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ADDRESSING CLIENTS' RACISM AND RACIAL PREJUDICE IN INDIVIDUAL PSYCHOTHERAPY: THERAPEUTIC CONSIDERATIONS

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Psychotherapists lack clear guidelines regarding how to address clients' racist and prejudicial comments in clinical work. The authors explore the contributions of multicultural, social justice, feminist, and ethical theories to the field of psychotherapy and apply these theories to 2 clinical vignettes in which clients made racially charged statements. These clinical examples highlight the importance of using racial, in addition to traditional, theories to decipher the clinical meanings of racial comments and dynamics in clinical work. The article provides therapeutic conceptualizations regarding how to address clients' racist and prejudicial comments in psychotherapy and elaborates on the complex meanings that might arise from engaging in racially charged discussions with clients depending on the racial composition of the therapeutic dyad. In addition to highlighting how social justice, multicultural, and feminist lenses are necessary to fully understand the meaning of clients' comments, the argument is made that addressing clients' racist and prejudicial comments is at once a clinical and a social justice issue.

Keywords: racism, individual psychotherapy, client's racist and prejudical comments, transference/countertransference

Tina is a White woman in her mid-30s attempting to find some peace as she wrestles with a history of sexual abuse and an eating disorder. Mark is a Latino man who is struggling to find meaningful and fulfilling connections with his peers.[1] As their psychotherapist, you help them express their beliefs and emotions to enable them to work through their histories and feelings, and therefore lead fulfilling lives. In this process, you strive to respect their perspectives and to assist them in becoming who they aspire to be, both in thought and behavior. As you do so, you are able to find a number of theoretical perspectives in which to ground your work, depending on your clients' preferences as well as your training and style. Such a therapeutic approach is certainly valuable in the cases of Tina and Mark, at least until their speech and emotions take on a different tone.

Tina begins a session by describing an interaction where she felt angry toward a Latino man, whom she described in derogatory terms. Mark, in the middle of his session, makes a disparaging comment about "those people," as he describes his views of African American women. Neither of these comments is directly related to these clients' presenting concerns. As their psychotherapist, your anxiety is likely to rise as you attempt

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[1] Clients' names are pseudonyms. Throughout the article, clinical cases are derived from our practices. Some cases are composites, and all cases have been altered to ensure confidentiality while preserving the salient clinical content.

to find appropriate ways to respond. Unfortunately, the same theories you so easily accessed before to assist your clients seem inadequate to help you decide whether, how, and when to therapeutically address their racist or prejudicial comments. Your training, even when it might have invited you to consider multicultural issues in clinical work, is likely to have never addressed such situations.

The scarcity of clear guidelines on how to address racist or prejudicial comments in psychotherapy is striking, given the prevalence of racially charged interactions in psychotherapy sessions (e.g., Ali et al., 2005; Davis & Gelsomino, 1994; Iwamasa, 1996; Lee, 2005; Maker, 2005; Ochs, 1997; Thompson, 1997; Tinsley-Jones, 2001). In addition, the messages psychologists receive regarding these issues from different areas of the field are at times contradictory, as discussed below. Finally, as clinicians, we often feel that no matter how we choose to proceed in these kinds of cases, we will inevitably compromise our relationship with our clients: Should we point out the racism or prejudice inherent in our clients' words, our clients might end up feeling rejected or judged (e.g., Ochs, 1997); should we decide not to address our clients' racist or prejudicial comments, we might lose some of our authenticity and distance ourselves from them (e.g., Ali et al., 2005; Lee, 2005).

It is important to define at the outset what is meant by racism and, consequently, racist statements. In this process, it will also be useful to distinguish between racism and racial prejudice. These definitions will prove instrumental in providing us with a valuable framework to address our clients' racist or prejudicial remarks. First, we define the terms; then we elaborate on how these definitions relate to our conceptualization of clients' racially charged comments. For our definitions, we rely on the works of Dovidio (2001), Ponterotto, Utsey, and Pedersen (2006), and Ridley (2005).

Ridley (2005) clearly distinguishes between *racial prejudice* and *racism*. The former is defined as "negative attitudes, thoughts, and beliefs about an entire category of people" (p. 19), whereas the latter is defined as a behavior that perpetuates inequalities. To carry out racist behaviors, one must have the power (or access to means) to act on one's prejudice. Therefore, when using these terms, we keep in mind the social (which often implies racial) status of the client and therefore his or her power to act on his or her prejudice.

Ridley (2005) also distinguishes between *individual* and *institutional racism*, both of which can be overt or covert as well as intentional or unintentional. Individual racism, on the one hand, is perpetrated by a single person. Using racial slurs is an example of overt individual racism. As Ridley argues, overt individual racism is always intentional. Covert individual racism is more subtle, however, and it can be either intentional (e.g., consciously dismissing the validity of information offered by a client of color on the basis of race) or unintentional (e.g., misattributing more severe psychopathology than actually exhibited to a client of color than one would have to a White client).[2] Institutional racism, on the other hand, is not perpetrated by a single person but rather by an organization (e.g., the judicial system, the educational system). Institutional racism can also be overt or covert (in other words, more or less subtle), as well as intentional or unintentional.

