Renowned spiritual teacher, Vimila Thakar, describes the nature of karma: "I am a result of the karma of my parents, the society in which they live, the racial product. In modern psychology, you might call it the product of conditioning, collective conditioning: the parents, community, race, religion, society and so on. . .If I get acquainted with the nature of my conditioning, then it doesn't bind me. If I can see the prejudices and preferences, the norms and criteria, then I become aware of how they can interfere with my perceptions and responses. . .If that is not done, then obviously the karma or the conditionings go on determining the perceptions and responses and can lead to such misery and suffering."1

Understanding the nature of conditioning and personal history is essential to understanding the nature of the therapeutic encounter. In an informed encounter, therapists are aware of their conditioning and how it may distort their lives, work, perceptions of clients who are different from them, and the power dynamics of the therapeutic relationship. By attempting to move beyond conditioning and societal privilege, therapists can assist clients in understanding the effects of their own conditioning on their lives and the role of outside influences on internal processes.

**Inherent Imbalance**

The therapeutic relationship is inherently unbalanced in terms of power. Clients invest therapists with power and in a functional therapeutic relationship, therapists use their privilege and power to help clients empower themselves. But this imbalance can threaten therapy particularly when societal power dynamics become more prominent, as in the case of a White therapist working with a Latino client, a heterosexual therapist working with a gay client, or a seronegative therapist working with a seropositive client. This is particularly true when power differences are not acknowledged and when therapists misuse power and privilege.

Without attention to power dynamics in such encounters, the profound effects of marginalization by the dominant culture are overlooked and therapy may be skewed. In such cases, a therapist who attributes a client's internalized oppression and lack of self-esteem to deeply rooted personal issues alone may contribute to that client's further alienation: in reality, the effects of societal power relationships can be as significant a cause of psychological distress as family relationship dynamics and traumas. Failure to acknowledge these factors may lead a therapist, however unknowingly, to devalue a client and his or her experiences.

As sociologist Elaine Pinderhughes explains, the appropriate power imbalance can degenerate into an exploitative one when practitioners who are members of a society's dominate culture engage in practices that promote the aggrandizement of the practitioner, thus devaluing a client's own values and perceptions.2 To avoid this situation and to be an effective healer, it is important for counselors to carefully examine the power dynamics in the client-therapist relationship and the internalized oppressive tendencies that they may bring to encounters with clients.

Jann Van Mens-Verhulst questions traditional therapeutic practice and the image of therapists as "outside the therapeutic process, observing clients, and looking for possibilities to intervene."3 Van Mens-Verhulst says that therapists are in fact "part of the therapeutic process," but they are able to stand temporarily outside the process and reflect upon the possibilities for shifts in the therapeutic relationship.
Editorial: Seeing Beyond the Familiar
Robert Marks, Editor

White privilege is invisible. . . to White people. It’s like a pair of contact lenses—undetectable when you are wearing them, all too apparent when you are frantically searching for one that’s popped out. Without them, the world looks very different.

You can’t buy these lenses. As Karla Boyd demonstrates in this issue of FOCUS, they are manufactured by personal history and societal conditioning. Giving them up is tantamount to giving up your eyes—or at least the comforting vision of a familiar world.

As do contact lenses, White privilege filters experience and determines perception before the mind consciously interprets the meaning of events. It is this pre-perception that makes White privilege so difficult to identify and approach.

There are plenty of moral reasons for learning to see without the “correction” of White privilege, but for counselors the imperatives are also professional. As Francie Kendall asserts in the second article in this issue, to be an effective therapist is to embrace a stance of “not knowing”; the more deeply experienced this stance, the more open a counselor can be to his or her clients’ experiences.

The process of acknowledging White privilege and its effects is not about giving up clear vision. It’s about accepting a different way of seeing. It is not easy, not like getting a new prescription—more akin to the exacting regimen of eye exercises that have freed some people from corrective lenses after years of wearing thick glasses.

It is about, in Kendall’s words, “staying at the table” even when the conversation becomes unbearable—for both parties. The payoff for perseverance is immense: a glimpse of reality beyond the familiar.

Changes that offer clients opportunities to transcend social circumstances and experience psychic and social emancipation.

The Case of Linda

The case of Linda may not be typical, but it offers a good record of the journey therapists must travel to recognize the mark history may leave on therapeutic practice. Linda is a 35-year-old White Anglo-Saxon psychologist. Raised in New York and educated at Yale University, she had lived most of her life in middle-class comfort, ill-prepared when first Sylvia and later Manuel entered her practice. Linda’s father was a judge in a large Northeastern state; her mother was active in the Junior League. Linda remembered little warmth in the family especially after her five-year-old sister Emily died when Linda was nine.

