Psychoanal Cult Soc (2023) 28:476–486
https://doi.org/10.1057/s41282-023-00376-7

Decolonizing my therapeutic identity: Going beyond the surface

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Published online: 29 March 2023
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Abstract In this essay, the author discusses ways people with marginalized identities within training programs may be impacted in their identity development as clinicians of color due to systemic oppression and the history of colonization. The author explores how the lack of literature and representation of non-White individuals in positions of power and the absence of conversations around White supremacy in training programs resulted in the erasure of the trainee's cultural background in building their identity as an early career professional. This erasure of coloniality, culture, and language resulted in invisibility and silencing of the individual, as well as allowed for the dangers of colonial mentality and socialization toward Blackness going unprocessed. The author reckoned with their struggle to incorporate aspects of their own culture into the work and how the absence of acknowledgment of their Latinx identity in predominantly White supervisory spaces created an experience of shame and inferiority that can be politically localized. The reader is invited to feel and experience through the writer's lens the damaging impact of these dynamics, revisit ways in which they withhold their identities from the therapeutic encounter, as well as ways in which they may enact this standard of Whiteness in their therapy and supervision.

Keywords training · race · clinicians of color · immigration · colonial mentality · White supremacy · postcolonial stress disorder

Note A version of this essay was presented at the Division 39 Society for Psychoanalysis and Psychoanalytic Psychology 2022 Spring Conference.

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Introduction

Coloniality and race in the United States has been spoken about in terms of domination, power, and privilege (Leary, 2000) over territory, resources, and behaviors of other people, who are left deprived, rejected, and powerless (Báez, 2018; Comas-Díaz, 2021; Leary, 2000). Among the many definitions of race in relation to society, Dorothy Holmes (2016) depicts how it is a "constraining social regulator … of how one is devalued in general, of how high one can aim, or of how our bodies and sexuality in particular are denigrated … [and where] at any time one can be reminded of the socially imposed limitation based on race" (p. 571). Therefore, race creates a perpetual wariness of being, for a lack of a better phrase, put in your place, as well as intense guilt for any behaviors deemed outside of these socially stated limits (Báez, 2018; Chapman, 2006). Imperialism and cultural imperialism enforce what these limits are and expose Eurocentric values as desirable while denoting people of color's physicality, collectivistic values, history, and culture as undesirable (Comas-Díaz, 2021). Holmes's research on the development of racial bias in children highlights how this becomes internalized in White and Black children (Báez, 2018; Holmes, 2016). Frantz Fanon (1952/2008) had quite a gift for voicing the internal processes of being from a colonized land, addressing the complexity of love and hate evoked in colonized people toward themselves in relation to Whiteness and the sense of inferiority that develops within colonized, oppressed individuals. He termed the process of approximating Whiteness "lactification" (Fanon, 1952/2008, p. ix), and, in his writings, he depicted the development of internalized racism within the individual and how this internalization can manifest itself as anxiety and fear of being seen as *other* regardless of already being racially *other*. He speaks to colonized people being raised within the racist cultural assumptions of the colonial system and the survival drive to want to align with Whiteness. The closer to Whiteness, "the closer [a person] comes to becoming a true human being" (Fanon, 1952/2008, p. 2).

Lillian Comas-Díaz (2021) adds to this understanding in her work bringing to light the degree of harm, terrorism, and postcolonial effects upon the survivors of colonialism. Comas-Díaz (2021) gives voice to the historical and generational trauma in what she refers to as *soul wounds* and the ways in which colonial mentality and the legacy of colonialism continue to promote "discrimination based on the intersection of race, class, gender, and sexuality; one that affords power to privileged White groups over disenfranchised racial minority groups" (p. 66). Cultural imperialism and racism have themselves been described as instruments of terrorism due to the levels of traumatization and its detrimental ramifications at the individual and collective levels of a person's identity (Comas-Díaz, 2000). Among many things, cultural imperialism, racism, and internalized racism can lead to conflicts in identities, fragmentation in communities, assimilation, alienation, deep emotional and psychic wounds, such as depression, shame, post-traumatic and post-colonization stress disorders, and somatic and physiological harm (Comas-Díaz, 2000). These are some of the lived experiences I hope to depict throughout this paper in addressing the retraumatization that can occur in clinical training when