The literature also speaks of *cultural racism* (Ponterotto et al., 2006), which implies a group's ability to impose one's values and worldviews on others (e.g., most history books are written from the perspectives of White middle-upper class men, and other voices and realities are absent or marginalized). Finally, Dovidio (2001) describes the dynamics of what he refers to as *aversive racism*. Aversive racism is usually perpetrated by individuals who hold strong egalitarian values and do not view themselves as racist or prejudiced. Their racism is therefore not only unintentional, but also rationalized in the name of other

[2] The ideology and processes by which a person is considered, or identifies, as a White person or as a person of color vary across time and space. Race is a socially constructed, rather than a biological, concept; therefore, racial categories are based on a number of factors that go beyond skin color. We deem that in a psychotherapeutic context a combination of self-identification and experiences of discrimination based on race (potentially due to others' perception of racial belonging because of appearance, ethnic background, or other), rather than simply skin color or census classification, is potentially most helpful in determining (a) a client's racial background, and consequently (b) the relevance of the considerations expressed in this article for any given client (A. R. Gillem, personal communication, October 19, 2008). For a more thorough discussion of racial classification from both a historical and sociological perspective, see Rothenberg (2005).

plausible variables, which spare them the otherwise painful awareness of being racist (e.g., rejecting an applicant of color ostensibly because the applicant is not qualified but in fact, albeit unconsciously, because of the candidate's race).

Given these definitions, in our discussion of racism and prejudice, as they manifest in treatment, we propose that one cannot fully grasp their meanings in isolation without looking at the institutional and cultural forces that have created the ground for these racist or prejudicial ideologies and behaviors to flourish. In other words, cultural and institutional messages shape the way we judge our own worth in relation to others on the basis of many variables, including race (one may consider, for instance, the negative psychological impact of internalized racism; Speight, 2007). Therefore, it may not be as helpful to reflect on individual racism or prejudice per se as it would be to reflect on how clients may make use of the cultural or institutional racism to which they are exposed in order to better cope with their difficulties. Such a contextual understanding of racism and prejudice will enable us to detect the complex meanings embedded in our clients' racially charged statements.

On the basis of the theoretical background offered above, this article is aimed at providing clinicians with a framework that will enable them to decipher the multiple meanings embedded in clients' racist or prejudicial comments and address them therapeutically. First, we highlight the implications of social justice, multicultural, feminist, and ethical theories for addressing clients' racist or prejudicial comments in psychotherapy, pointing out potential conflicts among these perspectives. We then describe how this literature might apply to the cases of Tina and Mark briefly introduced at the beginning of this article. We present these cases as examples of the dynamics that might underlie clients' racially charged comments and of how one might then address them. The interpretations we propose of the cases are to be taken as demonstrations of how one might use racial theories to interpret clients' comments rather than as definitive ways of understanding these particular cases. Finally, we discuss the complex factors affecting psychotherapists' work with clients who express racist or prejudicial ideologies depending on the racial background of both the psychotherapist and the client. It is our intent to reframe what may initially appear solely as an ethical or social justice-related issue into a clinical issue, which nevertheless incorporates ethical and social justice perspectives (a critique of current diagnostic categories are used to highlight the latter point).

Social Justice, Multicultural, and Feminist Perspectives in Psychotherapy

The fourth force in psychology, brought about by feminism and multiculturalism, has broadened psychologists' perspective on clients' concerns and, therefore, psychologists' roles (American Psychological Association [APA], 2003). Psychologists were once confined to understanding psychological issues as arising mostly from intrapsychic dynamics. Multiculturalism has challenged us to consider the social, cultural, historical, and political forces affecting clients' well-being and mental health (e.g., Goodman et al., 2004). From this expanded perspective, as psychologists, we are encouraged to consider not only ways in which we can aid individuals to develop optimal coping skills, but also ways in which we can transform the very environmental factors that might be at the root of clients' concerns (Hoffman et al., 2006; Vera & Speight, 2003). In this context, there has been a growing body of literature addressing social justice and organizational approaches to psychologists' work (Aldarondo, 2007; Arredondo & Perez, 2003; Constantine, Hage, Kindaichi, & Bryant, 2007; Constantine & Sue, 2005; Goodman et al., 2004; Vera & Speight, 2003).

From a multicultural perspective, neglecting to draw from a broad approach to psychotherapy (one that accounts for environmental factors) is unethical in that a narrow approach fosters clients' adaptation to the status quo and, therefore, in many occasions, oppression (Ivey, 1995; Thompson & Neville, 1999; Constantine & Sue, 2005). Central to a broad approach to psychotherapy is empowering clients to understand their symptoms and unhelpful (e.g., prejudicial, self-defeating) ideologies as products of oppressive forces, which they are then called to fight in their road to "liberation" (Ivey, 1995). Feminist therapeutic perspectives take a similar stance, urging psychotherapists to look at the context in which the clients' symptoms emerge, with the aim of empowering clients to take action against institutionalized oppressive forces (Brown, 1994; Park,

2004; Vasquez & Magraw, 2005). Both feminist and multicultural perspectives conceptualize clients' symptoms as possible reactions to the limitations imposed by the oppression clients have experienced, thus more often as signs of resistance or survival, rather than psychopathology (Goodman et al., 2004). Therefore, a social justice framework is intrinsic to both multicultural and feminist theories. Within this model, both client and psychotherapist are invited to become activists.

