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Negotiating within Whiteness in Cross-Cultural Clinical Encounters

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ABSTRACT Despite awareness in social work and related literatures that socio-cultural power dynamics are reproduced in practice, there is little research on how whiteness manifests as an oppressive discourse in clinical settings. This article analyzes audio-recorded therapy sessions between white therapists and racialized immigrant clients from an urban community mental health center in Canada to explore the ways in which whiteness shapes clinical encounters. Using poststructural theories of discourse and conversation analysis, the authors examine how discursive strategies that therapists and clients use in therapy sessions produce and reify whiteness as a prominent feature of cross-cultural communication. The findings illustrate how therapists maintain whiteness as an unmarked norm in their assessment of individual development and the family life cycle and how clients respond to, negotiate with, and resist whiteness, which positions them as subordinate others in Canada. The authors conclude with a discussion of implications for practice and future research.

INTRODUCTION

Social workers strive to achieve social justice and equity for vulnerable populations. In support of this professional commitment, various scholars propose guidelines and approaches for working with diverse populations in mental health and social service fields (Helms and Cook 1999; N. Razack 1999; Sue and Sue 1999; Lum 2000; Gaw and Mohr 2001; Razack and Jeffery 2002; Cardemil and Battle 2003; La Roche and Maxie 2003; Tinsley-Jones 2003; Lum 2006; Schiele 2007; Abrams and Moio 2009; Lee 2010; Ortiz and Jani 2010). However, a split remains among approaches to inequality and diversity in social work practice and education (Lee and Saini 2008). On the one hand, practical approaches of cultural competence emphasize culturally responsible, sensitive practice within clinical settings (Sue, Arredondo, and McDavis 1992; Pope-Davis et al. 2001; Lum 2003;

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Lee 2010, 2011), while anti-racist or anti-oppressive approaches, informed by critical race, feminist, and structural theories, stress the importance of addressing structural processes that fuel intersecting oppressions (e.g., the interplay of racism, sexism, and classism; N. Razack 1999; Razack and Jeffery 2002; Mullaly 2007; Schiele 2007; Ortiz and Jani 2010). Both approaches have noted limitations: cultural competence theories are criticized for essentializing culture, thereby categorically blurring together multiple oppressions while dismissing structural forms of oppression (e.g., institutional racism) and their effects on social relations; anti-oppressive theories do not provide clear direction to inform individual and interpersonal interactions in clinical settings (for detailed discussion, see McLaughlin [2005], Millar [2008], and Parrott [2009]).

Several authors, concerned by this split, seek to integrate both anti-oppressive and culturally competent principles into social work practice. Some scholars poignantly describe how culture, race, class, and other systematic issues are pervasive in clinical practice, using vivid case studies and everyday examples (Comaz-Diaz and Jacobsen 1995; Leary 1997; Perez Foster 1999; Eng and Han 2000; Keenan 2001; Berzoff, Flanagan, and Hertz 2008; Rasmussen and Salhani 2010), while others propose various ways of training social workers by incorporating both anti-oppressive and culturally competent services in client care (Goldberg 2000; Patni 2006; Charnley and Langley 2007; Parrott 2009). Still others investigate whether and how culture, gender, class, and race influence clients' engagement with therapists and therapy and treatment outcomes (Thompson and Jenal 1994; Thompson, Worthington, and Atkinson 1994; Seeley 2000; Worthington et al. 2000). While empirical evidence supports the claim that structural and systemic issues affect clients' lives and clinical encounters, few studies explore the ways in which dominant values and social norms arise within and shape cross-cultural clinical encounters.

This article draws upon interdisciplinary scholarship on whiteness as a dominant yet highly "invisible" sociocultural perspective that undergirds cross-cultural clinical encounters (Nylund 2006). The study of whiteness within academic and professional disciplines emerged in the 1990s with an interdisciplinary inquiry into the often unacknowledged construction of whiteness as a central feature in racial ideology. Ruth Frankenberg (1993), a leading scholar in the field of whiteness studies, defines "whiteness" as "a set of locations that are historically, socially, politically, and culturally produced and, moreover, are intrinsically linked to unfolding

relations of domination.” She argues that “to look at the social construction of whiteness, then, is to look head-on at a site of dominance” (6). For example, bell hooks (1997) recalls that black people in the United States have exchanged special knowledge about whites throughout the history of America as a means to cope and survive with white supremacy. Academic studies of whiteness emerged as a way to theorize the racialization of white people; whiteness is a standpoint that promotes Eurocentric ways of thinking, allowing the relational production of norms to remain unrecognized and invisible (Morrison 1992; Dyer 1997; Frankenberg 1997; DiAngelo 2006).¹

