HEALING AT THE INTERSECTION OF IDENTITY: QUEER WOMEN OF COLOR IN PSYCHOTHERAPY

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by
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Abstract

Amongst the presenting issues of the Queer woman of color in treatment are her beliefs around her identity – those inherited, chosen, and co-constructed by a larger system. To universalize an approach in therapy negates the uniqueness of the convergence of the multi-faceted identity and disregards the impact of each component. The therapist must hold the way a client organizes their understanding of themselves within the larger systems of family, society, culture, and so on. Additionally, the therapist must be willing to assist the client in navigating not only the pathways of the client's identity, but how the therapist's own identity interacts - based on personal beliefs and assumed values that undeniably enter the therapeutic space as a 'third' component to the dynamic. Using a Social Constructivism approach, I shift the general approach of Self-Psychology to "three-person" model of therapy. In the navigation of the multi-faceted identity the client becomes conscious of the roots of their beliefs, therefore further healing can occur.

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It is the therapist's duty to create safety within the therapeutic space and provide the client a place to tell of their journey. A therapist must offer the space for this story to unfold - to be told and retold, claimed and rejected – ultimately, for the clients to embrace their own narrative. Gloria Anzaldua, author of *Borderlands/La Frontera – The New Mestiza*, describes that often it's difficult to differentiate between the different components of our history that have created our sense of self - what one has inherited, what has been acquired/chosen and what has been imposed upon us. "*Pero es dificil* differentiating between *lo heredado, lo adquirido, lo impuesto*" Anzaldua writes, and continues, "She puts history through a sieve, winnows out the lies, looks at the forces that we as a race, as women, have been a part of" (Anzaldua, 1999, p. 104). Anzaldua refers to this process as "taking inventory." As Queer Chicanas "take inventory" and tell their story, clinicians must be aware of the navigation amongst a multiplicity of identities and cultures that will inform the process of engagement and healing, based on "how the client understands her situations in light of the way she organizes her self-understanding" (Suyemoto and Kim, 2005, p. 36). In light of the presenting problem, the client organizes her beliefs around the issue/s based on her experiences, her past – those identities she inherited, those she chose, and those that were imposed upon her. The therapeutic space should provide a freedom to explore, similar to how Anzaldua speaks to the creation of the *Mestiza*,

> She shapes new myths. She adopts new perspectives toward the dark-skinned, women and queers. She strengthens her tolerance (and intolerance) for ambiguity. She is willing to share, to make herself vulnerable to foreign ways of seeing and thinking. She surrenders all notions of safety, of the familiar. Deconstruct, construct" – Anzaldua, p 104

To begin such work in which we, the therapists, become the observer of this client's journey and hold the complexity and view the individual in context to their internal and external reality, we must first be willing to critically examine ourselves. Once we are open to critical self-analysis of our own identity, we are more equipped to create a safe space for our clients to explore the intersectionality of their identity and the impact it has upon their lives.

The "deconstruction and construction" of identity occurs when the therapist becomes curious as to why the client believes or behaves as they do. There are pitfalls to suggesting that healing only occurs once an individual examines the intersection of their identities. Therefore, I insist on meeting with clients where they're at with their exploration, if at all, and how they define this voyage. It is especially detrimental if the therapist is unaware of their relatedness in the client's journey, or if the therapist becomes over-focused on stereotypes and overtly applies cultural 'norms': "The therapist should keep in mind that there is as much danger in explaining individual differences away as culturally determined as there is in ignoring or rejecting impact of cultural influences on each woman's choices" (Espin, 1997, p. 49).

