people who have disabilities and physical differences would like nothing more than to get rid of them. Guess what? It turns out that is not true. I think about my own physical difference and I think if I had not been born with a physical difference, I probably would not be doing what I am doing today. That is the reality. I think that even if the therapist's intentions might have been good, somebody said earlier about sort of checking out the client's reaction to this. In fact, this client was quite angry about the therapist's reaction.

She had had experiences all week with people pitying her, and she was very unhappy about that. I do not quite know exactly how that worked out in their therapy relationship but I would really encourage everybody to sort of think about, "Do I believe that disability and physical difference is inherently a tragic, bad thing that we want to remedy, that we want to fix, that we want to, get rid of in some way? If I do, how then might that impact my work with clients?" I am not suggesting that all clients with disabilities and physical differences would feel the same way. There could be a client who actually appreciates this response, but my advice would be there are other ways to respond, such as "I see you are using a cane. Tell me what is going on." We are just noting this is a change in how she presents; tell me about it without value judgment.

Do we want to open it up just for questions in general? Things people would like to ask the panel?

Audience Member:

Hi, I wanted to ask about the research with Black women and the small number of professionals in the mental health field. Is there a reason that LICSWs were not included in the research?

Natalie Cort:

For social workers, sorry I did not cite the research on this slide, but the numbers are pretty similar. I think 4% of social workers are African American.

Audience Member:

I have a question about a dilemma that has come up for me as a therapist a few times. The most memorable example was when I had a client who was talking about his nephew. His nephew was a toddler, and I guess his nephew was always grabbing at things. He said, "Oh, yeah, he loves to grab everything. We call him the little Jew." Now this is a guy who grew up in a working class family in Charlestown where I was working at the time. I was quite sure at the time that he was not thinking about what he said. Nevertheless, this is the dilemma that happened. I am Jewish, but I would have felt the same had somebody used the word faggot, or I don't know, all kinds of words that I can barely even say. But it just makes me not want to be around that person anymore. It's like a thing in the air. My dilemma- and I would be interested in anybody's thoughts about this- is do I then say something? It is not part of the therapeutic agenda. This person is in for substance abuse treatment. It is not part of my agenda to teach him about cultural diversity or tell him what I think. On the other hand, if I do not say anything, then that is going to be a barrier between us and I may not feel comfortable sitting there in a way that I can attend to him. This is one that, again, has come up a few times, and I still feel like I do not have a good answer for it. I'm hoping that people might have some suggestions.

Audience Member:

The nature of alcoholism and substance abuse carries with it a certain self-centeredness in the addict: ism, myself, and me. In addressing what just happened, you are helping the patient, client, whatever you call them to recognize that there is another person in the room, which is really often relaxing for a substance abuser.

Audience Member:

I might also add that, often times, when people struggle with substance abuse issue, sometimes their development is derailed, so it could be educative to take time out and address that just in terms of furthering their horizons and their growth.

Susan Powell:

I think it is an excellent question, and I think it is one we probably all encounter at some point. I think the reality is it is a clinical judgment. There might be times when it is really clinically relevant to address it. I think about a middle-aged white heterosexual couple I worked with several years ago. The male in the couple, the female's daughter, so his step daughter was pregnant by an African American man, and he was talking in therapy about his negative feelings about this. I obviously had reactions to this, but I framed it also as this is your grandchild that is coming. How are your beliefs about this going to impact this child and your relationship with this child? If you are saying you

want no relationship with anyone, that is your choice, but there are real consequences of that. So is this something that you want to work on or not? He chose that he did want to talk about it. I think there might be times where it is more our own reactions and maybe we go off and we talk to a colleague or we talk with a supervisor. We see if we can resolve that on our own. I think it becomes more of an issue if, like you are saying, you feel like you do not even want to be in a room with that person anymore. Then it is going to need to be addressed as part of the therapy because it is impacting the therapy relationship.