This article examines how whiteness operates as an unmarked yet relevant feature of talk in clinical settings and how speakers, in this case a therapist and a client, position and reposition themselves vis-à-vis the production of whiteness. We understand cross-cultural clinical encounters as more than an encounter between two individuals, but also as filled with micro-interactions where broader social relations play out. This article draws empirically from video- and audio-recorded clinical sessions of cross-cultural dyads in clinical practice. Using critical, postmodern, and poststructural theories of language and discourse (Foucault 1980; Bakhtin 1981; Fairclough 1993, 2003; van Dijk 1993, 1998; Gee 1999) in conjunction with feminist approaches to conversation analysis (Drew and Heritage 1992; Hopper and LeBaron 1998; Stokoe and Weatherall 2002; Peräkylä 2004), we explore the discursive strategies therapists and clients use during clinical sessions (e.g., topic control, sequential organization, and interactional asymmetries), concluding with a discussion of different approaches to address the hegemonic and oppressive presence of whiteness. We suggest strategies to de-center, rather than to remove completely, the ways in which whiteness operates within clinical encounters, toward opening the clinical dialogue to the client’s worldviews.

1. We follow the lead of anti-racist scholars in Canada who use the concept of “racialization” to refer to “systemic and structural processes—social, economic, cultural, and political—that exclude, marginalize, inferiorize, and disadvantage certain groups and populations based on the categorization of biological features” (Zaman 2010, 164). Although a range of similar concepts (e.g., “visible minority” and “racial minority”) are often used interchangeably, Jane Ku (2009) argues that these state-created categories depoliticize anti-racist resistance, masking racialized hierarchies. Different groups may be racialized, or in other words marked as different *others* in relation to the norm of whiteness (e.g., Jewish immigrants in North America in the nineteenth and early twentieth centuries).

LOCATING WHITENESS IN CROSS-CULTURAL CLINICAL ENCOUNTERS

Social work literature engages with two major themes in whiteness studies: how whiteness produces unearned race privilege for whites (McIntosh 1990) and how whiteness remains invisible as a sociocultural perspective for most white people (Nylund 2006; Mindrup, Spray, and Lamberghini-West 2011; Jeyasingham 2012). Attention to white privilege in social work ranges from an emphasis on racial identity consciousness among social work students (Pewewardy 2007) to discussion of racial identity with white clients as a means to foster a more integrated sense of self of the clients (Blitz 2006). We agree with Catherine Phillips (2010) in her critique of the use of linear conceptualizations of identity development in social work education, as abstracted from “engaged knowledges on historical racialization patterns, political ideologies, and economics, the very materiality of racism is decontextualized and detemporalized” (29). While identity consciousness is a compelling heuristic for the anti-racist practitioner, we caution against the centrality of identity work in anti-racist practice. Phillips argues that “identity is a site of politics, but it is not a site of explanation; nor should it be a definition of competence” (2010, 43); the practice of naming social identities reifies identity as a fixed status. Following Judith Butler’s (1990) conceptualization of performativity, this study does not assume that identity is static or that identity is synonymous with one’s actions. In other words, people may consider themselves to be anti-racist yet take part in and contribute to racist discourse and practices. Furthermore, as a site of politics, each individual takes up different identities in different contexts and for different purposes. Thus, this article explores whiteness not as a social identity but as a sociocultural standpoint that is present within the therapy process.

To date, interdisciplinary research in counseling and psychotherapy has explored how therapists’ values and assumptions regarding societal norms shape client-therapist interactions during clinical encounters, with particular attention being given to the assessment of psychological issues and treatment recommendations (Cochrane 1979; Dean et al. 1981; Herr 2005; López 2005). Alfred López (2004) illustrates how whiteness operates as a “cultural imperative” in Freud’s theory of countertransference, while producing “universalizing diagnostic tendencies” (186). Clinical practice necessitates that therapists constantly negotiate and balance between promoting the social adaptation of clients, which requires clin-

icians to be responsible for social regulation and the discipline of others, and promoting self-determination and empowerment of clients, which obliges therapists to be respectful of clients' own agency and values. In cross-cultural therapy, the struggle to negotiate between these two seemingly opposite roles can be intensified due to the unmarked domination of white worldviews (Weinberg 2006).