As we are aware of the various facets of identity, we must acknowledge the importance that language plays in identification and belonging. Oliva Espin, author of *Latina Realities,* states, "Language is not transparent and does not merely reflect and

describe human experience. Rather, is an active creator of that experience" (Ibid, p. 75). I am reminded that we can often focus too much on the content of the client's story, and not the process. The language that a client uses to describe herself will vary depending on various factors – immigration status, class, education level, familial notions, age, ability, and so on. I'm not only speaking to language in the literal sense of extent of vocabulary and semantics, but also the client's use of metaphor, spiritual nuances, pauses, tone/volume, and similarly the use of body language. Rebecca Chamorro, in "From the other side: Countertransference in the Spanish-speaking dyads," states, "cultural metaphors can become a means of encoding and discussing personal conflicts" (Chamorro, 2003, p. 85). How an individual describes herself and the presenting issues is as important, if not much more meaningful than the actual self-applied (or the therapist's assumption) label. This language can be used as a tool in the therapeutic process to begin to understand the client's internal landscape. As the therapist, our duty continues with the task of allowing the client's language to penetrate our own process, finding meaning and translation for ourselves to understand, rather than to impose upon the client a new language that may demean, undermine, and invalidate the client's way of narrating their story. We are strongly urged to "embrace the holistic person within her multiple contexts" (Suyemoto and Kim, 2005), these contexts being conceptually defined by the client and her experience.

"Women of color lead lives immersed in unique experiences which uniquely qualify them to transform the personal in their lives into the political or theoretical perspectives necessary to create a true psychology of all women" (Espin, 1987, p. 77). Specifically, Chicana critical theory lends itself to understanding the psychological

process of healing and honoring the importance of identity. My focus is on working with Queer Chicanas in psychotherapy. I mean this in the broadest sense of examining the notion of psychological healing through exploration at the crossroads of the multi-faceted identity. Operating within a social constructionist paradigm, I will discuss the importance of examining the intersection of identities and how we can provide a safe space for Queer Women of Color to explore the multiplicity of her identity relative to the presenting issue/s. I focus on a social psychology, with an emphasis on empathic attunement and the role of the "other," from which to examine the individual in context to their environment, specifically working from a systems theory approach in relation to self-psychology, along with the shift to a three-person psychology model.

Before I continue, allow me to define the term *Chicana*, and the reason for the focus on this identity.

> The term *identity* is understood here as that which each woman tells herself about who she is when she is alone with herself. The term is also understood as that which each context to which she is field sensitive calls forth in a given moment. (Espin 35)

As I noted earlier in the writing of Anzaldua, *identity* becomes what one has inherited, what has been acquired or chosen, and what has been imposed upon us. The identity of Chicana is chosen, as it is an identity that embodies authority of her history, reflective of struggle and resiliency, with great awareness of the indigenous and ancestral ties. Norma Alarcon states, "the name Chicana, in the present, is the name of resistance that enables cultural and political points of departure and thinking through the multiple migrations and dislocations of women of "Mexican" descent" (Alarcon, 1999, p. 65). Each individual may have their own definition of the term Chicana, and will have assumed the identity for

many reasons, although I do believe that Alarcon's definition encompasses the general usage. I am also holding that the Queer Chicana identity is an integration of many identities. The term *Queer* in this paper is used to encompass all Chicana women who identify along the LGBTQ (Lesbian, Gay, Bisexual, Transgender and/or Queer) spectrum. I will also mention that although there is a focus on identity, my aim is not to address an individual's struggle in reference to theorized identity developmental stages, but the notion that one's awareness of their inherited and co-constructed identity can be used in the process of healing.

Working from a social constructionist paradigm, I find it necessary to state that my standpoint arises from the intersections of my own identity and subjective experience as a Queer identified Chicana. Just as with any theory, it is limited by our inter-subjective relational experiences and co-constructed world-view. I share specific experiences in working with Queer identified women of color, in the broader sense of navigating identity and its impact on the therapeutic space. Regarding these experiences, all identifying information has been changed to protect confidentiality.

Social Constructionism

"Validation of each woman's identity and of all components of her total self is provided through the expansion of feeling states and encouragement to understand their meaning" (Espin, 1987, p. 49). To do such, we must be cognizant of how these various "components" of self have been constructed. Suyemoto and Kim describe "building conceptual bridges across contextual terrains" as a means to understand and negotiate our relatedness to the complexity of identity – for our self-analysis as therapists, and for the

growth of our clients. The authors also note that identity is an "on-going process" that shifts and is organized by the individual's "meanings of themselves in interrelation with social meanings from others in their particular socio-cultural, political and historical experience," and they suggest that "emphasis on social co-construction of identities can be a useful way to conceptualize therapy with individuals" (Suyemoto and Kim, 2005, p. 18). Herein lies the paradigm of social constructionism that views "psychological characteristics as a result of social and historical processes" (Espin, 1987, p. 75).

