Clinical Toolkit: Providing Psychotherapy in a Contemporary Social Context

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Introduction

Psychotherapy, more than any other intervention for psychological issues, is recognized as a cornerstone of treatment. Yet the demand far outstrips the supply, and access is often inadequate to meet the needs of populations. In particular, the underserved are disproportionately affected, and providers' experiences in serving diverse populations are limited. One can then imagine the downstream consequences as the population of the USA continues to diversify: how will mental health professionals gain the expertise needed to recognize biases so they are able to provide better care for these individuals? More importantly, how will underrepresented minority groups gain access to mental health professionals who are competent to provide identity-specific psychotherapy in a contemporary social context? Unfortunately, the latter question is beyond the scope of this chapter, but what follows is an attempt to address knowledge gaps for providers eager to enhance their skills for working with patients from minority backgrounds. The chapter describes how the current sociopolitical context leads to emotional oppression, disproportionate resource allocation, and a reliance on racial minorities to articulate this suffering to their mental health providers, who often represent the race in power. The chapter also outlines how mental health providers—whether they are racial minorities or not—can share the emotional labor by changing attitudes, gaining knowledge, and learning skills to use as a means of redistributing power.

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Clinical Consideration: Introduction to the Patient, Stan

Stan is an African-American male in his mid-20s, who has lived in a large urban city in the Midwest for most of his life. He grew up in a predominantly black neighborhood with two working-class parents (his father was a policeman and his mother was a teacher). After high school, he completed college, received his MBA, and now works as a consultant in a top firm. He is one of three African Americans in a firm of 200 employees. Since the presidential election of 2016, he has felt increasingly isolated from his colleagues at work. He has perceived a negative undertone in some comments from his boss and coworkers related to race, resulting in uncertainty, mistrust, and difficulty confiding in colleagues. At the suggestion of a close friend, he decided to see a therapist. Realizing he would not be comfortable discussing these issues with a white therapist, he hoped to find a black provider. However, there were none with availability, so he has his first appointment with an older white male therapist today.

How the Broader Sociopolitical Context Impacts Patients' Experiences of Accessing the Mental Health Care System

The literature is rife with evidence of the sociopolitical factors leading to the underutilization of mental health services by racial and ethnic minorities [1–4]. The reasons for these disparities in mental health care stem from a broad spectrum of causes ranging from individual to chronic, systemic barriers. Research has shown that when racial and ethnic minorities seek mental health treatment, they are more likely than their white counterparts to terminate treatment early [5–7], to be seen by a primary care provider or in the emergency room [7], and to receive a lower quality of care than whites [7]. Racial and ethnic minorities also report receiving poorer care, such as decreased access to a usual source of care, problems seeing a specialist, and delays in care while waiting for approval [8]. Impressions of poorer care have also been correlated with decreased satisfaction with clinical interactions, such as perceived discrimination from providers [8]. Additionally, minority patients have been found to have beliefs that they would receive better care if they were of a different racial/ethnic background [8]. For Asian and Latino populations, language barriers have been found to be an important factor in reducing the use of mental health care [9]. Betancourt et al. [10] identified additional barriers such as limited clinical hours, long wait times, lack of interpreters, and difficulties accessing specialty care. Specific structural barriers such as lack of time, unreliable transportation, lack of adequate childcare, low insurance coverage, and high costs have also been implicated in contributing to mental health disparities [11, 12].

To appropriately consider the sociopolitical context of a patient, the complex link between socioeconomic status (SES) and race must be taken into consideration. Generally, SES comprises a set of economic and social factors within society, which are also influenced by race. Therefore, when one is treating a patient from a racial minority group, it is important to consider how the income, educational attainment, and health of that population are affected by inaccessible privileges that have been offered to white patients. For example, in thinking through the barriers to treatment of a black patient in the USA, the impact that slavery and the consequences of