Considering that whiteness is tied to the sociocultural history and context in which it operates, we follow David Goldberg's (2001) analysis of racialization as inherently linked to the modern nation-state formation, such that whiteness is "caught up in and reproducing local, national, and geographical relations" (Hunter, Swan, and Grimes 2010, 410). Sunera Thobani (2007) argues that since its foundation, Canada has been imagined as a nation of European settlers, with the British and French as the preferred races within the bureaucratic apparatus of the white-settler state. Canadian scholars and activists use the term "white-settler society" to recognize the colonial violence that founded Canada, while noting the social and cultural practices that continue to "mimic" the culture, values, and institutions of the British (and French) society (Stasiulis and Jhappan 1995, quoted in S. Razack 1999, 167). Although multiculturalism became the official policy in Canada in the 1970s, intended as a way for Canada to envision itself as a multiracial and multiethnic society, Thobani notes the paradox in Canadian definitions of itself as a bilingual and bicultural nation, where racialized constructs of the British and French remain its real subjects (Thobani 2007).

Our analysis of whiteness in cross-cultural clinical encounters explores the ways in which everyday social relations produce and maintain European hegemony through the constructed image of Canada as a white settler nation. Canada aligns itself within the global hierarchy, which is inseparable from the history of European colonization and imperialism. Prominent Aboriginal scholar Cindy Blackstock (2009) argues that Western ontology, which stems from histories of colonization, capitalism, and more recently, global neoliberalism, contributes to ineffective social work interventions, particularly with indigenous or First Nations communities (Blackstock 2009). Johanne Saraceno (2012) argues that "helping" professions in Canada are "embedded in a Western world view founded in the privileging of capitalism, heteronormativity, patriarchy, and whiteness" (264). As such, human and social services are deeply invested in the logic of free market values and globalized economics, including values

of competition, privatization, individual responsibility, surveillance, and managerialism (Phoenix [2004], as referenced in Saraceno [2012]).

In order to further locate our analysis within social work practice in Canada, we focus on how whiteness is expressed through the discourse of multiculturalism and how it operates within professional social work and the official discourse of the Canadian government. Feminist and anti-racist scholars criticize multiculturalism, claiming that it disguises liberal-democratic politics that essentialize nonwhite people as symbols of culture, while it maintains whiteness as the imaginary core of Canadian society (Bannerji [2000], as referenced in Saraceno [2012]; Razack 2002; Ku 2009). Whiteness in Canada is inextricably linked to histories of colonization and the domination of people of European descent. In their analysis of white-settler colonialism in the United States, Mario Gonzales and Elizabeth Cook-Lynn note: "Indeed American whiteness is a product of European invasion and genocide against American Indian people" (Gonzales and Cook-Lynn [1999], 261, quoted in Allen [2006]). We similarly argue that rhetorical inclusion of "nonwhite" groups into Canada through multiculturalism represents the ongoing struggle of non-European peoples to be fully recognized in society. While multiculturalism professes to include all groups, this discourse is illustrative of marginalization faced by racialized immigrants and indigenous peoples within Canadian society such that their racial and cultural backgrounds become "visible" (often as inferior) and their culture becomes marked by this struggle (Flores and Benmayor 1997; Allen 2006).

Multicultural discourse in social work also relies on a deficit model of culture, which, according to social work historian Yoosun Park (2005), constructs culture as difference that must be managed. Critical race scholar Sherene Razack (1998) similarly challenges the widely held view that cross-cultural encounters between unequal groups can be "managed" as pedagogical moments. Social workers and other professions are charged with maintaining knowledge about the "other" as a means to improve racial, cultural, or gender sensitivity, but in doing so they assume that this knowledge is key to assisting the other while maintaining social control. Razack argues that cross-cultural approaches presume that "the colonized possess a series of knowable characteristics and can be studied, known and managed accordingly by the colonizers whose own complicity remains masked" (1998, 10) and that reading differences from the unmarked vantage point of whites reinforces the gaze of the colonizer in multicultural

discourse. The Western gaze refers to the reference point or perspective of whites in society that is pervasive but invisible, and thus operates as common sense. In cross-cultural encounters, this Western gaze positions the viewer (any person who is viewing another person as other) within the norms of whiteness, removed from the resistance and the suffering that this gaze continues to produce (Allen 2006, 67; also see hooks 1997).