Audience Member:

I think the issue is exactly as you are saying. When supporting another individual, there are lots of issues that are going to surface. Our discomfort becomes an issue we have to deal with, so it is not necessarily that we really think they should be in that place because that is the right place to be. It could be talking about, "Oh, this kid's like an ADHD kid; he's wild." It could be anything. It could come out of many, many different reasons. I do think in final analysis it has to do with us. In terms of ourselves, you have to deal with the issues of where are we coming into when dealing with someone and what are the issues we bring in? How are we going to cope with issues that come our way? There are things that come up and you have to decide how you are going to deal with it or not. In therapy, you are there to support that person, so you got to. I think it is a tricky arena here, but I think if you are super uncomfortable with it then obviously you cannot go forth with the therapy because you will not be effective. You cannot just bury your own feelings.

Audience Member:

I am actually going to change the subject. Dr. Orozco, could you talk about that couple with the TV? I am not sure I got it.

Sara Orozco:

Actually, I was thinking that when you were talking about that case in particular, I was having the same reaction. When the couple came in, obviously I was not aware of their background. That was not discussed on the telephone when they did the intake. When they came in, I was unaware that one of the issues they were going to be talking about was trying to get the husband to be more open-minded or to deal with issues of allowing the kids to be more exposed to diversity, especially issues of homosexuality. I think in that case, I was talking about self-disclosure and the complexity of it, especially as a minority therapist. In that case, when I found out that she had researched me, I understood that to mean she was looking for a gay therapist and had brought him in hoping that I could be an ally in supporting her to be more open-minded and supporting her in her goals.

When he, of course, announced that there is no way he was going to expose his kids to homosexuality, and he even went on to say especially two men, I had to check in with my-self. I had to draw the line in the sand to determine what my next comment was going to be and if it was in the best interest of the client. Had I done enough of a check-in? We are talking about seconds. Am I going to have a big reaction because he is saying these words, or do I need to really clarify for him or tell him not to use words like that in therapy?

I had to make a quick decision about which way I was going to take this case. In that moment, I decided not to say anything about his comments but I had a conscious rationale: If I say something in that moment he would never come back to couples work. I thought it was in the best interest of the couple to continue coming to couples work and engage in the therapeutic process so that we can get to some core issues addressing his beliefs and other things, including sexual orientation, and I thought that might be in the best interest of the couple. If they did not stay in therapy, I would not be able to address his beliefs. It is not that I put away my feelings about his beliefs; it is just that I, in that moment, I had to think truly what is in the best interest of the client.

Susan Powell:

Maybe I would think in that situation even exploring with the client. Tell me why. What's so hard about that? Why is it that you do not want your kids exposed, especially to two men? I want to understand that more. It could be that as he comes to trust you more, then down the road there might be more of an avenue where there is less risk to the therapy.

Sara Orozco:

That is not to say that after that session and there after I did not do some work around that session. It does stay with me. I do have to process it, and I cannot just say it does not affect me. It does because if I want to stay in a relationship with both of these people I have to be really honest with myself and, therefore, I must also do my work.

Audience Member:

I am just wondering how you decide at what point you might reveal that. Would he feel betrayed that you did not tell them?

Sara Orozco:

Yes. I was aware that at some point he was going to Google me because they were driving a little bit far to come see me versus why not see a therapist in their own community? I figured at that point, I hoped that they would bring it up and we could talk about it, or that I could find the right time to discuss it. I was hoping that we would get

to a point where, in the therapy itself, we would start addressing it. By the third session, it became very clear that the issues in their relationship and family were much larger than just his views on homosexuality.

Audience Member:

I have an issue as a White person, so-called majority. If you hear racist comments and things like that from clients and you say nothing, they probably assume that you agree with them as part of your culture too and therefore it is okay. It just seems to support racism, so I have a problem with ignoring it.

Audience Member:

I think that is just so tricky, and that is what supervision is for. I have worked with adolescents in the juvenile justice system, and obviously language is always an issue with them. But it is really starting where they are and being with them where they are. My saying something to them directly is not going to stop them from using that language or having those feelings. Over time, I think, through the relationship I have seen kids change and you have conversations about where their attitudes come from, what it was like growing up and for adults, too. I think you really have to hear people's stories and know that that is the language they were brought up with. I see that in people I know at the dog park, and over time you can confront them on that. Only through having a relationship with them that I can really confront them in a way that makes them think about it, that does not get defensive about it.