The APA supports both multicultural and feminist perspectives in its code of ethics (APA, 2002) by requiring psychologists to consider people's diverse backgrounds in all of the various roles psychologists might assume in any given work setting. However, the APA code of ethics, just like multicultural and feminist theories, also aims at safeguarding consumers' autonomy and self-determination. Thus, all of these perspectives warn psychologists against the temptation to force their values and worldviews on clients or to define the goals of treatment in a noncollaborative way. Feminist theory has been particularly articulate about the necessity of working collaboratively with clients in ways that allow for sharing power rather than in ways that might lead psychotherapists to impose their own agendas on clients (Brown, 1994; Goodman et al., 2004; Park, 2004).

The dilemma in cases where clients raise racist or prejudicial material in ways that are apparently disconnected from their presenting concerns is how to act in the best interest of clients' autonomy and self-determination while drawing from feminist or multicultural perspectives. On the one hand, does the psychotherapist who addresses the client's racism or prejudice work against, or simply tangentially to, what the client's agenda might be? On the other hand, does the psychotherapist who does not address the client's racism or prejudice work against multicultural and feminist principles by not questioning and attempting to transform a clear manifestation of oppression?

In the next section, we return to the cases of Tina and Mark with the aim of clarifying how we might reconcile the contradictory messages we receive from these different theoretical perspectives about addressing racism and prejudice in clinical work. We first provide some therapeutic guidelines to address these concerns; then, we speculate on how such resolution might vary depending on the racial composition of the therapeutic dyad.

Two Vignettes: The Cases of Tina and Mark

Tina comes from a well-to-do White family that has had many opportunities to interact with communities of color, many of which have been, even if not always, of equal social status. She is very successful in a prestigious profession, but longs to find companionship and a more cohesive friendship group. At the time when her anger toward a Latino man was aroused, Tina was attempting to make time for social events in order to feel less lonely. She was attending a fair where she ended up playing a game against a Latino man, whom she did not know. In describing the incident and without knowing the man's ethnicity, Tina described the man as "Mexican" in a disparaging tone. Furthermore, without knowing the man's nationality, she insinuated that he was probably an undocumented immigrant and that he did not belong there.

Tina's racist comment emerged unexpectedly in her work with her psychotherapist (also a White woman). Tina had initially sought treatment because of depression (connected to her loneliness), a lingering history of eating disorders (alternating between binge eating and restricting), and a complicated history of sexual abuse (perpetrated a number of years earlier by a valued member of her community). During treatment, Tina's work focused on exploring the impact of her history of sexual abuse on her eating disorder and on her difficulties connecting directly with her anger about her past history of abuse. Treatment also focused on identifying barriers to creating a satisfying friendship group, barriers that were both external (e.g., working long hours) and internal (e.g., being guarded, fearing being shamed) in nature.

Because racial issues were not overtly part of Tina's presenting concerns and because she was meeting with a White psychotherapist, race had not emerged as a topic in Tina's work. Her friendship group was not exceptionally diverse, but no less diverse than her profession, and she did not express any concerns about her interactions with the people of color she and her family crossed paths with on a regular basis. Within this context, there would be no reason to think that Tina wished to work on her latent racism when she made the disparaging comment about a

Latino man (it would have been different, for example, if Tina had self-identified as an antiracist ally and had expressed interest in increasing her awareness of racial issues). Furthermore, as mentioned above, Tina did have difficulties expressing anger, and she found it difficult to connect to the rage she harbored about her sexual abuse—rage that she easily expressed as self-hate through her eating disorder. It was out of character, therefore, when she demonstrated palpable anger in her racist comment. Tina seemed surprised herself at the depth of the rage she experienced in the context of a benign interaction, but was at the same time energized by it.

How could we understand Tina's reaction if we considered not only intrapsychic motivations but also contextual ones? In other words, could it be meaningful that the one place Tina was able to express anger was toward a person of color? If we were to analyze the same scenario by making race a salient variable, we could speculate whether Tina was able to find some sense of self-respect and power in her, however unconscious, identity (and associated privileges) as a White person (McIntosh, 1988), while she felt quite powerless in her identity (and associated experiences of oppression) as a woman. Both the culture in which she was raised and the institutions to which she was exposed (influences described in the definition of institutional and cultural racism at the beginning of this article) gave her an easy target toward whom to displace and express her anger (Glick, 2005). Therefore, Tina, feeling silenced as a woman but empowered as a White person, was able to make use of readily available racist ideologies to avoid experiencing her sense of inadequacy, insecurity, and powerlessness—at least in the context of her interaction with a person of color. Drawing on multicultural theories, then, allows for the possibility of seeing Tina's racism as diagnostic of a number of her concerns rather than a variable extraneous to her presenting concerns.