Even for social workers who embrace anti-racist principles, Donna Jeffery identifies inherent tensions between anti-racist practice and the role that social workers play in “the management of difference” (Jeffery 2005, 410). Social work scholar Bob Mullaly (2007) notes that multiculturalism emerged in the 1970s in Canada, the United States, and Australia as a dominant theory in social work to improve social workers’ cultural sensitivity and minimize institutional racism. Cultural competence approaches focus on how social workers can become more sensitive to cultural differences “to better establish a ‘helping relationship’ with members of other races and cultures to make services more accessible and to advocate for the enactment of equal rights legislation” (Mullaly 2007, 281). We support Shona Hunter, Elaine Swan, and Diane Grimes’s (2010) call for a “critique of white liberal benevolence” (412) in social work, particularly within multiculturalism and anti-racist practices, which ostensibly challenge white supremacy and oppression.

This article seeks to further develop scholarship on whiteness in social work by exploring the ways in which whiteness manifests as an unmarked but clinically relevant feature within cross-cultural communication in clinical practice. Our analysis of whiteness addresses the following themes: (a) how therapists affirm and maintain whiteness in clinical talk and how whiteness informs their assessment; (b) how the production of whiteness in society in general and its re-production in therapy encounters reifies clients’ subjectivity as a subordinate other (in this study as racialized immigrants); and (c) how clients resist whiteness while negotiating multiple discourses of belonging and performing their subjectivity as immigrants within Canada.

Before continuing, we want to clarify our own location with respect to the current study. We both study the role of culture in practice and research with immigrants. The first author has a substantial practice and research background in cross-cultural clinical practice, and the second author works primarily in the areas of anti-violence and anti-racist practice and community-based research with immigrant, refugee, and indige-

nous groups. As two female academics in North America with Asian heritage, we also have personal experience as racialized subjects within the Canadian nation-state. We are mindful that our perspectives are shaped by both our minoritized position within North America and our privileged status as tenure-track professors in academia. We want to review critically how whiteness is a pervasive yet relatively unmarked phenomenon even for us and how it shapes the production of knowledge in which we take part as social work educators and scholars.

METHODS

The data used in this study come from a study on cross-cultural communication conducted by the first author (Lee 2008). The original study explored the question of how cultural dialogues are initiated and integrated into the therapy process in cross-cultural clinical practice. This section presents a brief summary of participants, data collection procedures, and data analysis (for a detailed description, see Lee [2008]).

PARTICIPANTS

The authors examine five cross-cultural dyads, consisting of three therapists and five clients who participated in the original study.² The authors initially recruited therapists who self-identified as white in larger urban areas in Canada. When there was a referral and clients self-reported their racial and ethnic background as a racial or ethnic minority, the therapists or intake workers in their agency recruited clients to participate in the study.

The three female therapists ranged in age from late 30s to 50s at the time of this study and had from 7 to over 20 years of clinical experience. Therapist A participated with three different clients (Clients 1, 2, and 3). Therapist B participated with Client 4, and Therapist C with Client 5. All the therapists reported experience working with culturally different clients, though Therapists A and B said they did so “occasionally,” whereas Therapist C reported working with such clients “on a regular basis.” Therapists A and C were social workers with a master’s degree, and Therapist B had

2. The original study included a sixth dyad, which included an African-American client who was recruited from a community health network in the United States. This case is excluded from the current study, given our focus on the production of whiteness in Canada.

a master’s degree in counseling psychology. Therapists A and B worked in a family counseling agency, and Therapist C worked in the psychiatric unit in a general hospital.

The five clients participating in the study are all first-generation immigrants to Canada—from Mexico, Iran, Pakistan, Argentina, and the Philippines. Table 1 summarizes the demographic information of the client participants and their presenting issues.

RESEARCH PROCEDURE

The therapist and client participants were informed that the study was to explore cross-cultural therapeutic processes between clients of color and their white therapists. Having given written informed consent to participate in the study, the client and therapist participants commenced their therapy as usual. The first three consecutive sessions from each dyad were audio- or video-taped, with the exception of one case in which both the client and therapist agreed to terminate after the second session. All taped sessions were transcribed verbatim for analysis. Clinical judges then identified excerpts from the transcripts as cross-cultural dialogues based

TABLE 1. Demographic Information of the Client Participants and Their Presenting Issues

	Client 1	Client 2	Client 3	Client 4	Client 5
Age	40s	Missing data	40s	40s	40s
Gender	Female	Female	Female	Male	Female
Country of origin	Mexico	Pakistan/ Kuwait	Iran	Argentina	Philippines
Racial/ethnic self-identification	Latino	Indian (Muslim)	Iranian	Argentinean	Chinese Filipino
Immigration history	About 3 years ago to Canada	About 3 years ago to Canada	12 years ago to Canada	Years ago (unidentified) to Canada	25 years ago to Canada
Primary language	Spanish	Urdu	Persian	Spanish/English	Tagalog/ Chinese/ English
Presenting problems	To address her struggle with her acting out 17-year-old daughter	To address her 5-year-old son who was shy and fearful about starting school	To address her depressive symptoms	To address the ongoing stress with his ex-wife during the divorce process	To address her stress after her daughter was hospitalized in an inpatient psychiatric ward

on a described procedure below, and these excerpts were then reinterpreted using conversation analysis and discourse analysis.