Audience Member:

I am sort of changing the subject, but I am curious about the term microaggression. It just seems like it is not naming what you are talking about. If I were not in the clinical field, I would say what the heck does that mean? It just seems like a euphemism. It is a euphemism for what you are really trying to get at. If you said to a client, "Hmm, that's a very interesting microaggression…"

Susan Powell:

I probably would not use that word.

Audience Member:

Can somebody explain to me the history of it?

Susan Powell:

Sure, a microaggression is a term that I believe was coined in the 70's. I am sorry, I forget by whom. It is a slight against whoever did develop it. There are a couple of

references, and one is called *Microaggressions in Everyday Life* by Daryl Sue. He has sort of revived this term, and he talks about using the term microaggression because it is occurring, typically, on a micro-level as opposed to a sort of institutionalized level. I do not disagree; the language sometimes is a little harder to understand, but I think that the construct of thinking about the unconscious ways or the unconscious types of bias that we hold- that is obviously unexamined because it is unconscious- is a really critical thing. It is a term that is used more commonly. Even the word aggression presumes something that the person may or may not be intending, but I think it is coming from the perspective of the one receiving it. It feels aggressive even if it is not. I am always so bad with sayings, but what is that saying? The road to hell is paved with good intentions. We all have good intentions, but we all also say things or do things at times that are offensive, and we need to learn from them. I may come across as very psychologically aggressive or hurtful to somebody, and it may not be my intent at all. I think it is based on the perception of who is on the receiving end.

Sara Orozco:

I am here today only to tell you my experience and to only share with you how far I have come in my own work. Even coming here today and publically announcing that I am a lesbian therapist was challenging for me. Even coming out to my clients is hard work. Although I usually come out as Latina, it is a little easier; the other one is harder for me. It is my work and even though it seems like it might be easy to address racism and heterosexism and all those –isms. In session it is an individual journey, and I am here to only describe my own personal experience.

Susan Powell:

I just want to say how much I appreciate you sharing that, and also you just sharing about your own personal experience because I think it is important for people to hear the variety of experiences that exist. I think, too, I would just say that where we are in our own identity development about things is so critical in how we deal with things in therapy, and especially if we are talking about aspects of identity related to privilege and stigma. How we think about those aspects of ourselves, or whether we think about them, is so important and we shift in that over time and even in days. Some days, I do not want to talk about anything related to diversity and difference, let alone my own experience.

Audience Member:

That is so powerful what you were just saying. Through the whole afternoon, I was thinking because I work in Boston with families who have lost children to murder and with people who have also lost other family members to murder. My experience as a person who lives here in Newton of connecting with people in that neighborhood is that

we are all speaking English so we kind of think we are understanding each other, but not so much. I mean, it is the same language but the experience is just so fundamentally different. What we are trying to do is create these urban-suburban connections, and we are trying to bring people together across these divides, which is not easy at all, and a lot of times even to talk about what they have gone through, it is just very hard. There is a lot of anger. There is a huge amount of anger. It is like when people from the media say, "Oh, if such and such had happened in Wayland, everybody would be up in arms." I think everything that you are talking about here is just so important and to understand how difficult it is no matter what the difference is or no matter what. When I think about myself knowing a little bit of Spanish, but knowing that when I hear people speak Spanish I really do not know what they are talking about, and my paying gig is with elderly folks. I am really good at talking with extremely demented people in Spanish. I do really well. That is the level I can function on, and I think similarly it is like for us to really be able to communicate with each other across all the instances. It is so hard, and this is such a good place to start, so thank you for this.

Susan Powell:

Thank you. Great point. I just wanted to say one thing that I meant to comment on earlier and that being when Natalie was talking about some of the data from the research. There were some very clear assumptions that were made by many of the African American women in the study about White women, and I just wondered if anybody in the audience when those were being read were like, "Whoa, wait a minute." I think that what is really important is to be aware of and to do the work before-hand so you have a context for where that is coming from, and so you do not respond defensively in the moment because the temptation is to say, "Hey wait a minute. You don't know that I come from southeastern Ohio and I grew up poor, and my family is still working class. You don't know what I've been through. Maybe I'm not like other White people." But the minute I do that, I have lost that client. She might keep coming back, but I have lost her in terms of connection versus if I really sort of address her belief. I have had students say to me, "What if a client says to me, well you're White. How can you ever understand me?" I think about how practically every person of color I have worked with at some point the issue of- either directly or indirectly- the issue of racism and whether I believe racism exists comes out.

