6 Use of Self: Assessment and Early Stages of treatment

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Counseling Models

There are at least four prominent counseling models. Each of these models argues for a somewhat different aim of treatment; ascribing a somewhat different role to a clinician's identities. The evidence-based practice (EBP) model (American Psychological Association [APA], 2005) parallels the medical model in its focus on identifying the most successful techniques for relieving symptoms. Within the EBP model, neither the context from which symptoms emerge nor the ultimate impact of "relieving" them is necessarily relevant. Symptoms are viewed as pathological by definition and relieving them is a scientific and value neutral (or intrinsically beneficial) process. In this context, the practitioner's identities are altogether irrelevant because practitioners are viewed as technicians in essence. The multicultural counseling (MCC) model (American Psychological Association, 2017a) builds on the EBP model by placing emphasis on clients' identities, and therefore on the applicability, or lack thereof, of mainstream EBP treatments for specific populations. In this context, the practitioner's identities are viewed primarily as potential depositories of biases to be uncovered and set aside. However, within the MCC model, the role of social context begins to emerge as relevant in the development of psychological symptoms and the aim of counseling is expanded to include a client's sociopolitical empowerment. The feminist (Brown, 2010) and social justice (Greenleaf & Bryant, 2012) counseling models focus more centrally on contextual understanding of the etiology of symptoms and consider "maladjustment" (i.e., symptoms, King, 1967) to oppressive factors as appropriate and at times necessary (rather than evidence of psychopathology). Here, the aim of counseling switches from symptom relief to client empowerment *in the aim of* social change. Finally, liberation counseling (Tate et al., 2013) focuses not only on client empowerment and social change, but also on "decolonizing" clients' minds and deconstructing internalized oppression. The aim is to enable clients to develop new modes of being outside of what might be prescribed by, and required to maintain, white[1] supremacy.

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These four perspectives appear in clinical training in somewhat disconnected ways, with dedicated courses in one or more of them (rarely all of them) and little cross-fertilization (Bartoli et al., 2014). This leaves clinicians on their own to figure out how to choose "a camp" (as these models are often talked about, whether implicitly or explicitly) and decide which of these perspectives to use and when. Further, while training in evidence-based practices is often skill-based, multicultural, social justice, and liberation counseling training (when they even occur) remain more theoretical and therefore less easily applied to clinical work (Bartoli et al., 2014). All of this makes the integration of different counseling models, and the relevant use of self by the clinician, difficult to operationalize.

Relevance of Clinicians' Sociopolitical Identities to the Counseling Process

A key distinction between the four counseling models is the extent to which they overtly acknowledge and engage the role white supremacist ideology plays in clients' mental health and the counseling process. Since white supremacy is an ever-present and impactful cultural force, it is necessary for clinicians to recognize how such socialization operates in clients' lives and in the structures clients operate in (including counseling). This is true because it allows clinicians to accurately assess clients' concerns and create beneficial treatment plans. In turn, the capacity to recognize this socialization, and therefore the ability to appropriately assess and treat clients, relies heavily on clinicians' awareness of *their own* racial socialization.

Socialization within white supremacy gives meaning and relevance to a number of intersectional and sociopolitical identities, within which we are all located. In order to highlight the central role played by clinicians' identities in the assessment and treatment process, I will utilize Hays's (2001) ADDRESSING model. I will relate this model to white supremacist ideology—which ultimately gives it relevance—by amplifying the emphasis of the identities that are most central to the white supremacist project. Liu (2017) makes the compelling argument that (within each sociopolitical identity) power and oppression are, in actuality, dichotomous; they may be experienced on a "continuum," but only via proxy privilege. This is the case because white supremacy assigns full human value exclusively to individuals who are white, cis-gender, able-bodied (and neurotypical), heterosexual, male, and Christian[2]—understood as one set of interconnected variables characterizing "Whiteness." White supremacy awards full humanity and value only to holders of such "Whiteness," who then have unquestioned entitlement to material wealth and power. White supremacy also defines "Whiteness" in opposition to "blackness," conceptualized as everything outside of "Whiteness" (therefore, at times, applicable to more than racial categories), and from which space one can only secure temporary proxy privilege (Liu, 2017; Mckesson, 2018). Therefore, proxy