SELECTION OF THE CROSS-CULTURAL DIALOGUES

The first author drew upon existing literature on cross-cultural research to conceptualize and identify cross-cultural dialogues. For example, Roger Worthington and colleagues (2000) define multicultural verbal content as “explicit verbal reference to culture, race, ethnicity, minority status, cultural values, cultural differences, cultural conflicts, racial-cultural identity, and environmental, geographical, or social conditions arising from any of the above factors” (463). Elizabeth Keenan (2001) developed the Sociocultural Category Coding System (SCCS) to consistently examine 12 key elements of sociocultural categories: race, ethnicity, social class, gender, sexual orientation, religion, (dis)ability, nationality, political affiliation, age, geographical origin, and residence. This literature provides the basis for coding the recorded therapy sessions for cultural content, when one or both speakers made verbal reference to culture, race, ethnicity, religion, nationality, majority or minority status, cultural values, cultural differences, cultural conflicts, racial-cultural identity, and geographical conditions arising from any of these factors, such as references to community (e.g., neighborhood in an inner city area), subnational regions (e.g., Northern Territories in Canada), national (e.g., other than Canada), or continental aggregates (e.g., Latin America, Asia).

The first author and a clinical social worker independently reviewed all recorded sessions using both transcripts and audio recordings to assess what portions of talk qualify as cross-cultural dialogue. After highlighting the transcripts for any references to cultural content as defined above, both reviewers met to address discrepancies and to reach consensus on when episodes of talk met the criteria for cultural content. Out of approximately 700 minutes of the data pool, a total of 17 episodes comprising 110 minutes (16 percent) were identified as cross-cultural dialogues. Of these 17 episodes, the first 10 were from case 1, two episodes from case 2, two episodes from case 3, two episodes from case 4, and one episode from case 5. Cross-cultural dialogues across all of the sessions covered a range of topics, including child-rearing practices (10 out of 17 episodes addressed this topic), immigration (8), nationality (5), religion (4), English as a second language (3), arranged marriage (2), race (2), and poverty (2).

During these identified cross-cultural dialogues, values and beliefs that stem from whiteness were raised by the therapists. Specifically, the manifestation of whiteness included reference to privileging individual self (I-self) over family self (we-self); preference for personal choice versus parental guidance with regard to marriage, education, and career choices; adolescence as a turbulent period for negotiating autonomy and self-discovery; and child-raising practice as primarily the parents' responsibility as opposed to a shared community or collective responsibility. In some cases, therapists employed cultural stereotypes when suggesting treatment options (e.g., Latino men love soccer and therefore playing more soccer was suggested as a self-care strategy for a Latino client in case 4/Client 4). In addition, whiteness as a normative standpoint sometimes reinforced individual coping skills while minimizing or dismissing systematic oppression (e.g., racism or the marginalization of newcomers in Canada).

FRAMEWORK FOR DISCOURSE AND CONVERSATION ANALYSIS

We draw from sociolinguistic theories of language as social action (Chafe 1997), employing critical theories of discourse and conversation analysis to investigate how the structure and content of talk allows us to “be” and “do” things: James Gee (2011) states that, “in language there are important connections among saying (informing), doing (action), and being (identity)” (2). While the subjective meaning, intention, and content of language between a client and therapist are a central theme in much clinical research, this study addresses the often overlooked but important link between the content and the structure and pattern of talk. The focus on what speakers “do” draws attention away from theorizing about their intentions when they speak (Stokoe and Weatherall 2002; Allen 2006). In the analysis of how whiteness emerges in cross-cultural dialogues, we follow Allen's approach to thinking about whiteness “as a signifier implicated in both ethnic performance and historical processes; treating ‘whiteness’ not as a ‘thing’ (or even several ‘things’) but as a signifier helps us see its use as a *practice*” (2006, 66). Thus, our analysis of whiteness seeks to explore multiple forms of whiteness that emerge in cross-cultural clinical dialogues.