White supremacy is not being challenged and colonial and imperialistic trauma is being re-enacted.[1]

As I undertake this disruption of visibility and invisibility through the lens of colonization and the ongoing loss and trauma, I want to acknowledge writing this essay from settler occupied Manahoac land and the continued trauma of Indigenous lives in the United States and across the world. Invisibility is a process that can be explored across many avenues and can afford me an area of privilege in the form of protection when allowed to align with Whiteness. In this way, this paper explores a different extent of erasure, silencing, and invisibility than to Indigenous folk and this acknowledgement serves as an extension to the aim of disruption of settler colonialism.

Racism and Internalized Racism Within Training

Colonial mentality, internalized racism, and feelings of shame, inferiority, and guilt can often lead to perpetuating racism, cultural racism, and anti-Blackness. Some of these signs include disliking features of physical appearance, upholding White European beauty ideals, preferring light skin individuals as romantic partners, suffering from imposter syndrome, and potentially perpetuating racist and xenophobic ideas within your own communities, among other things (Comas-Díaz, 2021). Given these impacts, coloniality, racism, and internalized racism are imperative to hold in mind while in training given how these dynamics impact the development of minority therapists stepping into a role that holds power.[2] Rene Chapman (2006) provides a lens from within when reporting on the difficulty and shame associated with stepping into a position of power in becoming a therapist, and how "part of the power of racism that becomes internalized lies in the acceptance of the 'I am something wrong' identity" that creates these feelings of shame and guilt (p. 221). In internalizing the messages of *I am something wrong*, we begin to glimpse at the depth of shame, pain, and guilt that holding positions of power, such as being a therapist, a supervisor, or enrolling in a graduate program, can evoke in non-White individuals (Báez, 2018). In turn, minority-identified clinicians may also be left to enact and re-enact their own internalized racism and *soul wounds* in their position of power as therapists within the therapeutic dyad, a potential parallel process from their supervisory and training spaces as well as their own socialization (Báez, 2018).

[1] White supremacy as defined by Frances Lee Ansley (1997) is "a political, economic and cultural system in which Whites overwhelmingly control power and material resources, conscious and unconscious ideas of White superiority and entitlement are widespread, and relations of White dominance and non-White subordination are daily re-enacted across a broad array of institutions and social settings" (p. 592). In this paper, it is in reference to institutionalized White supremacy that, consciously or unconsciously, reinforces Whiteness as an ideal or default standard in education, literature, and evaluations, standards of professionalism, unspoken privilege across identity statuses and unaddressed policies and practices rooted in White normative standards, and denigration of otherness.

[2] There is intentional use of the word "minority" to distinguish a lack of representation of an identity group rather than the problematic overuse of the word minority to depict inferiority.

Historically, conversations about race in training have been impaired due to traditional psychoanalytic attitudes towards race (Leary, 2012) and a profession that has overwhelmingly been composed of White folk of higher socioeconomic status hindering further discourse and teachings (Báez, 2018; Leary, 2012). Comas-Díaz (2021) references the term *coloniality of knowledge* in describing how the colonizer uses "a false authority of knowledge to suppress and or disqualify the colonized's knowledge … aiming to silence the colonized's wisdom" (p. 66) and culture. In my experience as trainee, teacher, and supervisor, much of the studied literature comes from White authors with limited access to research and writings from people of color, and the training surrounding race takes the approach of a majority trainee learning how to have conversations about race with a client of marginalized identity, and seldom (if at all) addresses the minority's therapist's experience or work with a White privileged client. There are other challenges in addressing race in therapy and supervision due to the overall experience of race in culture and society, and its impact at the individual level (Báez, 2018). It may be useful to understand how minority countertransference signals a level of anxiety and fear in the therapist or supervisee given the *soul wounds* (Comas-Díaz, 2000) that may be carried and how racialized therapists are socialized to overidentify with an oppressed status rather than explore it (Báez, 2018; Holmes, 1992). Without a shift in the ways psychoanalytic theory and race is taught institutionally and when addressing race and culture in supervision and training (Holmes, 2016), minority clinicians are left to internalize and potentially act out the ensuing sense of incompetence, unsafety, helplessness, and inexperience that might arise in the supervision and their beginning clinical work, as well as potentially become alienated from their own sources of empowerment (Báez, 2018).