privilege is by definition unstable, and potentially fraught with *founded* fears of losing it—as anti-"blackness" has been codified and punished at all levels of society (from laws to values), and living while perceived as "black" comes at a (purposefully visible and fear-inducing) cost. By virtue of inhabiting a white supremacist society, we all participate in and are affected by "the matrix" of "Whiteness"; there is no space (yet) for "neutral" standing.

As I will demonstrate via clinical examples, awareness of one's sociopolitical identities or simply becoming aware of one's biases, is not sufficient enough to promote a qualitative, liberatory shift in the assessment and treatment process and therefore in clients' lives. A sophisticated and nonoppressive application of treatment models relies on clinicians' ability to locate the ways in which their identities manifest in their own lives, and clearly understand their own relationship to, and role within, white supremacy. Wherever we come short in doing so in our clinical work, we cultivate white supremacist spaces and agendas (which are our default cultural settings) through the ways in which we frame the counseling process and enter in relationship with the client, the ways in which we conceptualize the client's concerns and identify treatment goals, and the ways in which we utilize various counseling tools.

Since perfect awareness is unlikely, and perhaps even not possible, the reality is that with our counseling practices we unintentionally contribute to oppression, at least to some extent. However, it is important to remember that clinicians do not operate unilaterally; the client is a co-constructor of and co-conspirator in the treatment process. Once the "liberation" achieved by the clinician can support the development of enough "liberation" in the client, the intrinsic wisdom and agency of the client—including their ability to consciously identify their unique experiences of, and socialization within, white supremacy—will enable their further growth, often past the limited confines of the counseling relationship and process.

Within this framework, it becomes easier to understand how the personal is *always* political, for both the clinician and the client. Their identities, relevant experiences, and frames of reference cannot but exist in conversation with, and emerge from, white supremacy. Therefore, to the extent that we are not able to perceive the ways in which we are embedded in such a context, we distort reality to the advantage of white supremacy and actively keep clients in (external and internal) oppressive systems. And I mean *all* clients, including white, cis-gender, able-bodied (and neurotypical), heterosexual, Christian men, because white supremacy inevitably requires compromising one's humanity (not least one's bodily perceptions and needs) to fit and abide by white supremacist norms, including the values that promote and maintain such norms. To further illustrate these points, I will first describe the relationship of my sociopolitical identities to white supremacy, and then I will provide examples of how I have used such awareness in my clinical work with clients.

The Author's Sociopolitical Identities

I am a white, cis-gender, bisexual[3], temporarily able-bodied, Italian[4] woman. After living in the United States (US) for a decade on a number of different student-visas, I formally immigrated via marriage to a cis-gender, white, US born man[5]. While both my native country and family context are squarely Catholic, I was not raised as Catholic within my nuclear family. I was raised within contemplative spiritual practices, which I have practiced in various forms since. That said, given the religious context of my native country and family of origin, one might say that I am "culturally" Catholic, which in turns means that I can "pass" as Christian and am relatively comfortable in Christian contexts.

Age and socioeconomic status may not be directly relevant to the construct of white supremacy; however, they both acquire salience due to intersectionality with gender and to living in a capitalistic and individualistic cultural context. The fact I am middle-aged and upper-middle class positively impacts the ease with which I currently navigate my personal and professional lives in the US. For example, as a middle-aged, cis-gender woman, my intelligence is less questioned and I am the subject of less sexual harassment than in the past.