Critical theories of discourse analysis (CDA) are employed to link the significance of talk to the context in which it occurs. Talk between two individuals represents a site where broader social relations are produced,

managed, and negotiated. Rolf Kroger and Linda Wood (1998), however, caution that talk between people of different social locations may or may not explicitly illustrate their social differences. For example, talk between people of different age groups is not inherently “intergenerational communication,” because from a social constructionist standpoint, they contend, “we do not actually ‘have’ intergenerational communication; there is no such ‘thing’ in the sense of some physical object or movement. All we have is talk between two people of particular ages; whether it is reasonable to frame it as intergenerational depends on how the people involved treat it, whether they see their ages as ‘different’ and take this into account in their conversation” (Kroger and Wood 1998, 269). Following this work, we do not presume that all talk between white therapists and their racialized clients automatically becomes cross-cultural. Indeed only 16 percent of speech in the recorded therapy sessions includes explicit cross-cultural dialogues. Nor do we assume that all cross-cultural talk that involves a white and nonwhite person manifests whiteness. Rather, we examine the ways in which whiteness surfaces as a relevant feature within talk that naturally occurs in the clinical setting.

We also use theories of conversation analysis (CA) to examine the interactional processes in cross-cultural dialogues (Drew and Heritage 1992; Peräkylä 2004). In particular, we identify the structures, general sequences, and patterns of utterances between a speaker and hearer and ultimately the power dynamics between therapists and clients in clinical dialogue. These include attention to turn-taking, closing conversations, introducing or changing topics, asking questions, making requests, and other related features of talk (Forrester and Reason 2006).

METHOD OF ANALYSIS

The first author performed the preliminary case-by-case, turn-by-turn analyses of each identified episode of cross-cultural dialogue, focusing on two domains of CA: sequential organization and interactional asymmetries. The former is defined as how the speakers (either a client or therapist) link each turn to the previous in a way that enables hearers (either a therapist or client) to follow cultural dialogue. Abrupt changes in the organization of the talk, like over-talking and foot-dragging, indicate interruptions in talk (Viklund, Holmquist, and Nelson 2010). Interactional asymmetries include systematic differences in the participants’ modes and

affective states of participation, any indication of power struggles in turns, lexical choices (i.e., word choice), and length of the talk. The first author coded the episodes of cross-cultural dialogue according to the transcript symbols in CA, listed in table 2, which were cross-checked for the accuracy of coding by a second coder who was a graduate student and had advanced training in CA. We then interpret this turn-by-turn conversation analysis with our close reading based on critical theories of discourse.

RESULTS

We selected the two vignettes presented below from two different cases (two different client-therapist dyads) to illustrate the identified themes, with consideration of the brevity of this article. The discussion of clinical data illustrates the discursive strategies employed by therapists and clients, including speakers’ use of interruption, repetitive talk, direct questioning, focus of talk, and turn-taking organization. A discourse analysis of how the therapist signifies whiteness as a normative concept to assess parenting and human development complements the turn-by-turn conversation analysis. We also describe how the clients positioned and re-

TABLE 2. Transcription Symbols in Conversation Analysis

Symbol	Description
[	Starting point of overlapping speech
]	Ending point of overlapping speech
↑	Upward shift in pitch
↓	Downward shift in pitch
wꞤrd	Emphasis
wo:rd	Prolongation of sound
“word”	Section of talk produced in lower volume than the surrounding talk
WORD	Section of talk produced in higher volume than the surrounding talk
wo(h)rd	Laugh particle inserted within a word
wo-	Cut off in the middle of word
word<	Abruptly completed word
>word<	Section of talk uttered in a quicker pace than the surrounding talk
<word>	Section of talk uttered in a slower pace than the surrounding talk
.hhh	Inhalation
Hhh	Exhalation
()	Inaudible word
((word))	Transcriber’s comments

Note.—Simplified from Drew and Heritage (1992) and Peräkylä (2004).

positioned themselves with regard to the production of whiteness in the clinical encounter.

CASE EXAMPLE 1: NEGOTIATION WITHIN THE PRODUCTION OF WHITENESS

This client (Client 5), who was in her late 40s and whose primary languages was Tagalog and Chinese, emigrated from the Philippines to Canada 25 years ago. She came to therapy in an adolescent psychiatry unit after her daughter was hospitalized in the ward for paranoid thoughts and attempted suicide. The client's husband, who was not Filipino but was also an immigrant to Canada, was traumatized by living in a war region of Africa, and he had severe mental health issues. The client entered therapy to address her guilt and regret around the daughter's illness and hospitalization. She perceived that if she had not refused her parents' wishes for her to participate in an arranged marriage, come to Canada, or met her husband, she and her daughter would have not suffered from psychiatric issues.