The psychotherapist working with Tina chose to base her further interventions on such a conceptualization. One of the goals of treatment then became to lessen Tina's use of displacement and possibly racism as strategies to avoid facing and overcoming her sense of inadequacy and powerlessness. To this aim, the psychotherapist helped Tina identify settings where she felt safe and powerful enough to work through her anger in constructive ways in the aim of establishing more satisfying and supportive relationships. In this process, understanding what made settings more or less safe became increasingly important. Therefore, incorporating—initially perhaps more implicitly than explicitly—a deeper understanding of Tina's racist comment led at once to deeper clinical work and, potentially, to the lessening of Tina's racism.

We can look at the case of Mark in a similar vein. Mark is a Latino man who initially presented with symptoms of depression and concerns about his work performance. However, as therapy progressed, he began disclosing other stressors, including a rejection he experienced several months prior from an African American woman with whom he worked. Mark had indicated a romantic interest in her, but she declined him both romantically and as a friend. Since that time, Mark found it difficult to concentrate on his work, was withdrawn, and ultimately received a poor performance evaluation at work. He began to question whether there was something inherent to his personality (or perhaps racial background) that others did not like, which might have led to such poor evaluations.

During the course of therapy, Mark made a concerted effort to address his depression, but was reluctant to consider the rejection he had experienced from his colleague as a precipitating or contributing factor to his depressed mood and avoidance of work. However, he did state that he felt he could not trust women anymore, or, more specifically, that he could not trust "certain women." When asked to clarify what he meant, Mark spoke of his view of African Americans as subhuman and fundamentally different from him.

There are situations in which addressing assumptions and generalizations related to race in a direct manner can be helpful. Maker (2005), for example, describes a psychoeducational approach aimed at dismantling racist beliefs in order to strengthen the therapeutic alliance and ultimately promote treatment goals. Along these lines, Mark's psychotherapist, a South Asian woman, encouraged him to explore alternative explanations for the rejection he experienced by asking him to consider the African American woman's response not as racially representative but rather as the reflection of a

lack of mutuality in the interest he experienced for her. Mark rejected that perspective and articulated that what he thought about African Americans was consonant with the worldview espoused both by his family and community.

Is it possible that Mark's racial comment can be understood in such a way as to ultimately serve his therapeutic goals? We might begin by asking about the function of Mark's racial beliefs. It is possible that Mark's racial beliefs provided him with a way of managing his feelings, in particular, his feelings of rejection. In other words, rather than experiencing the rejection, Mark both projected and displaced his negative emotions (about himself and in reaction to the rejection he experienced) onto a target fashioned by his worldview. In this case, prejudicial views presented themselves as a readily available means to cope with emotions that he found difficult to tolerate. In fact, Mark asked his psychotherapist how he could have been attracted to someone he considered subhuman. Therefore, Mark's prejudicial comment could have been a reflection of his own view of himself as inherently not likable, and his displacement might have functioned as a way of devaluing what he was not able to have. Mark's prejudicial statement, which initially might have appeared disconnected from his presenting concern, actually points to the highly clinically relevant issue of his fears about others' perception of him as well as his own insecurities.

Mark's psychotherapist had another challenge to overcome. Frustration and anger felt in response to Mark's prejudicial statement made it difficult for her to maintain an empathic bond with him. Had she not worked through these emotions in the context of her relationship with Mark, she might have withdrawn from the therapeutic relationship and Mark's fears would have been confirmed: that he was not worthy of connection and that he should distance from, and be distanced by, others. Mark's psychotherapist, however, was able to use her emotional reaction to gain insight into Mark's own possible encounters with, and subsequent reactions to, racism as a Latino man. In this way, she drew on her countertransferential experience to explore Mark's internalized racism, thereby allowing him to reach a deeper understanding of his fears of inadequacy, rejection, and marginalization. This deeper understanding might have not occurred had the psychotherapist simply ignored or deflected the statement, or stayed focused exclusively on deconstructing the content of the prejudicial comment in the name of promoting social change.

In the above interpretations, we argue that Mark and Tina appeared to have used racism and prejudice to project or displace their anger and insecurities. Furthermore, in both cases, clinical and social justice goals converged when a contextual understanding was used to analyze the clients' racially charged comments and formulate subsequent interventions.

Racism and Mental Health

How can a psychotherapist distinguish between those cases in which a racially charged comment implicates a client's mental health and those in which such a comment is not negatively implicated in the client's own well-being? The case analyses presented above at some level raise the question as to whether we should consider racism and racial prejudice in themselves as signs of psychopathology. Given our understanding of individual racism as deeply intertwined with institutional and cultural racism, it might be difficult to fully separate a client's racism or prejudice from his or her overall worldview. Therefore, even though we cannot say whether racism (or prejudice) and psychopathology are connected in all cases, it is important to be able to detect the ways in which, and the times when, there may be a relationship between the two. Exploring such possible connections between racism (or prejudice) and psychopathology can further our understanding of how to most sensitively and therapeutically address these issues in treatment.