Constructivism itself came to light in the early 1980's, influencing family therapy technique, asserting "we perceive and relate to the world on the basis of our interpretations" (Nichols, Schwartz, 2006, p. 95). Theorists such as Irwin Hoffman were proponents of social constructivism "He [Hoffman] believes that there is a reality external to our construction that constrains us and that our constructions may fit more or less well, but that is fundamentally ambiguous and thus susceptible of being apprehended validly in more than one way" (Altman, 1995, p. 68). The expansion of Constructivism brought about Social Constructionism, in which the interpretations that individuals have of their world, "are shaped by the social context in which we live" (Nichols, Schwartz, 2006, p. 96). Within this paradigm, the therapist refrains from assuming the role of expert, "the role of the therapist isn't to change people but to open doors for them to explore new meanings in the lives" (Ibid, loc. cit). The focus is not only on the individual processes, but also the group and systemic contexts – institutional, political and familial. Suyemoto and Kim suggest that emphasis on the social co-constructed identity "creates a map that connects the multiple pathways and assists us as therapists to see their interdependence" (Suyemoto and Kim, 2005, p. 20). It is crucial to acknowledge the

convergence of the pathways, yet also deconstruct the importance of the individual impact of each path - "as therapists, we do not have the option of ignoring cultural influences" (Hays, 2007, p. 190).

That being the case, Altman suggests a "three-person model" in which the "third person represents the social context" (Altman, 1995, p. 56). Altman proposes such a model as an "integration of one- and two-person models, of intrapsychic and interpersonal dimensions of the analytic situation" (Ibid, loc. cit.). Whereas one-person models such as drive theory and ego psychology, focus on the intrapsychic struggle of the client, a two-person model addressed by Object-relations theory, suggests that the therapist is an active participant in the healing process of the client, using the relationship that manifests in the therapy room. Altman distinguishes between one- and two- person psychology, "a one-person drive theory can regard the analyst's social class, for example, as only an incidental trigger to a fundamentally drive-related mental process within the patient," whereas a two-person psychology will address the feelings that arise from the social class differences between therapist and client (Ibid, p. 78), in which transference and countertransference are heavily relied upon to inform of the clients relational pattern and for the therapist to better understand the shaping of the client's beliefs. Altman has incorporated both one- and two-person psychology, with use of social constructivism to enhance the notion that there are three components (persons) in the therapy room at all times, of which the third, cannot be ignored. It "frames both analyst and patient attitudes about socioeconomic issues in the context of the society of which both are socialized members" (Ibid, p. 58).

In "Notes on the management of difference*,"* Carmen De Monteflores states that "current psychotherapy" emphasizes "the internalization of responsibility, the rationale being that we can empower ourselves by recognizing that what we do to ourselves, we can also undo," yet as the "stigma of being the bearer of rejected traits of a society is added the secondary stigma of being seen as someone who does not choose to make himself, or herself, feel better, in essence as a malingerer" (De Monteflores, 1986, p. 74). Proponents of Social Constructionism, such as Altman, invite the therapist to assist the client to examine these traits, to deconstruct the attached stigmas, and own what is actually inherent, assumed and what has been imposed upon. "For rejected groups, power and the power to change, is not an internal psychological reality: power is rather an external fact, often at odds with our needs" (Ibid, loc. cit.).

The role of power and the limitations faced as a "rejected group" intensely impacts the internal process. I am currently working with Carmen, a self-identified Latina Lesbian in her early thirties. She is undocumented, having come to the U.S approximately ten years ago after facing rejection from her family and community for her Queer identity. Carmen presents for therapy with the desire to abstain from her poly-substance use, which she attributes to increased stress after losing her job. The focus of our work has been to explore not only Carmen's internal psychic struggle and feelings of failure, but also actual limitations due to immigrant status, and additional barriers as a woman of color. We have discussed how these perceived and actual limitations impact one another, and how to understand the role each play in the shaping of her identity; therefore holding that the beliefs she has about herself influence her substance use as a possible 'escape' or to make sense of the intersections of 'spaces' she is a part of. In our

work together, many other issues have come to light, including her immense fear of deportation, flashbacks of childhood sexual trauma and signs of an abusive dynamic with her partner.