The Writer's Own Reckoning

Across my identities, there are multiple layers of visibility and invisibility, and I have struggled with some of my visible identities since the realization of being gazed at as *other*. Being *other* has impacted my sense of belonging, safety, worth, and connection particularly with being a queer female light-skinned Latina of Afro-Latinx descent from a colonized Caribbean country that holds collectivistic ideals, and that has lived in varying points of socioeconomic and ability status. Additionally, as a clinician with multiple marginalized identities, there are many aspects of who I am that may be used to perceive me as incompetent, lazy, unprofessional, aggressive, and unboundaried. These are projected aspects that comprised my training experience and which I continued to internalize throughout my career. Still, the privilege and downfall of being a light-skin Latina is that the White gaze has the power to decide when you are *other* and when you are just similar enough to Whiteness to not be aggressed upon, in so erasing the history and nuances of who you are—some privilege at the price of erasure. In training and supervision much of what was invisible were my cultural experience and expression that were often not allowed to enter the room because of negative projections and lack of safety. I felt the silence of my identities, culture, language, immigration,

political trauma, and history of colonization and imperialism, and felt unsupported in my experiences, ultimately diminishing my voice. Supervisory spaces did not know the impact of being in a predominantly White institution with these identities and cultural history and their involvement in cultural imperialism, *coloniality of knowledge*, and resulting colonial retraumatization. I would like to use my experiences and development to showcase the negative impacts of these dynamics.

The Dominican Republic, of course, has its own history, with colonization, slavery, colorism, anti-Blackness, and its fight for freedom. After the arrival of Columbus in 1492, the Dominican Republic became the first European colony established in the Americas by the Spaniards, and, "(along with the other half of the island, now Haiti), the island became the first unique racial space in the Americas where Black, White, and Indigenous People met" (Adames & Chaves-Dueñas, 2018, p. 95). A known story across colonized communities, the colonizing Spaniards enslaved and massacred the Taínos and other Indigenous populations on the island, brought disease, and established an "immoral sense of racial superiority and greed" (Adames & Chaves-Dueñas, 2018, p. 97), with a caste system based on skin color and phenotypical characteristics of White, mixed-children, dwindling Indigenous folk, and enslaved Africans. After acquiring independence from Spain, the Dominican Republic had a second revolution for independence from Haiti's domination, which propagated further advancement of anti-Black rhetoric and practices in defense of trauma and freedom, and has prevailed through two invasions and occupation from the United States in its imperialistic actions to reap natural resources, and control political actions, outcomes, and the armed forces. The United States has deeply impacted the island's politics, economy, history, and immigration patterns to the United States and parts of Europe, and reinforced White supremacist ideals (Adames & Chaves-Dueñas, 2018).

My experience of growing up in the Dominican Republic is awash with many examples of this history and the legacy of coloniality and occupation. I have been taught many ways to align with Whiteness and have tried to survive Whiteness with the fantasy of blending just enough by, for example, attempting to erase my accent, adopting understated clothes and expression, straightening my hair, the use of various beauty products with an emphasis on hair products and perfume, among other things—a representation of Fanon's (1952/2008) *lactification,* in defense against my own anxiety to be perceived as *other*. Whiteness is linked to beauty ideals, education, intelligence, and wealth, as Comas-Díaz (2021) references, so it is not a shock that my community's wish would be to offer protection in the practices taught to children—ways to hide while holding on to your cultural pride, resilient spirit, and joy-inducing music with our merengue and bachata—all while seeking immigration to the United States. Ergo seeking education from "the better educated," and pressure to marry White or light-skinned individuals in search of lightening the racial composition and phenotypes with cultural statements, among many others, about "*Tienes el negro detrás de la oreja*," "*Mejora la raza,*" and gushing at light-skinned children—acting reminders of White supremacist ideals in our history and the African composition of the island. For me, a direct recognition of the fifth generation African slave I descend from. In our history books, Camateta, as she was called, is romanticized and her enslavement and sexual abuse cloaked in

words about her beauty. *Hermosisima*, the history books say, to condone the sexual abuse and her body and womb being used to bear children for her slave owner whose wife struggled with issues of fertility, with her *mulatto* children sent to Europe by their father to obtain sociopolitical status and education (Báez Guerrero, 2015). My parents originally introduced this part of our history to us children as we are descendents of an African princess, potentially to shield us and themselves from our history; however, what could be more loving and empowering than knowing your truth and where you come from?