Even though psychologists will not find racism or racial prejudice among the current *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) diagnoses (Lee, 2005), authors such as Thompson and Neville (1999) argue that racism is "a malignancy that dehumanizes people and obstructs meaningful relationships" (p. 157).[3] These authors also

[3] Thompson and Neville (1999) in their article use the term *racism*, rather than *racial prejudice* or both *racism* and racial *prejudice*. Therefore, in referring to their work, we use the term *racism*. However, we believe that Thompson and Neville's work is applicable to both racism and racial prejudice.

contend that we have not fully considered how racism relates to psychopathology because of a bias in our psychological theories.[4] They then propose a definition of mental health that highlights its negative connections with racism. Their conceptualization of racism as a form of psychopathology is useful in further examining the cases of Tina and Mark. We therefore describe Thompson and Neville's approach—grounded in a psychodynamic perspective—and continue describing how it might contribute to our understanding of the complex meanings embedded in clients' racially charged comments.

Thompson and Neville (1999) write about a number of specific defense mechanisms engendered by racist ideologies: denial or selective attention (in recognizing the impact of racism), rationalization or transference of blame (by blaming the victim), intellectualization (to avoid the painful feelings associated with witnessing oppression), identification or introjection (by identifying with the victim), and projection (of one's disliked characteristics onto others). We can see some of these defense mechanisms at play in the cases of both Tina (e.g., transference of blame) and Mark (e.g., projection, denial, or selective attention).

Furthermore, Thompson and Neville (1999) identify ways in which racism affects both Whites' and people of color's ability to accurately perceive reality. For people of color, the racism they experience leads to erasure of race (or striving to pass), autocolonization (or internalized racism), false consciousness (justification of a racially biased system), and rage (at the realization of racism). Mark shows signs of both autocolonization and false consciousness. For Whites, racist ideologies lead to a wish to deny the salience of one's racial background, or of racial backgrounds altogether, and to experiencing a number of negative emotions (e.g., guilt, shame) every time they become aware of racism. Such negative feelings might have been responsible for Tina's initial difficulty in engaging with her psychotherapist's attempt to connect her racist comment with her reluctance to experience and express anger toward the people who were directly responsible for her unhappiness (e.g., her parents, her teachers) but whom she viewed as more powerful than people of color. The concept of aversive racism provides another helpful framework to understand both Mark's and Tina's potential resistance in recognizing their prejudice.

What happens, then, when as psychotherapists we confront such defense mechanisms and distortions of reality? Whereas people of color must constantly find ways to appreciate themselves despite the negative social messages they receive, Whites must constantly affirm their worth as "good" people while benefiting from a racist society. This is a delicate and difficult balance to maintain, and both people of color and Whites invest much energy in it because of the strength of negative emotions associated with not doing so (e.g., rage, shame, guilt; Thompson & Neville, 1999).

When we then, as psychotherapists, decide that it is therapeutically appropriate to address our clients' racist or prejudicial comments, we must be aware of the range of emotions that we might be stimulating in our clients. Among these, we must recognize the emotions that might be specifically connected to the clients' presenting concerns as opposed to the ones clients might have in common with other members of their racial groups because of their shared racial histories (e.g., rage among people of color, guilt among Whites). In the case of Mark, for instance, his pain surrounding his internalized racism appeared to be connected to his view of himself as inherently not likable. Therefore, Mark's emotional reaction to discussing his racial views was tied to his presenting concern. In the case of Tina, had her psychotherapist directly confronted her use of White privilege, Tina might have found it difficult to receive the feedback because of the guilt White people usually feel when they become aware of the ways in which they might benefit from White privilege (Comas-Díaz & Jacobsen, 1991, 1995). In Mark's case, the emotion he felt when he was confronted with his prejudice was connected to his presenting concerns; in Tina's case, her emotional reaction

[4] Perhaps one of the reasons why traditional theories are not helpful in addressing racially charged discussions in clinical work is because these theories continue to cater primarily to the cultural majority, which is often not as aware, and at times not as invested, in understanding the more or less subtle ways in which racism makes its way into people's psyches. As much as racism affects everyone (Spanierman & Heppner, 2004; Spanierman, Poteat, Beer, & Armstrong, 2006), its costs are not as evident to Whites as they are to people of color. The cultural biases within which we operate as psychotherapists might then transpire in these theories' at-times unsophisticated view of racial dynamics.

would have more likely reflected a common experience of White people when confronted with their racial history (e.g., Hardiman, 1982; Helms & Cook, 1999; Ponterotto, 1988, as cited in Ponterotto et al., 2006).

The effect of challenging the defense mechanisms built around racist and prejudicial behaviors or ideologies is probably not radically different from the impact of addressing any other defense mechanism our clients may use. Timing of the intervention is extremely important, as well as considering the racial identity development status of the client (see Maker, 2005; Ochs, 1997; and Thompson, 1997, for a description of how to foster racial identity development in clinical work). It could be argued that the more salient an integrated status of racial identity development (e.g., Helms, 1995) is for a client, the more receptive he or she will be to the psychotherapist's intervention, especially if these are formulated in explicitly racial terms.