Now, maybe I allow that more, I do not know but I have had that come up so often in therapy. I think if I can sort of understand and not get defensive and instead say, "I can understand why you'd see it that way. I can understand. You've probably had a lot of white people in your life that A. haven't acknowledge your experiences, and B. that don't believe." There is a lot of research on this that shows the incredible gap between White

people and Black people, Black Americans in particular. There are perceptions on how much racism continues to exist, how much race impacts experiences. There is a reality to that. There is a reason people come in believing that, so I think the first important thing is to validate. Meet the client where he or she is, and then maybe there will be an opportunity for more discussion about what it would be like to know that maybe that has not been my experience. The validating, I think, is so important, and I know I am preaching to the choir. We know that as therapists, but we don't always do it.

Audience Member:

I am a yoga teacher, and this fall I will start going in to Boston and working with some women with the Lift Up Program. I am thinking of myself as a White female from the suburbs. I am going in to Dudley Street to Project Hope, and I want to try to share my experience. The meditation and the breath work has really helped me through some really tough stuff, and these ladies who cannot stop eating or are really depressed, and I want to be able to relate to them, not just as a White female but as somebody who has been through some kind of rough stuff myself. I am going to go to the graduation on the 23rd of June, the Lift Up Program graduation on Copley Street. I am not too nervous about it, but I am a little nervous about it. I feel a lot better about it having all this discussion today. Thank you.

Audience Member:

I work at Boston Latin Academy right up from Dudley Square. Welcome to the community. That is great.

Audience Member:

I live right off Dudley Street.

Susan Powell:

You have got some support.

Natalie Cort:

I wanted to just share a little bit more about what the women in the study had to say. It was really fascinating and very sad for me to experience with them the depth of their sadness. As they talked about these idealized images that they have of White women's lives, there was such a huge distance. From their perspectives because these women that they idealized were White, and being White meant that you had a lovely husband, that you have a wonderful grandmother you can go to and get support, that you were safe and you were comfortable. They were never going to ever achieve those things because they are not going to be White. That is what actually underlined a lot of what we were

experiencing in this study. It was extremely poignant, and I think what they had to say, in fact, reflects the White bias that exists in this country. Sixty-six percent of Black children have White bias, meaning that they think lighter skin, White skin is more attractive, is more reflective of being more intelligent, being reflective of the skin color that adults like. Seventy percent of White children have White bias pretty much to the same degree as they did in the 60's, so things have not really changed that much.

You have for Black children the internalization of a real sense of inferiority, as well as the internalization that being White is reflective of everything good. I just want to highlight the depth of what happens for many people of color. And for me, as someone coming from a different country I am very, very aware of the fact that because I grew up in South America, I have a privileged bubble around me because I did not have to fight through the internalized sense that I was less than or inferior. They did not have that. I recognize that there is a way in which I can step aside from the rage that many Blacks feel because I did not have to be in that place.

Audience Member:

One is a little bit personal, related to a lot of what I think has been said, especially what Natalie said about stereotypes. I am a Dominican woman psychologist- probably part of that 2%- with an accent. One of the comments, I think, highlighted one of the comments of stereotypes and microaggressions. I was engaged once in an interesting political conversation. I will spare you the details. It was very heavy. An older White guy looked at me and says, "Wow, you can say pretty intelligent things for speaking so funny." Maybe that will be a microaggression. These are just an example of stereotyping things. It is underserved populations or poor clients and we all get it in different ways. Like you said, not just racial but different things, and I think on a day-to-day experience. This is point that I appreciate very much. This is the work that I do every day and it is very thought-provoking, so I appreciate your honesty to the three of you.

One of the things I appreciate the most, and I think you said it in different ways, was to be an ally. I think most are here because we have some kind of awareness this is important, and we want to advocate for different groups. I find that when someone invites me to come and talk about the Latinos and whatever. Well, I can talk to you about what I know because I study it, but not represent the group. I actually say if it is a non-Latino person inviting me, "I'd be happy to help you prepare something to present," and I say that because I think, especially for the White people in the audience, I think you guys have a language that other White people understand best. You will be speaking English, and I will be speaking the same thing, but you have a bridge to a population that I do not have. Many times, I get to a room to talk about what interests me because this interests me, not because I was born in the Dominican Republic. It is bigger than that.