As Dr. Rev. Jamie Washington says, "we tend to live in the pain of our marginalized identities, but we tend to act out of the arrogance of our mainstream identities." Accordingly, I have been acutely aware of some of my identities for as long as I can remember, while others have become increasingly apparent only as I have been acculturating to the US or expanding my awareness of white supremacy. Due to the overt sexism deeply embedded in both my native country and family of origin, I have always been acutely aware of being a woman. While not directly relevant to the US context, I was also aware that my non-Northern inflection in Italian[6] positioned me in a somewhat "less than human" category when I moved to the North of Italy. I was not consciously aware of any other identity until moving to the US, when I slowly began uncovering the meaning of being white, bisexual, non-US born and specifically Italian, cis-gender, and temporarily able-bodied. I certainly have not come to the realization of how all of these identities impact my life all at once, to the same degree, or once and for all. In fact, it's an ever-growing realization, not simply because "the more I see, the more I see." but also because the sociopolitical context changes the valence of my proxy privilege. For example, I have a non-American, non-British English inflection in my speech, and therefore will never fully "pass" as a US citizen. With that being said, as a white immigrant from Italy, I have felt almost always welcomed in the US, until the current exacerbation of anti-immigrant sentiments has opened the door to more frequent less than welcoming experiences. These, in turn, have led me to become more self-conscious about the inflection in my speech and much more aware of my immigrant status and associated vulnerability.

After becoming licensed as a psychologist, I opened a small private practice while pursuing an academic career, which eventually led me to become the director of a masters in counseling program for 12 years. In my faculty and administrative roles, I have strived to promote inclusion and to deliver a "liberatory" curriculum. This was partly accomplished by inviting students', faculty's, and staff's feedback and perspectives to inform both the curriculum and structure of the program. Over time, this process mirrored back to myself and my values, assumptions, norms, and preferences. Specifically, it showed me how such norms and assumptions related to my (professional and cultural) socialization, where these norms and assumptions enhanced my inclusive aspirations, and where they worked against the well-being and "liberation" of the faculty, staff, students, and clients we collectively aspired to serve.

Through that process, I came to ask myself: "who does [insert a specific value, assumption, norm, preference] benefit?" Such a question facilitates the identification of factors that maintain, or dismantle, inequities. As I have been working with this question, I have come to notice the potentially problematic impact of wide-spread (often white-normed) cultural values around being kind, polite, well-intentioned, self-effacing, productive, logical, dispassionate, and self-reliant. Furthermore, I have noticed the additional cost these values have when the bodies carrying them out are seen as less than fully human. In other words, as I was aspiring to promote equity, I realized the ways in which some norms, values, and expectations arise from specific cultural structures, are designed to maintain those structures and are actively policed (both internally and externally) when violated[7].

This ever-increasing awareness of how white supremacy operates in the very fabric of my personal and professional lives informs my clinical work. The more I notice the specific ways in which white supremacist ideology manifests (e.g., Saad, 2020), the more easily I detect the biases implicit in counseling theories, in educational processes, and in the ways in which I "hear" (i.e., assess) clients' struggles. Even though the impact of white supremacy is more evident in clients with non-dominant identities, white supremacy is foundational in US culture; therefore, it operates in dehumanizing ways within *everyone* and it is to some degree implicated in the etiology of symptoms for *all* clients. To the extent that we are unable to detect how white supremacy impacts a client's well-being, we inevitably leave the client at the mercy of continuing to participate in their own and others' oppression. In other words, as clinicians, we cannot abide by the Beneficent and Non-Maleficent ethical principles (American Psychological Association, 2017b) without integrating an understanding of the impact of white supremacist ideologies on both our own lenses and our clients' experiences.

The challenge is to see "the matrix" while living *in* "the matrix"—it's an ongoing, never complete effort. This is where using the four models of

counseling described at the beginning of this chapter in *complementary*, rather than disconnected, ways becomes essential. In the remainder of the chapter, I will provide clinical examples to demonstrate the impact of this perspective on clinical work.