Furthermore, sustaining our clients as they delve into painful topics is extremely important for the intervention to be effective. Psychotherapists' ability to do so, while remaining nonjudgmental, will ultimately depend on their own comfort with racial dialogues as well as on their racial identity status (Atkinson, Morten, & Sue, 1989; Cross, 1995; Hardiman, 1982; Helms, 1995, 1992). In Helms's model of White racial identity development, for example, the "autonomy" status is characterized, among others, by the ability to recognize the subtle ways in which racism affects both Whites and people of color and the complexity of people's identities (e.g., not reducing the entire identity of a person to his or her racist ideology). Such awareness—together with the realization that we all contend with internalized racist ideologies, however examined these might be—might enable a psychotherapist with high levels of "autonomy" to hold a nonjudgmental and empathic attitude while working with clients' racist or prejudicial ideologies.

It is clear that a psychotherapist might not be able to address all of the unhealthy statements or behaviors that his or her client exhibits all of the time (whether they are of a racial nature or not). However, to even consider addressing them, one must be able to recognize such statements or behaviors and connect them to the rest of the client's concerns. For this to happen, psychotherapists must consider employing racial theories, as described in the cases of Tina and Mark, given that traditional theories do not always, by themselves, give us adequate lenses through which to understand racial comments. Furthermore, for psychotherapists to be able to recognize possible unhealthy statements in their clients, they must have dealt with their own racial views and be aware of how they themselves might make use of defense mechanisms that might obscure their own vision of racism or racial prejudice, and therefore their understanding of how racism or racial prejudice might affect their clients' thoughts and emotions.

Throughout this process, psychotherapists must clearly model ways to constructively and safely discuss racial issues given that we can assume that most clients probably have had few experiences or role models in this arena. In fact, on the basis of Helms's (1990) Black/White interaction model, we could describe both Tina's and Mark's relationships with their psychotherapists as progressive (i.e., relationships where the racial identity development of the psychotherapist was more integrated or autonomous than the one of the client). Without such a progressive relationship, the analysis proposed above most likely would have been missed and the subsequent interventions never applied.

This discussion of the connection between racism and psychopathology assumes that racism and prejudice imply some degree of misperception of reality (e.g., overgeneralization) and potentially the use of defense mechanisms to sustain its credibility despite possible evidence to the contrary (as described by Thompson & Neville, 1999). Such misperception of reality, however, may not ultimately be directly relevant to treatment. In these cases, generally speaking, psychotherapists may be able to address the underlying racism or prejudice by taking the time to validate the experiences that might have given rise to the racism or prejudice without validating the content. Should it be therapeutic for a client, one might also more explicitly point out the disadvantages of the inaccurate generalization(s) for that client's well-being.

This general guideline, however, comes with at least two important caveats. First, in the case of a client of color, psychotherapists must assess whether the prejudicial statement made by the client is a reflection of the client's internalized racism. Should this turn out to be the case, further exploration of the statement may be warranted. Second, as it will become clearer in the next

section, when a client makes a racist or prejudicial statement while working with a psychotherapist of color, the psychotherapist will always have the task of assessing whether the racist or prejudicial statement made by a client is a reflection of the client's views of, or relationship with, the psychotherapist.

In this second context, Gelso and Mohr's (2001) concept of cultural and culturally reinforced transference reactions is particularly helpful. Gelso and Mohr describe *cultural transference* (and countertransference) reactions as derived from an individual's past exposure to another's cultural background, and *culturally reinforced transference* (and countertransference) reactions as deeply connected to one's individual history and, therefore, "fueled partly by the earlier roots and partly by cultural phenomena" (p. 60). Even though one might argue that culturally reinforced transference reactions are more likely to be directly related to clients' presenting concerns, whereas cultural transference reactions may be more generally a reflection of cultural and institutional racism, both most likely affect the therapeutic alliance. Therefore, in these cases as well, further exploration of the racist or prejudicial statement in treatment is most likely warranted because of the complex cultural and culturally reinforced transference that might have been triggered by the presence of a psychotherapist of color and the possible consequent cultural and culturally reinforced countertransference reactions that the psychotherapist may experience.

Race Matters: The Therapeutic Dyad

How might the racial make-up of the therapeutic dyad influence the appearance of race in the therapeutic dialogue? Both Gelso and Mohr (2001) as well as Comas-Díaz and Jacobsen (1991, 1995), again from a psychodynamic perspective, illustrate a number of transference and countertransference situations in which the race, ethnicity, or cultural background of the psychotherapist or the client become central (whether positively or negatively) to the clinical work. In this section, we apply Comas-Díaz and Jacobsen's concept of ethnocultural transference and countertransference to highlight some of the possible psychotherapist–client dynamics that might foster the emergence of, or that might develop around, racially charged comments.[5] It should be noted that not all clients and not all psychotherapists (independent of racial background) will experience such transferential or countertransferential reactions, not all transferential and countertransferential reactions are due to racial concerns (Gelso & Mohr, 2001), and not all racist or prejudicial comments made by clients are transference reactions to the psychotherapist. What follows are examples of possible dynamics due to race that might arise among some clients and some psychotherapists at least partly on the basis of their own racial identity development, socialization, and experiences.