My mom and I had a song that we used to dance and belt out the lyrics to. The chorus was about something coming for you and running towards your mother, which made it exciting to dance to when being folded into the arms of your mama. With age, it is no longer lost on me as it was then, that what I am running away from *es el negro*, *el Africano*, the black man; this song later turned into an advertisement about improving hair texture. This escapism is not dissimilar to our history that as a people we try to escape from rather than give voice to the collective colonial trauma and truly acknowledge the mixture of *negro, blanco y Taino*, Spanish, Indigenous, and African composition of Latinxs and the deep psychic wounds of White supremacy. Now, looking back, I realize how culturally things were structured by anti-Blackness and, in these moments, I was being socialized into a particular relationality towards Blackness, including my own. This history and experiences significantly impacted my arrival in the United States in my late teens, where I joined my teachers and peers in this fantasy of becoming "better" by assimilating, becoming culturally invisible, getting swept away by the illusion of the American Dream, and the pressure from those here and back home to be grateful that I had finally made it to the supposed golden land, where (some true and some misperceived) personal (e.g., same-sex marriage, education) and financial opportunities abound.[3] It is easy to fall into the spiked pit when so cunningly being drawn in or as Comas-Díaz (2000) aptly notes, in drawing on the work of Edward Said, "people of color are often exposed to imperialism and intellectual domination at the expense of their cultural values" (p. 1320).

Regardless of my efforts to not seem too different, I learned early upon arriving in the United States and later in my first three years of clinical training that I was perceived as unboundaried, angry, aggressive, loud, and judgmental. I was told throughout my training that these aspects of myself could interfere with my ability to be a clinician—unfounded comments given the objective, positive feedback in my work with clients, professional roles within the program, close relationships with faculty, and achieving high honors in our comprehensive test. These messages, verbal or enacted, still managed to insidiously arise. At a visceral level, I felt that the underlying communication was to censor the qualities that made me who I am and that the task of supervision was learning how to work from an entirely White perspective, as referenced in Comas-Díaz's (2021) account of *coloniality of knowledge*. When providing feedback to White supervisors, it became an us-and-

[3] Dominicans who have immigrated to the United States experience a myriad of struggles rooted in systemic oppression, and studies have found that the percentage of Dominicans experiencing poverty is higher than that in the general population or other Latinx groups in the United States, in line with lower rates of homeownership and poor rates of health-insured individuals (Adames & Chavez-Dueñas, 2018).

them mentality, maybe more accurate them-and-me mentality, where I was then categorized as the enemy and targeted. I was made to feel shame for not just feeling grateful and had more than one supervisor outright express I should simply be grateful to be able to obtain this education and be part of this field because of my immigrant identity. As a field, we are beginning to understand that discussing race in therapy and supervision is important. And yet, the question remains about who would want to, or feel safe enough to be vulnerable around these experiences, when it makes you more liable to be thought of as incompetent and not belonging?