The therapist (Therapist D), in her 40s, was a social worker in an inner-city hospital adolescent inpatient psychiatry unit, with 7 years of post-graduate clinical experience. She worked with racially diverse clients "on a regular basis," and she identified her racial and ethnic background as Caucasian. The treatment plan comprised brief therapy for up to 10 sessions. This therapist employed psycho-education about trauma and mindfulness exercise (e.g., grounding techniques) in a manner that is consistent with trauma-focused therapy (Herman 1992), in addition to providing case-management services with regard to the client's hospitalized daughter.

The following vignette is from the second session. In this vignette, the client initiates a discussion linking her presenting problem, her daughter's psychiatric illness, to her decision not to follow her parents' wishes for her to have an arranged marriage. The therapist directly questions the client's beliefs and family values, which the client describes as "cultural," while focusing on the client's expression of individual choice as a positive trait.³

Vignette 1

26. C: And I sa:y to, uh:, my boss today, "I think, uh, I'm suffering because of my ideas ((not)) follo:wed what my parents was for me;" I sa:y.

3. In both vignettes in this article, the numeric number in the beginning of the dialogue indicates the line number of the episodes; T refers to Therapist and C to Client.

27. T: You said that? ↑ Hmm: interesting.
28. C: Ye:ah, that was uh, in my culture,
29. T: [Uhummm]
30. C: . . . [uh, we] had the pa:rents tell us, right? ↑ The pa:rents is the one cho:se your husband.
31. T: Your parents . . . OH! ↑ They ha:ve to choo:se . . .
32. C: [Yes.]
33. T: [. . . your husband for you ↑]
34. C: Ye:s.
35. T: OK.
36. C: So:
37. T: They did it for you? ↑
38. C: [Yeah].
39. T: [Because you're . . . ((inaudible))]
40. C: And I-I didn't agree: because< oh- and I left already Hong Kong and then my mom they went to Hawaii and then they say, "OK, now, so I have a guy" that they get for me and then I say, "Not right now, I need: to see another country and then: later on I come back." And th:en they are in separate ((*inaudible*)) so: my parents they ask me when I am 30 years old and: I the:n I need to marry a man and they said, "Da-ah." ((*laughs*))
41. T: ((*Laughs*)) Yo(h)u didn't like that? ↑
42. C: And then I say, "Oh, no, I find already another one," and then I say, "Mom, I am getting married so come home already," and then my mom and my dad they don't get home already but my grandmother did.
43. T: Oh, your grandma came? ↑
44. C: Ye:s, they did.
45. T: Oh, GOOD for her↑.
46. C: Yes, but they don't like it.
47. T: Yeah.
48. C: So ((*pause*)) . . . that's .hhh the thing.
49. T: That is all, so: it ma:kes ev:en harder for you: to sha:re with them
50. C: [Yes.]
51. T: [. . . what is happening?]
52. C: [Yeah, that's Hhh]
53. T: [But, you know, like,] so what-what . . . how can you be sure that the other gu(h)y . . . ((*laughs*))

54. C: ((*Laughs*))
55. T: Well, then he be:ttter.↑
56. C: I think so, maybe: < if I marry and then maybe I be:ttter like . . . I don't kno(h)w. ((*chuckles*))
57. T: Yeah.
58. C: ((*Sighs*))
59. T: Ye:ah, ye:ah. Do you believe that↑, uh, the parents re:ally have . . . would you want to provide partners for your kids? ↑
60. C: Uh, no. I'm—I believe in this fo:reign country and >then I say<, 'I ca:ll you 'cause your lo:ve me. Because you are my' . . .
61. T: Uhummm.
62. C: . . . 'because you have the right to do', so: no:thing, I say.
63. T: Uhummm.
64. C: But the most important I tell to my ki:ds, like my momma so they te:ll us, "OK." I te:ll to my ki:ds that 'the most important is education.'
65. T: Uhummm.
66. C: I say, You finish your e:ducation' . . .
67. T: Uhummm.
68. C: . . . so the:y . . . 'like your brother he:re and >the next day< you ca:n get ma:rried, I don't ca:re.'
69. T: ((*Laughs*))
70. C: 'As lo:ng as you finish your edu:cation.'
71. T: Yeah↑
72. C: That is something I te:ll to my ki:ds.
73. T: Yeah↑, ye:ah.
74. C: Because< no:w most of the kids these days, they don't care.
75. T: No, no, no, no, NO.↑
76. C: Especially here.
77. T: Ye:ah.
78. C: So: . . . [but . . .
79. T: [But di:d your parents, uh, choose, uh, uh, partners for your sisters? ↑
80. C: My o:ther sisters? ↑
81. T: Ye:ah.
82. C: Uh, two of my sisters . . . ye:s. And my . . . one of my brothers, [but]
83. T: [NO?]
84. C: [I . . . no(h)] ((*Giggles*))
85. T: See? ↑ You're NOT the only one.