In the case of Tina, one might speculate that the presence of another White person in the room might have led her to feel comfortable verbalizing her feelings toward Latinos. Was her racial comment an attempt to bond with the psychotherapist, who Tina might have thought shared her feelings, given their similar racial backgrounds? In this case, Tina might have felt rejected by the psychotherapist's reluctance to validate her views and by the psychotherapist's invitation to explore how her comment might have reflected biases in her own ethnocultural background. Alternatively, the racist comment could have been also a way for Tina to test the waters regarding the psychotherapist's comfort in addressing race and racism, perhaps because of her interest in safely exploring her own biases. In this second case, she might have felt reassured by the psychotherapist's engagement with her racist comment and might have been more ready to explore her own ethnocultural background.

If Tina had been working with a psychotherapist of color, would she have consciously or unconsciously censored her comment? If she still had expressed the comment, the psychotherapist would have had to consider whether Tina's comment might have been a way for her to express her feelings about the psychotherapy process, the psychotherapy relationship, or the psychotherapist him- or herself (as elaborated further below) perhaps more than if the psychotherapist had

[5] Not all of the specific transference and countertransference reactions described by Comas-Díaz and Jacobsen (1991, 1995) are entirely applicable to clinical situations when racism or prejudice enters explicitly into the psychotherapeutic dialogue given that only some of their case examples directly involved cases where racism or prejudice was explicitly voiced by the client. However, their discussion of ethnocultural transference and countertransference is still extremely useful, even in the cases in which the context differs.

been White (Comas-Díaz & Jacobsen, 1995; Gelso & Mohr, 2001). How might the psychotherapist have responded then, and how would Tina have reacted to the response? The possibilities, again, are varied.

Psychotherapists have the challenging task of assessing the client's expectations and, therefore, what meanings the client might make of the psychotherapist's intervention. We could speculate that Tina might have been relatively comfortable accepting an antiracist comment or stance from a White psychotherapist because the comment or stance might not have been construed as potentially derived from the psychotherapist's personal agenda. The same comment might have been interpreted quite differently had it come from a psychotherapist of color. Had Tina been a person of color, however, how might a White psychotherapist make an antiracist intervention without sounding potentially patronizing? One can see the complexity of the dynamics surrounding racial dialogues and how careful psychotherapists must be to investigate their possible meanings.

We must also consider psychotherapists' motivations, and potential ethnocultural, cultural, and culturally reinforced countertransference reactions, for voicing their racial views to their clients. Psychotherapists must make sure that their feedback to clients is inspired by therapeutic considerations rather than by the countertransference they might be experiencing in hearing a racist or prejudicial comment. Once again, some of the countertransference reactions described by Comas-Díaz and Jacobsen (1991) and Gelso and Mohr (2001) offer a helpful foundation to our analysis.

For a White psychotherapist, the anxiety stimulated by hearing a racially charged comment might arise from a number of sources. It could be derived from having classified oneself as a "good (antiracist) White" and feeling pulled by one's client to join what in the psychotherapist's mind is the mentality of a "bad (racist) White" or a prejudicial person of color, while being strongly invested in maintaining a clear separation between him- or herself and the client, in this context. This might be especially so if the psychotherapist is embedded in an early stage, or status, of White racial identity development (e.g., the Resistance stage in Hardiman, 1982; the Pseudo-independance status in Helms & Cook, 1999; the Zealot-Defensive stage in Ponterotto, 1988, as cited in Ponterotto et al., 2006). Being embedded in these stages, or statuses, might then prevent the psychotherapist from maintaining a nonjudgmental attitude, as described earlier. A White psychotherapist's anxiety might be stimulated also from experiencing White guilt in hearing a racist or prejudicial comment while being aware of the ways in which he or she benefits from racism (the psychotherapist here may be grappling with a later stage or status of racial development identity in the models mentioned above). In either case, the psychotherapist might feel the need to address the client's racist or prejudicial comment as a way of easing his or her anxiety by performing a self-conscious antiracist act rather than taking the time first to investigate whether and how the racist or prejudicial comment might be harmful to his or her client's well-being. In other words, such anxiety in a White psychotherapist will damage his or her ability to investigate fully the meaning of the client's racially charged statement. Maintaining the focus on the client's well-being might redirect the psychotherapist's attention in a way such that he or she might not feel alienated by the client's comment as much as empathy for what the comment might indicate about the client's struggles. The psychotherapist might then use this empathic understanding to connect the client's racist or prejudicial statement to his or her clinical needs and maintain a nonjudgmental stance in that process.