continued institutional oppression have on black people is important to consider, as are the ways in which socioeconomic factors impact the patient's individual life as a black person [13, 14]. After familiarizing themselves with this contextual knowledge, mental health professionals must also serve as advocates to help their patients overcome systemic obstacles and provide effective care. For example, the barriers for a patient to attend an appointment at 2 p.m. will depend on their occupation, access to transportation, and other factors such as the cost of treatment. They must be both in a financial position to miss income-producing activities on that particular day and still able to meet their personal and professional obligations. They must have functional and ideally safe transportation, including the means to legally register, maintain, fuel, and park their vehicle, or a reliable public transportation system with services to and from their residential location to the clinical office. Utilizing public transportation is time consuming, and in many municipalities it is inadequate to bridge the inherent limitations of lacking reliable access to a vehicle. The cost of simply accessing mental health care goes well beyond an ability to afford costly and limited insurance or public health options. Statistically, racial and ethnic minority populations tend to have fewer economic resources, which present challenges to accessing care because of institutional factors that are rarely recognized or addressed by the current system [7–14].

Clinical Consideration: Anticipating the Needs of Stan and Racial Minority Patients

With the above considerations in mind, there are a multitude of factors that may impact the therapeutic dyad. For a therapist striving to build a racially sensitive therapeutic relationship with Stan, it is important to provide psychoeducation about mental health treatment, as this may be his first time engaging with a mental health provider. Prior to the first meeting, providers may conduct phone consultations to assess the fit, and this serves as an important opportunity to demonstrate awareness and sensitivity to cultural factors that may impact care. Psychoeducation may include information about the background (identity statuses), training, education, experience, and role of the provider in therapy. The therapist should describe what to expect in therapy (from what occurs during each session to the typical course of symptom reduction). Additionally, the therapist should discuss with Stan his coping skills and what type of support he is looking for in therapy. The discussion should cover potential structural or systemic barriers that would prevent Stan from engaging in treatment. Transparent conversations about fees, insurance, transportation (ability to park or take public transit), communication (by e-mail, secure messaging, or phone), and the number of sessions will offer Stan the opportunity to decide if both the therapist and the mental health treatment plan could be a fit for his needs.

In addition to systemic barriers, the ever-changing dynamic created by the personal attitudes and beliefs of both patients and providers should be considered. More specifically, the therapist is accountable for ongoing self-examination of

attitudes and beliefs that may be counterproductive to establishing a racially sensitive climate for the patient. The influence of implicit bias among mental health providers has been shown to exert a significant role in maintaining racism-influenced disparities [15–17]. From the patient's perspective, stigma and negative internalized beliefs within racial and ethnic minority communities cannot be underestimated as factors that prevent patients from taking the initiative to seek care [15–17]. Racial and ethnic minorities may also hold beliefs about how to address and acknowledge mental health concerns, based on their cultural background (e.g., going to church, religious healers, spiritual practices, wisdom from elders, etc.), that do not include engagement with the health care system [15]. Therefore, for mental health providers to be prepared to effectively treat a diverse array of patients from racial backgrounds, it is imperative that they commit to ongoing self-exploration and education of their relationship to the racial "other."

Clinical Consideration: The White Therapist and Stan

Throughout the therapeutic relationship, the therapist should collaborate with Stan and support his agency by eliciting feedback about his experience in therapy. As with other patients, it is necessary for the therapist to remain mindful of the interaction between Stan's psychosocial environment and his presenting concerns. As noted above, given the different cultural perceptions regarding seeking mental health care, the therapist should investigate the extent to which stigma, or negative internalized beliefs, influence Stan's presentation and could impact the therapeutic dyad. The therapist should also assess any reactions he/she has to Stan from the context of his/her own identity, which in this case happens to be an older, white, male therapist. As a white provider (or a provider of a different racial and ethnic background from Stan's) it is important to be aware of and acknowledge any implicit biases specifically about Stan or in working with a black patient. It is also important for the provider to anticipate possible reactions Stan may have during the interaction as a result of racial discordance. Given Stan's initial concerns about dealing with racially charged comments from white coworkers, the therapist should be prepared for Stan to have some level of resistance to trusting a white provider. The therapist could initiate a conversation about identity statuses by asking Stan about his current experience of working with him as an older white man. This is a moment of vulnerability for the therapist but communicates to Stan that the therapist is aware of inherent power differentials and cultural differences. Pre-emptively, bringing these identity statuses into the room (age, gender, race/ethnicity) also shows Stan that therapy is a place where you can and should discuss the impact of race. Given Stan's upbringing and current presenting concerns, one may hypothesize that Stan will want to engage in conversation about his experiences related to being black. He may test or examine social cues from his provider to assess whether or not it is safe to discuss race and if the therapist is open to hearing his experience.