Clinical Examples[8]

Early in my clinical training (in the late 1990s), I worked with a Mexican American, bilingual, cis-gender, young woman who was not proud of her bilingual skills and considered her Spanish inflection in English a liability. Unaware of my own proxy privilege as an Italian international student, rather than considering my client's experience in the context of xenophobia and anti-Mexican sentiments, I conceptualized her devaluing of her bilingual skills as a sign of "distorted thinking." Within this conceptualization, cognitive restructuring targeting her negative self-talk emerged as an "appropriate" treatment plan. This narrow application of an evidence-based practice, outside of complementary multicultural, social justice, and liberatory frameworks and without the benefit of recognizing how my linguistic proxy privilege manifested in my own life, led me to miss the opportunity of assisting my client in disentangling herself from the context outside of which her symptom would simply have no reason to exist. Worst, my assessment led me to further oppress the client by essentially blaming *her* for her internalized xenophobia.

My ineffectiveness in this case relied on solid EBP training and a mound of good intentions, neither of which translated into clinical competence. While I continue to utilize cognitive theory in my conceptualizations and cognitive restructuring as a treatment modality (together with other EBPs), I have learned the dangers of using EBPs without the complementary lenses provided by the multicultural, feminist/social justice, and liberatory counseling models. An integrated perspective ensures that theories lead to accurate assessments and that EBPs are deployed appropriately.

With the awareness of cultural and contextual factors that are relevant for all clients, I worked with a young, white, non-binary client (socialized, and often misgendered, as female), who struggled with social anxiety disorder. The client's anxiety restricted their ability to connect socially as well as advocate for themselves and others in professional contexts. Professionally, the client was seeking pay equity and a higher position, more commensurate with their skills. The client valued being polite, humble, and hard-working, and was frustrated with a professional context that was not interested in increasing the client's institutional power—which seemed to be reserved for bodies perceived as white and male—all the while, the client was being praised for their "work ethic" and "professionalism."

Central to my assessment process and conceptualization was an investigation of the meaning of the client's values and the behavioral norms expected at work in the context of the client's identities: where did they

learn these values and norms, how did they become important to the client, who did these values and norms benefit, and whose expectations did these values and norms meet and to what end? We explored both the personal and sociopolitical dimensions of valuing and being asked to be polite, humble, and hard-working, as well as where and how these values and norms were being reinforced—whether externally (e.g., most recently by a work context that benefited from them to the client's detriment) or internally (e.g., as means for the client to avoid their social anxiety). As it can be noticed, such a contextual conceptualization included the utilization of behavior theory and did not preclude the use of exposure as a treatment modality. However, it demanded that both the assessment and treatment be healing and empowering, and that they include the practice of skills relevant to values and norms that were at once genuine to the client and effective for the client's specific sociopolitical identities and advocacy goals.

Another client for whom such a contextual, multi-modal conceptualization became central was a cis-gender, middle-class, Irish American white man in their thirties, who, despite his relative professional success and stable income, did not feel accomplished or worthy "enough." We explored possible relational wounds that compromised his sense of worthiness, while also investigating the potential impact of his socialization as a white man around concepts of masculinity, success, and power. Here again, we looked at the norms and values he cherished, where he learned them, the specific meaning these assumed for the client given his sociopolitical identities, who they benefited, and whether there were emotional costs to embodying them.

Themes around social status are not unusual when working with white, cis-gender men. However, clients' socialization into cultural expectations about financial and social success (corollaries of white supremacist ideologies) does not play a uniform or necessarily defining role in a client's symptomatology. Therefore, determining the degree to which white, cis-gender men are impacted by such socialization is crucial for an accurate conceptualization: what does it mean to "do the right thing" or be a "good person" for a white cis-gender man as opposed to, for example, the white, non-binary client described above? Where do the expectations around success come from for each of them? Who ultimately benefits from the embodiment of such expectations by each of them? What gets lost as far as wellness is concerned in each case? And in the end, is the target of treatment amplifying the client's sense of worthiness or redefining what being worthy means?