What might it mean, then, for a client of color to make a prejudicial statement when working with a psychotherapist of color? Looking at a psychotherapeutic dyad of color from yet another perspective, a client of color who makes a prejudicial statement with a psychotherapist of color may be struggling with his or her own internalized racism or xenophobia. The psychotherapist's own feelings of belittlement or alienation in hearing a prejudicial comment may provide insight into how the client feels about himself or herself as he or she navigates through everyday experiences of injustice and marginalization, as in the case of Mark and his psychotherapist described above.

It is also possible that any client working with a psychotherapist of color may invoke race as a way of equalizing power in the room, pointing here to the discomfort a client might feel in working with a psychotherapist of color (Comas-Díaz & Jacobsen, 1995). In all therapeutic encounters, there is an inherent power differential between clients and clinicians.

However, this power differential tends to become blurred with psychotherapists of color because clients may not be used to interacting with people of color in positions of authority. This new encounter may cause confusion and possibly cognitive dissonance, which a racist or prejudicial statement might aim at resolving. This may be the case for a White client or for a client of color contending with internalized racism.

Here, as above, consideration ought to be given to the motivations of psychotherapists of color in expressing their views about race with clients. For example, when a client of color voices a prejudiced statement directed toward a majority culture member or a racial/ethnic minority person (or group) not represented in the room, the client may be in some way "testing" the psychotherapist of color. The subtext of such a statement might be, "Prove to me that you have not sold out to White America through your profession" or "Prove to me that you are better than other people of color, just as I am better than them too" (similarly to the "traitor" transference described by Comas-Díaz & Jacobsen, 1991). In either case, the racial comment is an assessment of membership and credibility. The test has profound implications for the client's ability to trust and feel understood by the psychotherapist because some clients may feel validated and therapeutically engaged if they feel that the psychotherapist rises to the challenge.

In this context, it can be tempting for a psychotherapist of color to want to prove ethnic authenticity or superiority. However, the risk here lies in colluding with the client's prejudice or internalized racism, thereby neglecting an opportunity for clinical interpretation and intervention. As such, it can prove rewarding to the therapeutic process to resist the test presented by the client and to actually allow the client to project onto the psychotherapist what type of person of color he or she believes the psychotherapist to be. By doing so, through the course of therapy, one can explore ways in which those projections reflect the client's views of him- or herself, and draw on these insights to help the client attain his or her goals.

As one can notice, the impact of the client's and psychotherapist's racial backgrounds on racial dialogues is complex and multifaceted, similar to the racial experiences for each of the parties involved. Therefore, psychotherapists must have the training and clinical sophistication to investigate and determine the issues embedded in such dialogues. Once they do, the initial complexity will add much richness to the clinical work.

Conclusions: Race as a Clinical Issue

The clinical cases we offered in this article provide examples of how one may view social justice, feminist, and multicultural perspectives not as adding extraneous agendas onto clients but rather as offering lenses through which one may better understand the clinical significance of clients' racial comments and formulate interventions that will aid the therapeutic process. From this perspective, addressing clients' racist or prejudicial comments in psychotherapy does not necessarily give rise to a conflict of interest between clients' treatment goals and social justice agendas. Rather, it has the potential to add depth and power to both the therapeutic relationship and the therapeutic process.

In sum, when addressing clients' racially charged comments, psychotherapists should consider the following five steps:

1. Conceptualize racist and prejudicial comments in the context of cultural racism, thereby considering the cultural and institutional messages as well as the perceived social hierarchies based on race embedded in the client's ideologies.

2. Explore the possible relationship of the racially charged comment to the presenting concerns.

3. Investigate the possible meanings of the racially charged comment within the context of the therapeutic relationship, taking into consideration the racial composition of the therapeutic dyad and possible ethnocultural transference reactions.

4. Clarify one's motivations and identify possible ethnocultural countertransference reactions in the process of addressing clients' racially charged comments to ensure that one's interventions have primarily therapeutic, rather than self-soothing or damaging, purposes.

5. Assess the best timing for the intervention, considering both the overall course of treat-

ment as well as the racial identity development of the client.

The five therapeutic steps described above begin with a contextual, rather than exclusively intrapsychic, understanding of our clients' concerns, ideologies, and behavior. As Tinsley-Jones (2001), inviting such a contextual understanding, writes, "racism is not an inevitable by-product of being human; it is a creation of our history" (p. 574). Cushman (2000), citing DuBois, similarly states that "political ideologies and institutions such as racism are produced by existing political arrangements and by political [not psychological] motivations. . . . First, lines are drawn to separate groups; individuals then respond to them psychologically" (pp. 609–610). Therefore, we must first recognize that racism and prejudice are deeply embedded in our culture, and their logic colors the lenses through which we see not only others but ourselves. It is then the hierarchy and the power (or lack of power) embedded in racism and prejudice that provide the backdrop for how we view ourselves in relation to others. From this perspective, racial and prejudicial comments are saturated with clinical meanings. They bring to light the ways in which individuals make sense of their place in the world. In this context, grappling with our clients' racially charged comments is nothing short of central in our work as psychologists.

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