Carmen's experience is one of many examples as to how the lack of power in our external reality greatly impacts our internal psychological reality and sense of hopelessness, further exacerbating the trauma that has occurred to us. How our clients make sense of the trauma is directly linked to how it is they organize themselves in the larger construct of their culture, community and society. An individual, such as Carmen, with limited social, legal and familial support, will begin to fragment. By understanding the importance and value of each of these spaces and how they have co-created her identity - her ability to tolerate difficult feelings, her reactions, and her behavior – in her awareness of self, she can begin to integrate what is hers and what is 'theirs.' In this process, deepening the work into healing from trauma and current relationship violence, strength is implored to navigate amongst the external events that have impacted her Self.

Lastly, keeping in line with Social Constructionism and the "three-person model," Nichols and Schwartz suggest then "the goal of therapy shifts from interrupting problematic patterns of behavior to helping clients find new perspectives in their lives through the liberating process of dialogue" (Nichols and Schwartz, 2006, p. 95). The process of dialogue must happen with extreme awareness and empathy, on the part of the therapist. Provided a three-person-model, the therapist must hold that "pathology may be inside the patient, in his social context, or in the feedback between them" (Minuchin, 1974, p. 9). Much like I mentioned above with Carmen, it is crucial to distinguish

between the perceived and real limitations based on the societal context from which she is framing her beliefs.

Systems Theory

Minuchin asserts, "we see the problems and needs of individuals as if they existed in a vacuum, disconnected from their environment and other people" (Ibid, p. 15). Systems theory views biological systems as "…organized assemblage of parts forming a complex whole" (Nichols and Schwartz, 2006, p. 91). Systems theory influenced many aspects of family therapy, focusing on the "interactions and relationship among the parts," in which "the whole is always greater than the sum of its parts" (Ibid. loc. cit.). I suggest using the framework of systems theory as a contextual view of the Queer Chicana as part of her larger community. For a woman of color, Queer identity can also be viewed as a "system" itself, the many "parts" referencing the multiple identities we hold. Anzaldua speaks directly to this notion "the assembly is not one where severed or separated pieces merely come together. Nor is it a balancing of opposing powers. In attempting to work on a synthesis, the self has added a third element which is greater than the sum of its severed parts" (Anzaldua, 1999, pp. 101-102). To claim allegiance to an identity or community often means negating the importance of the other, where a Queer Woman of Color is faced with a sense of fragmentation and not belonging. She cannot be whole without the acknowledgement of the many parts. Without the feelings of wholeness and balance we are in distress, exacerbating the presenting issues of daily life – work, relationships, and so on.

Similar to how a family therapy perspective views familial relationships and each individual as a part of the larger organism (family), Anzaldua has drawn upon similar ideas for the Chicana's development of Self - the *Mestiza* - as does Virginia Satir for the family. Satir views the individual in context (of self and within the family), focusing on the role they serve, some that are explicitly labeled and some unspoken. Satir attempts to navigate family roles like "victim, placator, defiant one or rescuer that constrained relationships and sapped self-esteem" (Nichols, Scwhartz, 2006, p. 30). The *Mestiza* is the definition rooted in the idea 'to mix,' generally applied to a mix of racial ancestry , and Anzaldua reframes the *Mestiza* as "a racial, ideological, cultural and biological cross-pollinization," urging the Chicana woman to deconstruct and construct and to inhabit the "consciousness of Borderlands" (Anzaldua, 1999, p. 99). In the deconstruction, she must acknowledge the role each identity has served and is presently serving, and how, if it all, they function and contribute to the presenting problem. In a sense, the "identified patient," as used in family systems theory, then becomes one of the identities that, theoretically speaking, are displaying the most symptoms; therefore, in order to alleviate these symptoms, we can't just address one aspect of identity, but we must examine the inter-relatedness and contribution of them all. As within a family, roles are inherited, assumed and assigned, and similarly a person's identity is shaped – it is up to the client and therapist to examine the function and purpose in which all these components merge.