Disparities in diagnosis are also of great concern, as psychiatrists and other mental health professionals have been found to overdiagnose minority patients with psychotic disorders [4, 18], fail to identify and diagnose minority patients with affective disorders [4, 19], or fail to provide racial and ethnic minority patients with the same quality of care as their white peers [4, 12]. Despite an increased emphasis on cultural competence, training programs in psychiatry, psychology, and social work have failed to reduce racial and ethnic disparities in mental health care [10]. It is imperative that mental health providers not only acknowledge the disparities in mental health care that are prevalent in racial and ethnic communities but also actively strive to recognize these deficiencies, internally and systemically. This is critical to improving access to high-quality, equitable care for minority populations.

Implementation of empirically proven tools such as the Cultural Formulation Interview (CFI), a patient-centered assessment in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), may improve providers' awareness of cultural factors that influence mental health diagnosis and treatment [20]. The CFI [20] consists of 16 questions that allow the provider to gain an understanding of cultural variables that frame how the patient views their clinical experience, such as learned coping strategies, barriers to treatment, and preferences in working with the provider. The CFI provides a platform to open a genuine dialogue about the patient's experience while minimizing reliance on assumptions [20]. The questions framed in the CFI help providers elicit pertinent information leading to recommendations that are relevant to the specific cultural context of the patient.

Another helpful tool for unbiased provider and patient communication is the ADDRESSING framework [21]. This framework allows for exploration of the patient's feelings about group membership and which individual identities may be particularly salient to their presenting concerns in psychotherapy. The framework includes strategies for discussing multiple identities that may intersect, such as age, disability status, socioeconomic status, religion/spirituality, race/ethnicity, nationality, gender identity, and sexual orientation.

Clinical Consideration: Stan, Months After Starting Therapy

Months later, Stan is feeling more isolated at his job because of comments made by his colleagues and boss about an increase in gang violence among black people. Stan's mistrust in his work environment is likely to enter the therapeutic relationship. As the extent of his perceived isolation at work intensifies, he may worry that his white therapist thinks he is being "too sensitive" or that he is "misinterpreting his experiences." He is already questioning whether the events at work are as harmful as he sees them, because while he feels uncomfortable, no one else in the office seems to notice. Therefore, the more socially isolated Stan feels, and the more he discusses his fears in therapy, it becomes more likely that he will question his reality. It is imperative for a therapist, who may already be perceived as "different" from the patient worried about racism, to provide validation and empathic understanding. Stan

needs to know that the therapist understands how real the threat of racism can be, while reassuring him that his feelings are valid. This will provide the underlying conditions to facilitate a corrective emotional experience about an issue that is incredibly sensitive. Using the CFI [20], along with clinical judgment, the therapist begins to understand how Stan views his current level of support, salient identity statuses (male and black), and coping style. Information collected by using the CFI, along with Stan's presenting symptoms, can be used to formulate a biopsychosocial–spiritual understanding of Stan's current functioning and diagnostic picture.

Additionally, the therapist's use of the ADDRESSING framework [21] bridges the discussion about the different identities Stan holds and how they manifest and/or intersect in different contexts. For instance, Stan grew up in a predominately black neighborhood and now works in a predominately white environment. The therapist can discuss what function Stan's black identity serves in each of these environments. Stan may report that he is more aware of being black in the context where he is only one of a few African Americans. He may also explore how his relationship with the white men he works with are very different from those with his black childhood friends. This would also be a good time for the therapist to inquire about how Stan's relationship with him, a white male, compares with his relationships with his white coworkers and black childhood friends. For a therapist of a different race, starting and participating in these conversations convey an openness that others of a different race in Stan's life may not display. While this fosters trust, the therapist must be careful not to place the burden on Stan of being his educator on the black experience. Seeking consultation with other mental health providers, as well as reviewing relevant literature, may help the therapist strive toward cultural competence [10]. For example, it may be necessary to consult books, journals, lectures, or blogs on the arts and humanities such as sociology, history, and religious studies. Stan is likely to appreciate such efforts in therapy, which will undoubtedly strengthen the therapeutic alliance.