When Linda’s husband, Ross, an anthropologist, accepted a research position at a California university, Linda reluctantly closed her Boston practice. But, sensing that something was missing in her life, she hoped that moving would breathe new life into her marriage and her job. When Linda began work with Sylvia, however, both women were uncomfortable. Sylvia attributed her discomfort to beginning therapy after a hiatus of four years. Linda was unclear about her anxiety, but noticed her own disinclination to pursue Sylvia’s references to “Seders,” the “high holidays,” the Kabbala, and even the Jewish film festival.

Sylvia had been depressed for many years but had managed by closing her eyes to her pain. Linda focused on Sylvia’s relationship with her mother, missing several opportunities to learn about Sylvia’s cultural background despite indications that it might be relevant to Sylvia’s depression. Nonetheless, Linda reluctantly learned that Sylvia’s father’s parents escaped Germany during World War II, eventually ending up in Maryland. Her father was raised not to inquire about his Jewish heritage. His mother converted to Christianity and he, too, became a Christian.

Applying some briefly learned psycho-synthesis techniques, Linda facilitated Sylvia in a few guided imagery sessions. But even when Sylvia described her depression as a long corridor with shower heads, Linda failed to encourage Sylvia to pursue her exploration of the image or its meaning.

A year into the therapy, as Sylvia’s depression worsened, she spent a weekend with a group of women co-workers. Sylvia returned from her weekend with her eyes open to a possible source of her depression. Three of the women in the group had recognized the image of the German gas chambers in her guided imagery. Unfortunately, Linda met Sylvia’s revelation with disinterest and lack of understanding. Words like “holocaust” seemed vague and abstract to Linda and because Sylvia exhibited no feeling in sharing her insights, Linda dismissed the epiphany as irrelevant to their work.

With the support of her new friends and a counseling group she discovered, Sylvia finally had the courage to move on, chiding Linda for treating the reality of her Judaism much as her father did in her youth.
Power Relations in Psychotherapy

Mental health professionals should acknowledge and actively confront the environmental and external forces that contribute to feelings of powerlessness in patients. According to this essay, the normal power imbalance of a therapeutic relationship can help socially or economically disadvantaged patients by modeling the capacity to form alliances and relationships in their own lives.

Emotional disturbances can stem from different types of power inequalities: “interindividual inequalities” such as domestic abuse or oppressive societal forces such as poverty or tyranny. Power imbalances may also occur between people and the chemical substances they use, and self-help groups focusing on drug abuse are effective precisely because they recognize the powerlessness of the individual. People may also experience helplessness in response to the demands of reality, and mentally ill patients can be especially vulnerable to emotional outbursts in the face of the frustration this may cause.

The hierarchical structure of the therapeutic relationship reinforces the experience of inequality and helplessness that some clients experience in their own lives. When therapists do not acknowledge the realities of unequal power—ranging from the imbalance of knowledge and skill to the organization of treatment around the therapist’s schedule—they are in danger of repeating and reinforcing their clients’ feelings of helplessness and disadvantage.

An exaggerated focus on the sexualization of the therapist-patient relationship leads many therapists to shy away from simple contact and natural interactions. As a result, people have been “slow to discover the potential range and therapeutic power of non-eroticized, supportive, and warm treatment relationships.”

Recent Reports

Power Relations in Psychotherapy

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Psychotherapists can help empower clients by shaping the therapeutic conversation to explore, identify, and validate powerlessness both in the treatment relationship and in the client’s personal experiences. Through this process, a natural caring and giving relationship emerges that models for the client the capacity to give and receive love, advocate for self and others, and forge new relationships.

Black Faculty and White Students

An evaluation of the literature regarding cross-cultural pedagogy found that the degree of “racial identity development” by White students in counselor preparation programs is likely to affect their relationship with African-American teachers. White students who are entrenched in constricted world views are unlikely to have a positive learning experience with African-American teachers, because this limitation skews the normal power imbalance that favors the teacher.

Racial identity development is a continuum of feelings and reactions of White Americans to African Americans that ranges from “preexposure/precontact” to “prominority/antiracism.” Since many White students will go on to work with African-American clients, the nature of their contact with African-American faculty in counseling programs may be critical to their development of racial identity.