Continuing with a social constructionist focus, holding the idea of systems and families and influences upon the individual, let's consider society as the family system, and the individual's group/s as members of this family. Again, we can easily label the "identified patient/s," when we apply the ism's – racism, heterosexism, sexism, and so

on. In individual therapy, the therapist must remain cognizant that the Queer Chicana is a member of these groups in order to "explore the narcissist injuries experienced by rejected individuals and rejected groups. These chronic narcissistic injuries may contribute to intrapsychic structural vulnerabilities… so that a social problem is perpetuated as a serious intrapsychic conflict" (De Monteflores, 1993, p. 85). Using Altman's three-person-model, the therapist can attempt objectivity, acknowledging that "the dyad of therapist and client will be seen as a microcosm of power issues in the society, with the therapist carrying the majority view" (Ibid, p. 75).

This brings me to the process of another client I'm working with. Maria is a thirty-year old Queer identified woman of API (Asian American - Pacific Islander) descent. She initially presented with feeling overwhelmed by her work, family and community responsibilities. Maria has requested support in prioritizing and learning how to cope with times of increased stress. We were quickly able to narrow down the conflicting values that are inherent of the various cultures she inhabits. How then does she remain true to herself meanwhile in alignment with the communities she values? Maria struggles with feelings of guilt and shame within her family since she did not fulfill their hetero-normative expectations. She also struggles to maintain cultural and spiritual ties while wanting to be fully accepted in the Queer culture. Maria has identified that she has the tendency to attempt to appease all aspects, and often takes on the role of caretaker, which leaves her feeling drained and resentful. Consider how Maria is feeling in inhabiting many worlds, a responsibility to all, yet a sense of not belonging to any.

Self-Psychology as a three-person-model

Kohut's Self-Psychology model would be categorized under Altman's two-person model in which the relationship between the therapist and the client becomes the focus. Working within a deficit model, such as Self-Psychology, it presumes that the individual lacked vital components in their earlier development; therefore therapy consists of filling those voids. In summarizing Kohut, Flanagan outlines the three crucial components that make up Self-Psychology: 1) Empathy, 2) The Tripartite self (Idealization, Parental Imago and Twinship), and 3) the crucial role of self-objects (179). In this section, I am focusing on the tripartite self, and the crucial role of self-objects; in a later section I will address the role of empathy.

Within Self-Psychology there is an understanding that one experiences "narcissistic injuries" in their development, in which a normal level of failure is experienced and recuperated from – the focus being on the recuperation and its outcome (Flanagan, 2002, p. 179). De Monteflores, in line with Self-Psychology, suggests to "explor[ing] the narcissistic injuries experienced by rejected individuals and rejected groups so that a social problem does not become perpetuated as a serious intrapsychic conflict" (De Monteflores, 1986, p. 85). In doing so, the therapist invites a social context and understanding into the therapeutic space, therefore shifting from a two-person to a three-person psychology.

Using the notion of a deficit model, Self-Psychology informs as to the individual's cultural and relational experience within their environment. From a Self-Psychological perspective, the under-represented and depoliticized individual has lacked acknowledgement, and experienced possible outright rejection from the larger system,

"society can be seen as fostering a lack of self cohesion when it is oppressive" (Flanagan. 2002, p. 195). The impact this has on the individual (of the oppressed groups) is reflective of the notion of the fragmented tripartite self, and the lack of self-objects. De Monteflores further asserts we all experience "narcissistic difficulties since any part of the self which is different is vulnerable to rejection by self-objects, whether by parents or the larger social group" (De Monteflores, 1986, p. 85).

If the young Queer Chicana woman failed to receive the social mirroring (Idealization), internalization of strong images (Parental Imago) and a feeling of validation by the community that surrounds her (Twinship), she may be left to feel fragmented and overburdened. I will mention that the components that are lacking are from a societal level, are not necessarily lacking from the microstructure of the family, although I would postulate that because oppression affects beliefs, behaviors, and attitudes, it becomes a generational perpetuation; therefore the 'deficits' have been integrated as a means of survival, cohesion and stability, indirectly manifesting in any individual of an oppressed group.