Even when providers wish to explore the impact of race, culture, and identity with their patients, they may be reluctant to initiate these conversations because of the uncertainty of how to engage in a culturally sensitive manner that does not offend patients. Yet, consider the far-reaching ramifications of failure to explore these factors: recovery is what is ultimately at stake. It is imperative that providers utilize tools and evidence-based approaches that fit their practice style. The ability to tailor care, which addresses the unique issues among racial and ethnic minorities, is no longer a specialized skill; it is *necessary* to provide competent care. Mental health professionals must push to transcend the challenges presented in the contemporary social context. This is necessary to reduce disparities in care and ensure that treatment reflects the needs of the modern era—an era in which embracing diversity is a strength, not an inconvenience in performing the obligations of employment.

In fact, exploration of each patient's unique worldview results in twofold benefits to the therapist: it provides increased data to support interpretations, and it conveys interest in the patient. On a small scale, these behaviors will likely help to strengthen the therapeutic alliance. However, on a large scale, these behaviors lead to an enhanced understanding of how human complexity may manifest. By achieving greater awareness of how minority "labels" play out in a variety of ways, a more nuanced and intersectional understanding of identity results. Instead of achieving this enlightenment within the patient encounter, the therapist stands to benefit from an increased awareness of how these labels are applied outside the office and within the larger society. Therefore, a routine train ride could reveal knowledge about the "other" that was previously invisible. For example, a lone racial minority person on the same train car that the therapist has failed to notice every morning may elicit thoughts the next morning about why that person is the only racial minority person on the train car. Impediments in a society structured around the norms of the white majority may become more visible. It is imperative that mental health providers recognize their own context and how that context differs from their patients' contexts, and that they are dedicated to observing the invisible dynamics that influence the surrounding context during the patient-to-provider interaction.

Clinical Consideration: Talking About Race and Racism in Therapy
Many therapists may shy away from discussing race, out of fear of what may happen when they do so. However, avoiding talking about race with Stan, or simply focusing on symptoms without acknowledging the context in which those symptoms occur, would be a disservice to Stan. In fact, avoiding the topic of racism would be therapeutically insensitive and could result in an early termination of therapy. Being vulnerable, acknowledging biases, and showing empathy will aid in formulating a more accurate, context-specific diagnostic impression. The therapist's effort to truly understand Stan's worldview and put himself in Stan's shoes lays the groundwork for creating a corrective emotional experience.

Addressing Racial Identity and Self-Concept in Treatment

The prior discussion outlines the extent to which mental health disparities in access, treatment, and outcomes for racial minorities permeate the sociopolitical context. In order for psychotherapy to be effective for people of color, the therapist must acknowledge the nuanced and obvious impact of the broader context in individualized treatment settings. It is essential that psychotherapists recognize how racial identity and self-concept contribute to patients' psychological frameworks, and to their own lives. More importantly, providers must be dedicated to using their understanding of racial identity and self-concept in supporting patients' resilience in the face of ongoing racial oppression and racism-related traumatic experiences.

A strategic starting point for the therapist is to consider how societal systems of oppression fit into their preferred approach to psychotherapy with individuals from minority backgrounds. The therapist's history of training in psychodynamic, behavioral, cognitive, and/or humanistic approaches will influence how patients' concerns are heard, how patients' mental health symptoms are conceptualized, and how best to collaborate in developing solutions [22]. Concepts from these theories will be discussed, but the psychodynamic and psychoanalytic approaches, which focus on the importance of unconscious motivations in understanding internal conflict, will serve as the foundation of this discussion on the ideas of racial identity, self-concept, and possible interventions [22].