Traditional counseling approaches reflect White middle-class American norms. Cultural values such as openness, one-on-one discussions about intimacy, monolingual orientation, distinctions in physical and mental well-being, and cause-effect relationships influence and shape the expectations of White students who have been socialized by White faculty. White students, particularly those in the early stages of racial identity development, may regard African-American faculty who use non-traditional teaching techniques, communicate in a dialect, or organize their material to reflect different emphases as ineffective or inadequate.

A Continuum of Cross-Cultural Counseling
Ho DYF. Internalized culture, culturocentrism, and transcendence. *The Counseling Psychologist*. 1995; 23(1): 4-24. (University of Hong Kong.)

Euro-American counselors may compromise their relationships with minority
Clearinghouse: Power and Privilege

References


Pinderhughes E. Understanding Race, Ethnicity, and Power: The Key to...
One of the by-products of being White in the United States is the sense, however conscious, of being central to all processes and interactions. Often without being aware, we speak or act in ways that let everyone around us know who is in charge. We frame every conversation from our group’s frame of reference and then ask people of color to interact within those parameters.

This response, however natural and understandable it may be in places where White is synonymous with “normal,” has a variety of pernicious outcomes. In HIV-related counseling and educational settings, the most significant and insidious effect is the silencing of people from other cultures, people for whom this frame of reference is not the norm.

The Racial Dynamic

The concepts of White privilege and the silenced dialogue are complicated and loaded. In order to help readers get beyond the potential defensiveness that may arise, here are the bases for my thoughts:

• All of us who are White are not only individuals but also are part of a racial group.
• In the United States, this group runs all the major institutions and makes decisions that affect everyone’s lives.
• As individuals, White people benefit from our group’s position of power whether we want to or not. For those who have privileges based on factors like race, gender, class, physical ability, sexual orientation, or age, privilege just is. While privilege is hard to see for those born with access to power, it is very visible for those who were not. Further, since many White people do not feel “privileged,” it is difficult to talk about power imbalances.
• White privilege has absolutely nothing to do with whether or not we are “good” people. Privileges are bestowed on us by the institutions with which we interact solely because of our skin color, not because we are deserving as individuals.

The Silenced Dialogue

I addressed a meeting of White women and women of color called together to develop strategies for addressing social justice issues. As I, a White woman, spoke about what is required for women to work together authentically, many of the other White women became nervous and resistant. Why is race always such an issue for women of color? What did I mean when I said it was essential for White women to be conscious of how being White affects every hour of our lives, just as race affects women of color. They were all professionals: why did it matter what color they were?

These questions silenced the dialogue and made it impossible to communicate not only about racism, but also about the realities of each others lives: the White women didn’t see the race of all the women in the room as an issue. It did not occur to them that their daily experience was particularly different from that of their colleagues who were African Americans, Latinas, and Asian Americans. Had I not been asked to raise the issue, the responsibility of doing so would have been left to the women of color.

Being White allows me to decide whether I am going to listen or hear or do neither. As a member of what Lisa Delpit calls “the culture of power,” I silence others without...
intending to or even being aware of it. For example, another White woman and I were organizing a conference on racism. During the first planning meeting, I talked about my 25-year history of working on issues of racism, particularly about my own work on what it means to be White and Southern. I then presented the plan my friend and I had developed. At our second meeting, the women of color on the planning committee pointed out that I had fallen into the classic trap of White women: the come-be-part-of-what-we’re-doing syndrome. They said: “Creating this conference means building a plan together. If you want us to enter the planning process in the middle and add our ideas to yours, we’re not interested.”

Delpit wrote about the silenced dialogue in a 1988 article. She recounts the profoundly disturbing comments of an African-American teacher that illustrate how we silence dialogue without awareness or intention. “When you’re talking to White people, they still want it to be their way. You can try to talk to them and give them examples, but they’re so headstrong, they think they know what’s best for everybody, for everybody’s children... White folks are going to do what they want to do anyway. It’s really hard. They just don’t listen well. No, they listen, but they don’t hear.”

Delpit goes on to say that these feelings represent those of the vast number of people of color and that the “saddest element” is that White people “are seldom aware that the dialogue has been silenced. Most likely, the White educators believe that their colleagues of color did, in the end, agree with their logic. After all, they stopped disagreeing, didn’t they?”

Maintaining the Dialogue

For those of us who are White, and are also women, have AIDS, work with people who do, or are gay or lesbian, the experience of being excluded from the mainstream may blind us to the fact that we still benefit from our skin color and that we silence people of color. It becomes easy to perform a psychological sleight of hand, removing ourselves from the “White” group, which we see as composed either of demonically racist people who spout epithets or of White, straight, healthy males. By seeing oneself as removed from the privileged group, we are all the more blind to our silencing of people of color.