Let's go back to Maria and how her sense of being overburdened and fragmentation create her internal dissension. As a Queer API woman, she felt a constant pull in opposite directions, for her allegiance and commitment. Although I'm not asserting that one must come to resolution in a fixed identity, since much of identity is dynamic, I hold that an awareness of the convergence of the multiplicity of self can begin to heal the feeling of being split. With Maria, the work has been around holding not only one notion of self, but also the integration of those parts she values, including those that contradict themselves in the larger society. She struggles with keeping a solid

spiritual/religious foundation along with her family, when that very religion does not accept her Queer identity. Similarly, as a Queer woman of color, she has expended large amounts of energy creating community in which she is reflected, since the LGBTQ culture is still highly portrayed and accepted as White.

Along those lines, Anzaldua discusses the *Mestiza*, "The ambivalence from the clash of voices results in mental and emotional states of perplexity. Internal strife results in insecurity and indecisiveness. The *Mestiza's* dual or multiple personality is plagued by psychic restlessness" (Anzaldua, 1999, p. 100). I find it necessary to mention that this discussion has placed the Queer Chicana in the position of the oppressed, therefore contributing to a dualistic thinking, in which "a counterstance locks one into a duel of oppressor and oppressed," and Anzaldua suggests that in order to understand those convergences of our identity, we will have to "heal" the "split," "so that we are on both [or multiple] shores at once and, at once, see through serpent and eagle eyes" (Ibid, pp. 100-101). I am not suggesting that we allow oppression to prevail in dictating the notion of identity, therefore informing the struggles and process of healing - but that one assume ownership of our their own narrative, and begin the process of healing with an examination and understanding of these convergent paths.

Self-Psychology serves as a framework for the clinician to assist the client in creating a sense of cohesiveness of the self. "The very concept of *self* is itself a social construct rooted in time, place, and culture. The value placed on the development of an individuated, autonomous, flourishing self varies widely from culture to culture" (Flanagan, 2002, p. 175), in which it is the duty of the therapist to be aware and hold these variances.

"One's sense of self is essentially tied to one's relationships which become integral to one's identity" (Hertzberg, 1990, p. 285), therefore as these relationship occur at a group, cultural and societal level, this "two-person psychology" must invite the "third" into the room. Hence, the self-objects become the identities themselves, and the positive images that appear to be non-existent for the oppressed individual. By strengthening the identities, examining the institutional influences, and the intersection at which they meet, it can provide the individual with strong foundation from which to begin healing.

The self-reflection of the therapist

One of the components of Self-Psychology is the assertion that clinicians work from a place of genuine empathy; I believe this occurs when therapists can be genuine within themselves. In this section, I will discuss the importance of self-analysis and reflection by the therapist, prior to and during their work with clients. "When we are fully present with another human being and in our own self, we are able to create an environment that is both encouraging and affirming of the other's emerging selfhood" (Ibid, p. 294). To be **in** our selves requires "a sense of our own cultural identity" (Ibid, p. 293). In addition, Green suggests that therapists should explore and examine their "personal feelings and responses to ethnic minority clients," asserting that "if unexamined, predisposes therapists to make a range of inaccurate assumptions about clients and their experiences" (Green, 1994, p. 229). Altman additionally asserts, "we should expect to find racism in our countertransference and in our thoughts and feelings

generally and that reflection on our countertransference is an essential element…" (Altman, 2000, p.592).

Initially, a therapist must accept that they are always operating from their own biased experience as "…it underlines the importance of understanding the subjective experience of the client within her/his own frame of reference…" (Hertzberg, 1990, p. 287). In acknowledging one's own biases we can come to appreciate the worldview of the clients, which also means, "that we must learn to tolerate ambiguities and continue to question our stance in relation to the position and values of our client" (McGoldrick, Giordano, 1996, p. 25). Altman would suggest that via a three-person model we focus on the following:

> "…our attention not only to the analytic dyad but also to the patient's and the analyst's relationship to the social context within which the analytic dyad functions. This context includes the social class setup of the society of which patient and analyst are members and the taken-for-granted attitudes about social class within that society that condition both patient's and analyst's assumptions about self and each other." (Altman, p. 79)

Furthermore, Altman directly states that should clinicians identify "racism" within themselves, they "become familiar… not that they overcome their racist feelings and attitudes" (Altman, 2000, p. 602). To insist that therapist "overcome" their "racist feelings" sets-up the possibility "that they will mistake their conscious goodwill and good intentions for a thoroughgoing nonracist attitude" (Ibid. loc. cit.).