Defining Self-Concept and Identity

The words "identity" and "self" are often used interchangeably. Although related, these words have different implications. The concept of identity refers to an individual's belief about him or herself, while self-concept refers to an individual's ideas about him or herself that are shared by others [23]. Additionally, descriptions of self-concept are associated with the emotions evoked by this self-perception, whereas identity refers to the cognitive impressions of the self [24]. For example, a woman with a black mother and white father may have a self-concept of herself as "sensitive, outgoing, and perceptive," while her identity is that of a biracial, female millennial.

Examining how an individual's identity or self-concept develops is a prerequisite to thinking about how racial identity or racial self-concept manifests in the therapeutic setting. There are multiple theories outlining the development of identity; however, Erik Erikson's psychosocial theory is the most relevant to this discussion. Per Erikson, individuals face various conflicts that should be resolved as they progress through life. The fifth stage—identity versus role confusion—occurs as the adolescent (ages ~12–18 years) attempts to secure an identity, mainly in relational and occupational terms, that fits within society and will be consolidated throughout life [25]. Failure to establish this identity results in role confusion, whereby the adolescent is unsure about his role in society, leading to internal conflict [25].

On the other hand, researchers are not exactly clear on how self-concept develops, but most agree that it begins within the first year of life [24]. Self-concept is built upon the perceptions that individuals generate about themselves over time on the basis of personal experiences. According to the psychologist Carl Rogers, self-concept is based on three components: self-image (how you see yourself), self-ideal (how you wish you could be), and self-esteem (how much you value yourself) [26]. While early work by Erikson and that of others such as Rogers provide an initial understanding of identity and self-concept, early theories may not appropriately capture how major physical (or mental) characteristics disproportionately drive the formation of identity. The following sections will outline the potential impact that having dark, or black skin tones could have on the formation of black identity during various historical contexts.

Clinical Consideration: Addressing Stan's Self-Concept
Often the application of Erikson's and Rogers's theories to "race" is not explicitly discussed in training programs, which was the case for Stan's therapist. However, using these theories as a framework, the therapist may begin to wonder about Stan's adolescent experiences living in an urban area that was predominantly black, but attending high school in a predominantly white, suburban part of town. Undoubtedly, Stan grew up with friends in both settings, but one wonders about his self-esteem or confidence about himself when interacting with other adolescents in his community or when at his classmates' homes in the wealthy suburbs. Was he attracted to individuals in his neighborhood or church, who were mostly black, or to individuals in his class, who were mostly white? Does he consider himself handsome in the milieu of his school or capable enough to date someone from his neighborhood, even though he may have been considered an outsider because he did not go to the local school (self-image)? Did he compare himself with his male peers, wishing to be more like his black neighborhood friends or his white classmates?

Self-Concept and Identity in a Racial Context

Given these approaches to identity and self-concept, one can intuitively imagine the impact that being a racial "other" can have on securing an identity within society or solidifying one's image, ideal self, or value in the world. While these concepts begin forming in childhood, they are continuously transformed throughout adulthood as the complexity of personal experiences intensifies on the basis of the historical context of racial and ethnic groups within society. To capture the transformations that a racialized "other" may experience into adulthood, various theories have emerged that do not exclude the developmental theories discussed above, but supplement how self-concept or identity can be morphed by major historical events. Additionally, it is important to consider examples of key historical traumas that span a variety of marginalized groups. Examples include the normalized harsh treatment of the Japanese in internment camps during World War II, the post-9/11 period when profiling of Arab travelers increased, or the current initiative to build literal and metaphorical walls to ban Mexican immigrants. While some form of racial trauma is consistent across minority groups, this section focuses on the development of black identity and self-concept within the USA.

A prerequisite to the conversation about black identity and self-concept is first a discussion of the seminal work of Clark and Clark in the 1940s. Their work showed that African-American children between the ages of 3 and 7 years were more likely to attribute positive characteristics (i.e., niceness) to a white doll than to a black doll, as an illustration of internalized racism. Their findings contributed to the US Supreme Court's ruling in the landmark case of *Brown v. Board of Education*, ruling that racial segregation of the public school system was unconstitutional.