Another common theme among clients seeking counseling are difficulties maintaining what they deem to be "adequate" levels of "productivity" or feeling "burn out." In these cases, once again, we must be cognizant of conceptualizations that might lead us to use behavioral or cognitive strategies to identify barriers to self-care and encourage clients to add "supports" to resume desired paces of productivity, versus conceptualizations that might

lead us to question the concept of "adequate productivity" altogether. An investigation into the meaning, role, and impact of valuing "productivity" is key to the development of an accurate conceptualization leading to a liberatory, rather than further oppressive, treatment plan.

As demonstrated in these clinical vignettes, the ability to deploy evidence-based practices in liberatory ways can only take place when the clinician is able to detect the larger white supremacist context within which these values operate, and out of which symptoms might emerge. In the last example, what might be viewed as "facts" disputing the automatic thought "being productive makes me worthy" may look different if the thought is understood as a tool of white supremacy, rather than an individual "irrational" belief. How explicitly one might reference white supremacy within a session depends on the social locations and worldview of a client (e.g., Bartoli & Pyati, 2009). However, a sociopolitical understanding of a client's values is essential for the client to be "in choice" when it comes to determine what is liberatory to them—whether that is a new way of engaging with or operationalizing the underlying value, or disrupting altogether the role it plays in their lives. Without such an understanding, values and norms might be taken at face value and promoted, rather than contextualized, questioned, deconstructed and, if needed, dismantled.

Liberation Counseling as an Open-Ended and Collaborative Process

The path toward a greater awareness of the ways in which we, as clinicians, and our clients come to embody values and norms that maintain oppressive forces is neither linear nor perfect. The good news is that liberation begets liberation for both clinician and client, as again "the more you see, the more you see." Further, while clinicians' expanded perspectives and counseling tools can be useful to clients, a clinician's role is not to tell clients what their ultimate truth is or coerce them into what they should do to enhance their well-being. Once clients understand the impact of both relational and cultural experiences on their values, desires, wishes, and aspirations, and how these impact their well-being, they will have a map to navigate their own perceptions and make their own choices.

An integrated, liberatory perspective of counseling asks us not to reduce healing options to "camps," but rather utilize them in complementary ways, grounding that process in a deep awareness of the significance of our own identities within white supremacy. While the counseling practices we use to work with clients matter, they can only be healing if we, the clinicians, develop lenses in our own lives that allow us to view the nuanced ways in which clients are embedded in a web of values and norms, which are designed to play a specific role, within white supremacy, on the basis of

clients' sociopolitical identities. The lenses we use determine what we see and consequently the range of options we are able to invite clients to consider. From this perspective, the hand is just as important as the tool, and ultimately true freedom must transcend both.

Notes

1 The term "white" is here purposely not capitalized to avoid reifying the overvaluing of whiteness as a racial construct.
2 Preferably native English speaking, perhaps more than necessarily US born per se, as prescribed by Hays's (2001) ADDRESSING model.
3 "Bisexual" is a term which dates my identity formation; I would probably identify as pansexual if the construct had been available to me earlier in my development.
4 I came to the US in my late teens; I speak English with a slight and not easily "placeable" ESL inflection.
5 I married shortly after 9/11, therefore well before marriage equality became federal law. 2001 was another time in US history of critical shift in immigration laws, which would have made it unlikely for me to immigrate via routes that did not use, among others, heterosexual, racial, and economic privileges.
6 All regions in Italy have distinct accents, and mine reflected the region where Rome is located.
7 You might take a moment to consider the following question for some of the values you or your clients hold: where did these values emerge from? How were they learned and maintained? Do they manifest differently depending on given sociopolitical identities (e.g., does being "kind" or "self-reliant" mean the same thing for folx holding different sociopolitical identities)? Who do they benefit and how? What is the cost of abiding by them *and* of stepping outside of them (and does the cost differs based on one's sociopolitical identity)?
8 The clinical example used in this chapter are composites reflective of clinical work across multiple clients. Details have been modified to preserve confidentiality.

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