Green suggests "therapists who have not taken the time to explore fully the manifestations of these dilemmas will find it difficult if not impossible to unravel them successfully" (Green, 1994, p. 229). I interpret Green's "dilemmas" as the dynamics, within the therapist, that have led to a lack of awareness of self and role in the larger

society. Hertzberg asserts "to deal effectively with a wide range of clients, we need to have developed sociopolitical analysis of the distribution of resources and power in this society" (Hertzberg, 1990, p. 293).

The power dynamic present in the room is obvious to the client, based on the "expert" role of the mental health professional, which must be acknowledged despite similarities in sexual identity, race, and language. Regardless of how we attempt to distance ourselves from this role of "expert" and the "other," we cannot focus our attention on attempting to change this perception, but work amongst it to better understand our level of engagement. Therapists must be willing to place themselves on the clients "relational map as a means of understanding the 'other' as well as merger fantasies of being understood by the 'other'" (Chamorro, 2003, p. 87). The therapist's inability to own and navigate amongst their oppression and privilege in relation to the client inhibits the development of useful transference and counter-transference. "Through this unfolding of the client's inner world, facilitated through the attuned responsiveness of the therapist, the transference relationships can be utilized in the service of psychological growth" (Hertzberg, 1990, p. 289).

Pitfalls

As I mentioned earlier, working with a client within her identity in conjunction with her presenting issues may pose some pitfalls, should the therapist be either too eager or too dismissive. Hays asserts that "knowledge of client's salient identities gives the therapist clues about how clients see the world…" yet "questions about a client's identity may also be inappropriate when clients perceive the concept of identity to be an

abstraction unrelated to their presenting concerns. In fact, identity is an abstraction – one that may be useful to therapists but not necessarily to clients" (Hays, 2007, pp. 58 - 59). Should the Queer Chicana client find it unnecessary to discuss her identity, the therapist must be cognizant of assumptions about the client. Espin states, "to be subjected to the constant stress of racism and sexism has a definite impact on a person's mental health. Attempts at restoring a person's well-being (or "mental health") that do not include a considerations of all stressors in a person's life are obviously doomed to failure" (Espin, 1987, p. 54). For the Queer Chicana, include homophobia from the larger society and from her identified culture and community. Hertzberg states "Denying or minimizing the impact of these differences on the client and the therapy relationship… colludes with the denial of the pervasive and pernicious effects of oppression" (Hertzberg, 1990, p. 291).

Another pitfall will arise when therapists brings with them their own perspective and applies it to the client, provided the therapist's idea of being able to 'relate.' Should the therapist of this Queer Chicana be also Queer-identified, yet is White or belonging to another dominant group, attempt to relate based on gender and sexual preference alone, ignoring the essential difference of dominant culture in the equation. Suyemoto and Kim have stated, "Gender cannot stand alone as the primary source of influence or oppression." Without considering all the variables (race, ethnicity, religion, etc.) we have then asked that the individual prioritize their identity, which ultimately then negates the contribution of these other variables on their identity as 'Woman.' A therapist need not be of the dominant culture to fall into this pit-fall of being overly eager to identify; Hays states "although sharing a personal experience that parallels the client's may be intended to communicate empathy, it may also be perceived as undercutting the uniqueness of, or

pulling away from, the client's experience" (Hays, 2007, p. 79). The therapist must have awareness of their boundaries, and the motives behind self-disclosure of similar experiences.