For decades, the interpretation of Clark and Clark's results suggested that black children have a poor sense of self-concept and show a preference for Eurocentric values [27]. However, later work debunked this idea, positing that increased racial awareness was linked to a preference for majority-based racial attitudes, as in a "white bias" [28]. Studies showed that children who were more racially aware but also more well adjusted—or better able to differentiate themselves from others with less egocentrism—had a positive self-concept while endorsing the preferential racial attitudes [28]. These findings suggest that although the black children preferred the white doll when asked, it was not necessarily an indication of poor self-concept but, rather, possibly increased awareness that "white" characteristics were widely accepted as better. Racial awareness was found to be associated with the child's knowledge of racial stereotypes; thus, early messages about race may be instrumental in the formation of a patient's burgeoning racial identity [28]. However, additional findings suggest that these perceptions may be malleable by social forces such as education about black culture and buffering of negative stereotypes by black parents and the community [28]. Therefore, it is imperative to investigate the socio-political history that is pervasive during the childhood context of patients. Knowledge of these historical dynamics is key to understanding the downstream effects of how racial identity may manifest in the present moment.

The somewhat contradictory conclusions offered by Clark and Clark, and later research about black identity and what constitutes a positive black self-concept, can be elucidated by later work on identity development. Although minimal, Erikson's thoughts in 1968 on identity for blacks were largely based on an exploration of work by "Negro" writers. Erikson's work suggests "an absence of identity, or at any rate, the almost total prevalence of negative identity elements" [25].

However, it was not until the development of the Thomas and Cross models of Psychological Nigrescence in 1970 and 1971, respectively, that an in-depth examination of black identity formation occurred [27]. While these models are not generalizable to every black person, the process of undergoing nigrescence, or becoming black, is a seminal moment for every black person at some point in life. Thomas's model begins when the individual has already started to change their black identity: transitioning from seeking cues for identity formation from whites, anger toward self and then coping with anxiety about blackness, finding a connection to a larger black community, and solidifying their unique blackness [27]. The Cross model describes the transition from an old identity of blackness that is altered after a seminal racist encounter. Per Cross's model, the intensity of the racist encounter leads to a complete immersion in blackness, followed by an exit from psychological defensiveness, and culminates in a resolution of conflict where anti-white feelings decline [27].

It is worth mentioning that other theories of ethnic or racial identity formation have emerged from Thomas's and Cross's work on black identity. Most notable is Phinney's three-stage model of Ethnic Identity Formation, which has led to the development of models such as the Asian American Identity Model proposed by Kim [29, 30]. According to Phinney, stage one describes an unexamined ethnic identity, when a child has not given much thought to his/her ethnic identity or it is

derived from others [29]. After a period of socialization, where the individual consolidates messages about their ethnicity from the environment, stage two begins, which is an ethnic identity search. As in Cross's model, stage two is often initiated by a significant experience that highlights the ethnicity in question, such as an experience of discrimination [29]. The third stage is that of ethnic identity achievement, when a stable, internalized ethnic identity, realistically set in the larger context, is achieved [29].

Clinical Consideration: Putting Stan's Identity in Context
Using the theories of psychological nigrescence, Stan's therapist may want to explore how Stan has come to conceptualize his black identity, and how this has changed over time, in order to understand the present moment. Did Stan's idea of himself as a black male alter as he traversed the different settings of his life: neighborhood, high school, college, and now? It would also be important to investigate what cues, and from whom, Stan used to form his black identity. Further, is Stan proud and comfortable with his sense of blackness in some settings but not in others? The answers to these questions are extremely valuable in interpreting the impact of the election results on Stan's psyche, how to harness his feelings of anger, and how to reconnect with himself and those around him.