Over the four years of graduate school, I had over 20 supervisors and only one of them was a supervisor of color—one. She was a Black woman while I externed at an HBCU (historically black colleges and universities) college counseling center. When the opportunity finally came to work with her, I struggled to take in her teachings and care. It felt like I had to go against what I had already been taught and internalized. Week after week I would go into her office expecting negative feedback about my professionalism and clinical work—feedback that never came. I remember being angry and dismissive of her because of her encouragement to be myself and use myself as a therapeutic tool in sessions. She was so different from my experiences in my program and other supervisory spaces that communicated in one way or another a standard of Whiteness. A standard that was deemed to be the path of success and was for me a direct path to being unsuccessful, lacking confidence, feeling inauthentic, depleted, and wanting to quit. What a parallel process that I subsequently deemed her incompetent and not conducting supervision in the "right" way, in other words, the White way. I was gripped tightly within my own ancestors and colonial mentality, and looking back, I was also scared and confused because I did not know what being myself in the context of being a therapist meant when I was made to feel that was dangerous—me fully being me in the professional role of a therapist was scary and dangerous. I saw this mistrust reflected to me by White clients, which made it easy to internalize what I was already experiencing within my program. Most poignantly, I also experienced clients' internalized systemic oppression; in one instance by a light-skinned Hispanic woman (her warm light skin reflected my own) who arrived for a transfer session with me: upon looking at me, she mistook me for the secretary of the clinic and demanded a White male supervisor be present during the session, expressing that she did not trust my competence in being a therapist, and no attempts at building a therapeutic relationship were successful. This client was transferred to a White, male clinician without her own or the clinic's exploration of internalized systemic dynamics. It is also necessary to wonder how many clients were subjected to my own imposition of a White standard of therapy as the "right way" while I battled my own colonial mentality that was also being reinforced by practices embedded in White supremacy in training.

I spent much of my time in graduate school considering whether to withdraw from my program or continue making space to be authentic and accepted for what I knew I could offer. In tandem, I spent time in my own therapy trying to answer the question of what wrongness lay within me that I continued to be experienced as aggressive, unboundaried, and taking up "too much space." During this time, I listened to a podcast about joy and an Ethiopian-American musician, Meklit

Hadero, spoke about language and how the melodies and inflections of our native tongues bring us joy (Raz, 2018). It was very difficult to speak Spanish in my training spaces and even transitioning into a Spanish session was, and can sometimes still be, so fraught for me because I feel lesser speaking Spanish in these "educated" spaces, and yet anyone who sees me speak Spanish out of my professional environments immediately experiences me full of joy, laughter, loudness, energy, and excitement; this is an incredibly muted part of myself in this field. It is painful to limit my joy and to be asked aggressively and relentlessly to speak English and to be someone different. My time in graduate school looked like being exhausted from speaking English to the extent that I would become silent and tell friends and my partner I would not be speaking for the remainder of the day. I learned the unmistakable impact of living in an individualistic community and overworking, as well as the depth of the psychic and physical tolls that came with this. I considered what it would look like to return to the Dominican Republic, *a mi gente*, and was challenged with the reality of anti-queerness, heteronormativity, and machismo in our culture. Still, what I was seeking was solace.

Self-Depiction of Postcolonial Stress Disorder in a Trainee

When we speak about trauma and stress, or potentially post-traumatic stress and postcolonial stress disorders, we talk about how it also shows up in the body. Just to highlight what this pain looked like in my body, in the span of those first three years of clinical training, I was in the emergency room over five times with the worst flare-ups I have ever experienced to date of my autoimmune and gastrointestinal disorders. There were days I could not walk and therefore could not commute to training sites without additional expenditure on rideshares. There were days the act of sitting with patients was intolerable because of the pain in my hips, back, and legs. Some days, I was absent from some classes or externship sites, and was absolutely petrified about the repercussions that would come my way. Other days I could not shower by myself, and my partner had to supervise or shower me. At times I would get locked into physical positions and would have to have my partner or friends move and massage my limbs for me. I was exhausted, in pain, and depleted. In recent years, I was diagnosed with cancer and one of my doctors asked me if I thought it could be stress related. I did not have an answer for him, but this might be directly what we mean when we speak of postcolonial stress—a malignant tumor of self-doubt, feelings of inferiority, lack of belonging, and intense physical ramifications.

The emotional toll was also seen in the numerous breakdowns I experienced at the surprise of graduating; the mourning of how internalized oppressive systems so highly affected my view of myself, my confidence, and permeated every moment of life while being a trainee and in the United States; and in the relief of the last several years in finding my voice and authority to allow myself to be who I am and shed the standard of Whiteness that was such a major part of my higher education and of just existing in the United States. I spent much of my training trying to adopt this White cloak that I lost myself and only through distance could I really integrate all aspects

of myself rather than continuing to be fragmented and split off from my experiences and knowledge, my loving and humorous sides, my community and history, and so on. This is an experience that I have heard reflected to me from many peers, supervisees, and colleagues across training programs.