So, what can those of us who are White do to ensure that we do not, advertently or inadvertently, silence someone with whom we are working? First, begin (or continue) to examine how Whiteness affects perceptions, experiences, and behaviors. Second, make a contract with co-workers, both White and of color, to give honest feedback about communication style.

Third, design intentional and ongoing opportunities to examine institutional racism and its effects on behavior and relationships. Also, explore the intersections of racism, sexism, anti-Semitism, and heterosexism. Fourth, inquire and listen. As White people, what we need to do more often is ask appropriate questions at the right time and then really listen to the answers, rather than make assumptions while people are talking.

Finally, remember that recognizing and countering White privilege is a life-long process. All of us will make mistakes as we work to communicate across lines of difference. The important thing is to acknowledge and learn from our mistakes. The most important thing is to stay in dialogue about race even when we are uncomfortable. The motivation for “staying at the table,” as Cornel West says, is the opportunity for authentic relationships with all people—those whose skin color is different from ours and those who are of the same race.

For counselors and educators doing HIV-related work, this dialogue should be natural: it bears a strong resemblance to the therapeutic process itself, coming from a place of “not-knowing.” The role of the therapist working with a client or an educator developing an intervention is to present his or her ignorance, to seek to become informed by the knowledge and perspective of his or her client or target group. “Staying at the table” may be difficult when we are challenged by our colleagues of color, but as counselors and educators, it is essential for us to constantly examine our own biases and assumptions in order to strengthen our relationships and our communication.

References


Authors

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Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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UCSF AIDS Health Project, Box 0884
San Francisco, CA 94143-0884
Bewildered but determined to broaden her practice, Linda signed up for clients at a local clinic. If she had been unprepared to work with Sylvia, she was completely perplexed by Manuel. Manuel had lived in the United States for six years, having left Brazil because life there was dangerous for gay men. He had been a doctor, but without a U.S. license, he was now forced to wait tables. Richard, his life partner, was also a physician; both men were seropositive and both kept secret their sexual orientation and health status.

Linda could not help herself; she felt uneasy around Manuel. His dark skin was foreign to her experience and his HIV infection connoted to Linda a lifetime of promiscuity that she subconsciously judged as immoral. As with Sylvia, Linda's initial sessions ignored Manuel's cultural, class, and health issues as she attempted to fit his life into her orderly view of the world. Manuel cried about the loss of his family. In Brazil they were always close, and Manuel was puzzled and saddened to learn about how many of his U.S.-born gay friends, including Richard, were routinely alienated from their families.

As with Sylvia, Linda steered Manuel away from his pain around the differences between North and South American values. She asked him to talk about his relationships with other men. Manuel resigned himself to once again abandoning his own experience to fit into someone else's world view, complying with Linda's unspoken injunction to avoid speaking about his family life or displaying emotions about being gay. Manuel devalued his pain over the loss of a Brazilian friend who had been killed because he was gay. He began to believe that somehow he could have prevented getting AIDS and that he was inadequate in pleasing his therapist who was trying to help him.

At this time, Linda joined a consultation group to help her deal with the cultural differences she had experienced with Sylvia and now with Manuel. She realized, after a purge of tears one day, that she had been harboring her own feelings of disgust for same sex relationships and her condescension toward a Latin-American man. Patently, the group let Linda know she had a lot to learn about how her upbringing blinded her to the realities of her client's lives.

At another group session, as Linda expressed her growing despondence over her failing marriage, she tentatively began to explore if she had failed Sylvia in some measure. To her surprise, she broke into sobs about feeling as if she had failed her family after Emily died. Linda began to see how she continued to stifle and suppress both Sylvia and Manuel's feelings about their family and the burden of the secrets they carried. Taught by her family and her early analytic training to avoid her own feelings, Linda had no context for trusting Sylvia or Manuel going into their pain.

As Linda opened up, other consultation group members carefully suggested that Linda's air of superiority was intimidating to them. They wondered how both Sylvia and Manuel felt in Linda's presence and if they felt distanced by Linda's privilege in the world. Linda struggled for weeks trying to comprehend the concept of being privileged. She never had regarded herself as an unfair person, but slowly she began to see her arrogance and to admit a sense of feeling superior to people from other cultures.