What to Do with All of This

While the above information is key to understanding the individual experience of patients from racial minority backgrounds, the conflict experienced by racial minority groups cannot be overlooked. Chapter 7 highlights the disheartening extent to which disparities exist for minority populations. One blatant manifestation of this disparity is the drastic shortage of minority mental health providers. Therefore, cross-cultural training emerges as a necessary part of training for white providers, who will inevitably be called upon to care for minority patients. For providers from any demographic, examining self-identity and the various sociopolitical environments that have informed identity development throughout life is integral to helping patients do the same.

For providers of the majority race, understanding white identity formation is important when caring for minority patients. While there are multiple models of white identity development, the White Racial Identity Development (WRID) model, which was proposed and later revised by Helm, includes stages similar to those of the racial minority models discussed above [31]. The first stage begins with the individual being unaware, misinformed, and without conscious awareness of the benefits of white privilege [31]. After this stage, the individual realizes that his/her notions about people of color are different from those expected, leading to the development of pro-white feelings and a desire to protect his/her privilege [31]. In the next stage, a positive white identity begins to form, which sets the stage for

misconceptions about race being replaced with accurate information [31]. Finally, the individual achieves a positive white identity and mobilizes against the eradication of racism [31].

To best illustrate how self-exploration of a therapist's majority racial identity is therapeutically essential when caring for a patient from a minority background, see the continuation of the case below.

Clinical Consideration: Therapist Explores His Own Racial Identity

After a few sessions, Stan's therapist, John, becomes aware of intensely negative countertransference feelings. Not only is John uncomfortable, but he also disagrees with some of Stan's concerns about the racially motivated maltreatment of African-American men by white individuals. John does not believe that he, as a white male, is guilty of ever behaving in this manner. John's best friend growing up was James, a black boy his age, who lived next door with his Nigerian-born parents, who were both physicians. John wonders if his reactions to Stan are due to a difference in his upbringing compared with that of James, his closest example of another black man [32]. John discusses his thoughts with his personal psychotherapist, who asks John about messages he has received from his family and friends about people of color throughout his life. While John's parents and friends have never used racial slurs or spoken negatively about people of color, John realizes that his parents never had James's parents over for a meal, none of the guys in his college fraternity were black, and James (whom he has not spoken to in 3 years) is actually the closest black friend he has had. John starts to question if something is wrong with this and, further, if he has blind spots that are contributing to the negative countertransference.

While this description of John's inner monologue may seem rather specific, its core is reflective of what typical multicultural training leads to: thwarted attention from white identity formation due to a hyperfocus on the racial minority experience. How often has John engaged in thinking about his identity as a white male and its relationship to injustice, oppression, and the structural institutions around him? However, as a good therapist, John recognizes his instinct to reject the notion that Stan is being mistreated because of his race. He thinks through the evidence to support this—such as the fact that he himself has never been treated in that way because of his race, nor has he witnessed this type of treatment, and he works in a comparable milieu among highly educated individuals. While John finds it reassuring that his parents have never displayed racist behaviors, he cannot make sense of why all of his closest friends look exactly like him. He wonders if he is actually racist. This questioning reflects the emergence of cognitive dissonance, which is the first step in the process of racial socialization. Although uncomfortable, socialization is key to undergoing racial identity development and must occur for the individual to gain a stable sense of racial identity. However, many members of

the majority race do not complete the process of socialization, because of invisible social rules established by the majority that stifle dissonance, or awareness of their role in discrimination against others. Therefore, if John's goal is to help Stan uncover how his childhood, upbringing, and past behavioral patterns relate to the present, John will have to allow himself to do the same to uncover the implicit lessons on race instilled by his parents.

Steps toward long-lasting, effective racial socialization must be multitiered and targeted toward altering knowledge about how racial dynamics affect interactions, skills in addressing dynamics that arise, and attitudes that shape the ability to be open to learning why and how to address unjust racial dynamics [33]. To accomplish a change in attitude, knowledge, and skills directed toward racism, there must first be a redistribution of attention to how the majority group thinks about their own race. This may first require a change in attitudes or acceptance of beliefs they had not previously considered. For example, talking about race openly does not make one a racist [34]. Race should be viewed not as a subject that is "taboo" but, rather, as a meaningful identity characteristic. Also, every race, including the white race, has personal meaning and should be explored by the individual [35]. By accepting the importance of how race influences social dynamics in everyday life, therapists gain increased awareness and thus the potential to gather more data about how racial tension contributes to conflict. As a result, the therapist can develop a more sophisticated understanding of the role of race in interpersonal interactions, and more opportunities to acquire skills to manage conflicts related to race as they occur in treatment [36].