Years later though, I find that this one BIPOC supervisor's teachings laid the groundwork for who I am as a therapist now, and I began to seek out mentors who could help me heal and challenge my own colonial mentality. I spent so much time, energy, resources, and emotional labor trying to understand the projected messages imposed upon me and questioning myself as a therapist. And yet, this is how marginalized folk exist in the world, absorbing and processing a myriad of negative projections and aggressions because that is what we are socialized to do. It has taken me years and continuous reality testing about projections from my mentor to begin shaping a realistic impression of myself as a professional. It has also taken having to hear from my beloved mentor, "You're not White," and continuously challenge my colonial mentality to begin shedding the fear of existing in my identities as a person and therapist within an imperialist, capitalist, patriarchy embedded in White supremacy. Being empowered to trust myself allows me to take care of myself and be present in ways that were completely inaccessible before and this has transformed how I connect with clients now. My offices have since been decorated with bilingual artwork, and there have been countless clients who have cried simply, but maybe not simply, upon seeing this and expressed being empowered through this loving, cultural embrace. This journey of decolonization has also been a journey of building awareness and critical consciousness toward personal and collective liberation. In not healing this colonial trauma and shedding White supremacist ideals, we leave the door open to continue harming our Afro-Latinx siblings and to continue perpetuating anti-Blackness within our communities and the therapeutic spaces.

Discussion

There is much more that could be expanded on and explored than may be viable in this essay, however, I hope in highlighting some of these experiences we can acknowledge that the socialization and generational trauma of colonization, post-colonization, settler colonialism, racism, the role of colorism, imperialism, and internalized racism are integral to minority clinicians and their professional development and as such need to actively become a part of the discourse. I urge doctoral programs to be aware and speak to the imbalances that occur within their structure as they may be carried into the therapeutic and supervisory room by their trainees and that may lead to trainees questioning their place in higher education and questioning their abilities even more than is warranted for a therapist in training (Báez, 2018). To provide supervision that does not recognize the role of colorism and how the difference in culture can impact what therapy looks like, implies supervision that is enacting a standard of Whiteness, enacting cultural imperialism, and creating a retraumatization of colonization. The skill here then for a minority clinician is to learn the new standard of how to survive in this setting

versus actually learning the skills needed to themselves practice effective and rewarding psychotherapy in their career. Professionals involved in all levels of training need to develop critical consciousness to not retraumatize or cause harm as is ethically demanded of our profession. I hoped to highlight the short- and long-term effects of the retraumatization that can occur when training programs are not moving towards an anti-racist and Black-empowering community. Harm in our training communities can look many different ways and can lead to a shift from the excitement of accomplishing this major goal of entering a graduate program into a dissociative, fragmented state of "I just have to get this done"—a statement I am familiar with and have heard many times before amongst non-White students. Some questions to consider are ways in which cultural imperialism, anti-Blackness, and neocolonialism are infused into your community and curriculum? As a community, are you allowing for Latinx, Black, Afro-Latinx, or other cultures' psychology to exist in the room? How are you encouraging minority students to connect to their sources of empowerment? As professors, supervisors, and mentors I urge you to explore ways you add to this sense of not belonging and to be curious of the trainee and how they express care, empathy, joy, and whom they want to become as clinicians. This sense of agency could allow students to bring in aspects of their culture: collectivism; views of authority, gender, and other identities; experiences of imperialism, political trauma, immigration, and being othered; and internalized projections of these identities and senses of professionalism.

Decolonization and liberation in training programs must go beyond the surface of advocacy and accepting students of a wider range of identities; we cannot continue to invite students with oppressed identities into training and then not offer an opportunity to succeed. It is time to challenge this and examine how programs are actively working towards an anti-racist stance that will not be culturally imperialistic, allowing students to fully bring themselves into these spaces and to learn to practice in ways that align with their world view. To dismantle coloniality, we need decolonial, Black-affirming healing at the individual and collective levels, and to reject Western ideals imposed on non-White folk particularly in our field and in our research and practice. Only through acknowledgment of the history of harm and our own perpetuation of harm in anti-Blackness can we begin to repair, heal, and decolonize our communities. Healing is a community endeavor and erasure cannot continue to be the price of admission.

Author statement The corresponding author states that there is no conflict of interest.

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Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

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