Later, in a guided imagery session, Manuel spoke to the part of his personality that he felt was emotionally dead. "The lowly one," as Manuel described this aspect, felt unworthy of being in Linda's presence. The lowly one felt as if he had failed in life. Because of his love of men, he shamed his parents and put his family at risk. He gave up his profession and his oath to be a doctor by fleeing to the United States. He felt inferior to the others in his new community who were successful professionals, including his lover, Richard, and his therapist, Linda. His deepest grief was that of hurting his parents; the lowly one deserted his homeland and his family without explanation and caused his mother to cry during most of their phone interactions.

In a first step toward freeing herself of the damaging impact of privilege, Linda confided that she, too, had a part of her that felt like a failure: growing up, she felt as if somehow she had to make her parents laugh again after her baby sister's death. She also confided, in a low voice, that she felt that she had let Manuel and another client down by not listening attentively enough to their pain, which she said felt outside of her own world experience and conversely, because it reminded her in many ways of the personal pain that she wished to avoid. The effect of Linda's simple disclosure was immediate, and Manuel left feeling connected with a part of his humanity, not like the freak or leper he had felt he had become.

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*“White privilege [is] an invisible package of unearned assets that I can count on cashing in every day, but about which I was ‘meant’ to remain oblivious.”*

- Peggy McIntosh
clients in order to avoid feelings of guilt that may result when charges of cultural inappropriateness are leveled against traditional counseling techniques. A review of the literature on multicultural counseling suggests that therapists can respond to this danger by examining their internalized cultures.

Multicultural education often reinforces ethnic and cultural stereotypes by focusing on differences among cultural groups while making generalizations about a “White” establishment—an imprecise and pejorative term. Efforts to teach cross-cultural counseling emphasize awareness of broad cultural differences but fail to appreciate the transitory and complex nature of cultural boundaries.

Internalized culture is informed by the diverse cultural influences that operate within an individual and shape personality formation, individual cognition, and other areas of psychological functioning. Internalized culture differs among people of the same culture according to subcultural groupings such as socioeconomic status, age, and sex, and according to psychological variables such as class identification, maturity, and gender. Because of the specificity of the internalized culture, all counseling is cross-cultural.

Accusations that traditional counseling harms the “culturally different” can render counselors apologetic and timid with clients from different cultures. Fearing that they may be offensively “Western,” counselors may be diplomatic instead of honest and may condone an insulting double standard by normalizing behavior from minority clients that they would deem unacceptable from Euro-American clients.

Self-examination is a prerequisite for “psychological decentering,” whereby a counselor may develop a “comparative frame of mind.” This may allow him or her to transcend internalized culture and to achieve interpersonal understanding with clients.

Crossing Cultural Boundaries

Canning C. Getting from the outside in: Teaching Mexican Americans when you are an “Anglo.” *The High School Journal.* 1995; 78(4): 195-205. (University of Northern Iowa.)

A study of Anglo secondary school student teachers working with Mexican-American students found that the most important factor in crossing cultural boundaries was for them to be “open”: to share their own identities, to be willing to admit naiveté and limitations, to ask questions, and to be willing to listen to student voices.

Thirty-nine student teachers from the University of Northern Iowa completed a required course in multicultural education that emphasized communication skills and rapport-building with students. They kept journals about their classroom experiences which allowed for critical reflection throughout their teaching. Bicultural teachers and local Mexican-American educational consultants assisted by advising teachers about effective cross-cultural education techniques and by providing mentorship.

Subjects adopted a variety of approaches to being open to their students, including learning Spanish, teaching Mexican-American literature, or being sensitive to Anglocentric thinking perpetuated by popular culture (such as images of beauty). Ultimately, the teachers were best served by learning to be non-judgmental and to construct a working awareness of unfamiliar perspectives. Rather than requiring teachers to be familiar with every culture that they come in contact with, it is more useful for them to be armed with strategies for gaining information about cultural groups, for example, by visiting homes, conferring with community members, talking with parents, consulting with teachers from these cultures, and carefully observing students in and out of school.

**Next Month**

The key to HIV prevention is a conscious understanding of how people make decisions about reasonable risks. In the September issue of *FOCUS*, Walt Odets, PhD, a Berkeley psychotherapist and widely-read author on HIV prevention and counseling for gay men, examines the concept of risk and the ways in which people assess threats to themselves. He focuses in particular on prevention for gay men in the context of the U.S. cultural bias toward risk elimination versus risk reduction. He also compares attitudes toward HIV-related risks to those related to other activities.

Also in the September issue, Robert Marks, Editor of *FOCUS* and Publications Director of the UCSF AIDS Health Project, reviews the data regarding the risk of transmission via male-to-male oral sex and explores the controversy that surrounds prevention messages about oral sex.
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