As comfort with the role of race as a psychological mediator increases, so does the ability to freely participate in conversations about race that are often "taboo" in certain circumstances. More conversations lead to increased learning and knowledge about race that can aid in debunking false beliefs, stereotypes, and other inaccurate assumptions that cause barriers to understanding others. Once informed with knowledge about the history of race, and the misuse of race to hurt others, one can start examining one's own responses when an issue related to race is raised [33]. By having a better understanding of how race can be used to oppress others, individuals can intentionally work toward noticing how race impacts their thoughts, feelings, and actions for harm or for good use [36].

Clinical Consideration: Racial Concordance in Therapy

It is worth discussing how Stan's treatment would differ if he were working with a provider who was black or from another racial minority group. Race concordance between the patient and provider is associated with higher rates of patient satisfaction, but the findings do not clearly suggest improved treatment outcomes [34]. For example, it is likely that if Stan happened to seek treatment from a black woman (which is more likely than him seeking

treatment from a black man, given the demographics of mental health providers), there is no guarantee that he would have better treatment outcomes. Racial concordance does not excuse the provider from exploring the patient's ideas of race. In fact, it may be more important to discuss the topic to ensure that the provider and patient do not assume that the other shares a similar perspective or has had a similar experience as a person of color. Additionally, providers of the same race are still expected to think about how race may influence their interaction with the patient. Specifically, internalized racism can be particularly harmful if it is unexamined by the provider or may lead a patient to seek treatment with a therapist from a different racial background [37]. A black therapist could find himself or herself associating Stan with violence or unreliability, as studies have found that black providers may be susceptible to these biases when treating black male patients [38]. Stan could also stir up negative messages of intrinsic worth or capabilities within a black provider, or vice versa [39]. Regardless of the race of the provider, research shows that patients are less satisfied with care when the provider does not bring up cultural issues that the patient feels are important [40]. Therefore, it is safe to assume that racial minority patients typically want to discuss race, so providers of all races should broach this topic in treatment.

Conclusion

The effectiveness of psychotherapy is determined by the ability of the provider to meet the diversity of patient needs, which are often influenced by the surrounding sociopolitical context. Therefore, conflicts present within the larger society may manifest as conflict between the patient and the provider in the clinical encounter. At times, the patient may present with needs that pose internal challenges for the therapist because the two of them have markedly different socializations with respect to race, gender identity, or socioeconomic status. The beginning of this chapter outlined how the severity of inequality in society can lead to significant disparities in access to, quality of, and outcomes of mental health treatment. As a result, mental health providers from majority racial backgrounds can develop a subjective lens that does not overlap with that of racial minority patients. Therefore, it is imperative that therapists proactively educate themselves about current and historical sociopolitical forces governing their society. Additionally, mental health professionals must also examine how their identity, by virtue of external systems of oppression, may present a barrier to the patient's ability to feel safe. A commitment to learning the history that creates social barriers is necessary. For example, consider studying the long-lasting impact of topics such as colonialism, religious persecution, and inequitable distribution of resources by race. It is especially important for therapists to learn the history of groups that differ from their identity. For mental health professionals, not having personal experiences of racism, sexism, ableism, or other forms of discrimination that patients have faced does not excuse from the need to know

about these concepts. Although it is impossible to know the history of oppression for every unique combination of race, gender, and other identities, it is necessary to have a basic awareness of what the therapist's identity may symbolize to the patient in the clinical encounter. The therapist will also be required to conduct ongoing investigation of how one's identity or self-concept influences inner thoughts, feelings, and actions in response to individuals who are different. In the contemporary context in which clinicians now work, it is no longer an option to seek this knowledge; it is a requirement.

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