Similarly, "the gay or lesbian therapist who is also a person of color may be predisposed to certain countertransference dilemmas. The most obvious is observed in the therapist who is over-identified with the client and as a result tends to overlook or minimize psychopathology" (Green, 1994, p. 231). Consider Hertzberg's notion that "another pitfall occurs when the therapist oversimplifies and attributes all of the patient's problems to issues of discrimination" (Hertzberg, 1990, p. 291). A disservice is also done if the therapist "romanticizes the client struggles," which may "lead them [therapists] to avoid setting appropriate limits in treatment or calling client's attention to their own roles in their dilemmas" (Ibid, p. 229). The countertransference of the therapist, of their own analysis and hopefully with consultation, can inform if the feeling is sympathy rather than empathy. It is a delicate balance, as Green suggests, knowing when to push "personal responsibility" and when to acknowledge the "realistic barriers of the multiple levels of real, not fantasized, discrimination" (Green, 1994, p. 229).

There is a fine line between appreciating cultural differences and viewing the client as a vessel for the therapist to learn, making the client ultimately feel *exotified* and objectified. Insisting on knowing everything about the client's identity will objectify the client, in the mind of the therapist and in the therapeutic space. There's also the idea that "the therapist may be overzealous and over-involved with the client for reasons of alleviating her/his own guilt" (Hertzberg, 1990, p. 292). As mentioned above, if therapists feels guilty or "sorry" for the client, they end up reducing the client to no more

than just their identity. In considering Altman's ideas of social constructivism, we cannot expect to make amends or rid ourselves of "racism" therefore in an inauthentic over-interest only projects a sense of pity, further patronizing the individual.

Lastly, I will mention the pitfall of believing that all clients can be and should be addressed with the same approach, despite cultural differences or because of cultural differences. It has been suggested that certain therapeutic techniques appeal to specific groups of individuals, or that one can apply a universal approach. Both of these assertions focus heavily on developmental stages, assuming that all individuals experience development similarly. As De Monteflores discusses, "the developmental approach" tends to attempt to universalize and "ignore the specific effects of difference and the quality or uniqueness of each instance" (De Monteflores, 1986, p. 88). She further asserts that "inherent in the developmental attitude is the assumption that human nature is understandable by reducing it to simple, universal traits which can be discovered and categorized" (Ibid, p. 88). Altman would insist "this position amounts to taking personal responsibility for our moral commitments, as opposed to making appeals to universal validity" (Altman, 1995, p. 73).

Conclusion

In summary, I would like to reiterate that I don't believe we can ascribe to a specific universal psychotherapy technique in working with our clients. The only universal claim is just this - we must meet a client where they are at in their process of integration of the self-defined identity. In holding this space for the client to examine the

convergence of worlds they inhabit, we must be cognizant of the client's chosen boundaries, attributes, and how they associate their identity as impacting their internal psychic struggles.

I offer viewing the individual who holds multiple identities as a 'system,' with further consideration of how family therapy identifies a "patient" who requires treatment – similarly the individual will find within themselves an aspect that is problematic and possibly find ways to attempt to rid themselves of it rather than work within it. Furthermore, the view of 'family' as a micro version of the larger society, in which we bear witness to authority, caretakers, and "identified patients" amongst the 'ism's: racism, heterosexism, sexism, and so on. These beliefs are then internalized and perpetuated by the members of the groups, creating and further affecting their internal psychic process, ultimately creating further distance from one another and supporting a split of the Self.

The general framework of Self-psychology can be used to work with clients in integrating their identity, by incorporating the idea of three-person psychology that adds the social component into the therapeutic space. Self-psychology relies on the transference and counter-transference, and on full empathic attunement towards the client I draw from self-psychology specifically, as it speaks directly to the relationships of the therapist and client, in which race, power, privilege, etc., cannot be ignored.

Lastly, I touched upon the importance of self-reflection by the therapist, and the possible pitfalls of an over-focus on identity. It is imperative that a therapist be willing to, and have undergone, a process of self-exploration, which means identifying not only one's oppressions, but one's privileges as well. As a woman of color, I am not free of privilege, and to not acknowledge my role in the larger construct I will provide a

disservice to my clients who will, regardless of my awareness, project every possible identity onto me and make assumptions that I must be prepared to navigate gently along with them.