Then the reaction is, "Oh, here comes the Latino to talk about their issues." Right there is half the point. Sometimes advocating for groups we don't directly belong to becomes even more important, so I appreciate that very much.

Audience Member:

Natalie, I have a question about clinically working with Black women. What you were just describing is what I would characterize as sort of structured. Working with more superficial cognitive structures, for example, that we know contribute to depression and maintain depression and so forth. I was wondering if you would feel comfortable sharing a little bit about your experiences as you, on the one hand, try to validate the very real experiences they have had but also attending to the fact that they have stayed in that stance that is really kind of a disempowering, depressive stance to be in. Sort of that balance between honoring the experience but trying to shift it so it becomes an empowering recognition rather than a kind of deep, internalized structure.

Natalie Cort:

Wow, that is quite a question. I might go off on a tangent. For this study, I did not address what they shared, simply recorded and witness for them their experiences, but I can share with you that there was a Black woman that I was working with for a number of years and I think she taught me so much about my own experience as a Black therapist and what that meant. This woman said to me one day, "Dr. Cort, I really want to bring my kids to meet you," and I was confused. She said, "I really need for them to see a Black therapist, a Black doctor." So she brings these little kids, and they are bored out of their minds, like why are we here? She just wanted them to shake my hand, and in that moment I was so incredibly uncomfortable.

Then I felt deep shame because I did not appreciate what that meant to her, the power that she felt and felt a sense of pride and ownership because she had the opportunity to work with a Black doctor. I had absolutely dismissed, neglected, ignored, and avoided the fact that that had such importance in her life. For me, that experience really started me thinking and going through my own self-exploration. You do not want to be the token person where you can compensate and go in the other direction, and I think I was in that place, and as a result could not really be a fully safe, reflective place for her because I was not fully validating her experiences as a black, poor woman in this country who faces a great deal of challenge. For me coming from a different place, it is easier for me to think about autonomy and think about self-determination, and I have even been taught in that way to think about how to get around barriers, how to bulldoze through obstacles. That is a privileged place that I'm coming from even thinking that way. I have been able to go through my own process of realizing that I have to find a

really delicate balance where I do a whole heck of a lot more validation because, in fact, I have seen it happen with so many of my patients who are fierce and want to fight through the system, but they get smacked down repeatedly. I cannot from my own psychological culture, from my own background promote too much self-autonomy without recognizing at the same time and appreciating the real, systematic, concrete barriers for many of my patients, and that's a hard place to be. It's been difficult. I hope that answers your question.

Audience Member:

I wanted to address this to Dr. Cort, too. I just cannot get over how many assumptions people have made about you as a Black woman, even your patients feeling that they came from a similar background. I think that the task is really the same for anyone to get to know what another person's background is. I guess all I know about Guyana is what I saw in the film about a White Jewish woman from Chicago who became the president of Guyana and was married to an Indian man, and she was like from an Ashkenazic Jewish family. So I have no idea about the cultural acceptance.

Natalie Cort:

It is a pretty interesting place!

Audience Member:

Or what it must have been like to grow up in Guyana, and then I think it is certainly layered on who is your family in Guyana. It is really different from somebody who just because of you being a Black woman thinks that they are exactly similar to you, so it is such a learning process.

Natalie Cort:

Thank you for saying that because, in fact, with many of my patients I have wondered about whether or not to disclose that I am not African American, and I have chosen not to because I did not feel it was going to be relevant, and I even feared at times that it would be distancing. It is been interesting work. Thank you so much.

Sara Orozco:

Yes, thank you.

Susan Powell:

I just want to say I love discussions like this. I really appreciate people's thoughtfulness, especially being here on a Friday afternoon until 5 o'clock. I know it is not easy. I know some people are here just because they need their CE's, but thank you

for coming here. I am happy if people want to e-mail, have more discussion. I'm happy to do that. It is just my first name underscore last name at MSPP dot edu.