86. C: Yes, yea(h)h.
 87. T: You're not the only one.
 88. C: Yeah. So . . .
 89. T: Ve:ry independent . . . it is OK.
 90. C: Ye:s.

Conversation Analysis: Turn-by-Turn Analysis of Language Use

In this vignette, the therapist's explicit interest in the content of the client's narration is indicated by questions (turns 31, 33, and 37). These questions invite the client to explain further how her parents' disapproval of her marriage of choice (turns 40 and 42) contributed to her current stress. In turns 49 and 51, the therapist acknowledges that breaking the cultural norm still influences how the client manages the presenting issues (i.e., it is difficult for the client to share her current struggles with them). In turns 53 and 55, however, the therapist interrupts the client to offer an alternative view, suggesting that she might not have been better off with a partner chosen by the parents. This suggestion dismisses how the client previously framed her suffering (i.e., in turn 26: not following what my parents wanted for me). After this interruption by the therapist, the client begins to express confusion (e.g., in turn 56: "I don't know"). The client hesitates to further discuss the issue in her own terms (turn 56). Instead, when the therapist directly questions the client's cultural norm on arranged marriage in turn 59, the client joins the therapist in challenging her own culture's view of arranged marriage by making a unilateral statement of her loyalty to the Canadian context: in turn 60, the client states, "I believe in this foreign country." In turn 79, the therapist brings the focus of the session back to arranged marriage. In turns 85 and 87, the therapist elicits the client's agreement with her view by pointing out that the client's other siblings also chose their marriage partners. From turns 80–90, the client makes minimal engagement with the therapist, using responses, including "Yeah" and "Umm."

Critical Discourse Analysis: Positioning (and Repositioning) One's Place as "Other" within Whiteness

In this excerpt the client introduces arranged marriage as a "cultural" practice, and the therapist questions the merits of this practice, producing an othering effect in the clinical interaction. By referring to her family's expectation to follow her parents' wishes as "in my culture," the client

implies a difference between her family's frame of reference and that of the therapist's, even with regard to Canadian practices. The therapist then reproduces this difference when offering an alternative view of the client's choice in marriage. Therapists typically present alternative explanations when working with clients to reassure them, encourage insight, or change their perspective on presenting issues. In this circumstance, however, by offering an alternative viewpoint, the therapist reifies the perceived cultural difference between arranged marriage and marriage by choice. Furthermore, when the therapist frames the arranged marriage as an undesirable option, she produces a colonial gaze toward this practice; while marriage practices vary both cross-culturally and intraculturally, societies that have a strong value for individualism (like the United States, Australia, Great Britain, and Canada) are also more likely to consider romantic love to be an important basis for marriage, whereas more collectivist societies consider family union or connection to be an important basis for marriage, thereby favoring parent selection of marriage mates (i.e., arranged marriages; Dion and Dion 1996; Zaida and Shuraydi 2002). By problematizing the merits of arranged marriage, the therapist reinforces the unquestioned normality of individual choice in marriage. For instance, in turn 89, the therapist emphasizes being autonomous when she says to the client, "Very independent. It is OK." In this dialogue, the therapist responds to the client's "culture" as undesirable, thus positioning the client as a visible "other" within Canadian society, while encouraging the client to embrace her autonomous, individual self.

As the therapist reframes their conversation within a discourse of whiteness, the client at first appears to accept the therapist's construction of personal choice in marriage as normal and preferred. Through an overt display of loyalty to Canada, the client positions herself as a good immigrant who has adopted the normative values of her host country (turns 60 and 62). The client then, however, immediately shifts the topic to her value of education, which she represents as associated with her mother (who is not from Canada). She reframes marriage as appropriate only after education (turn 64), repositioning her otherness as an asset, a source of knowledge upon which she draws to inform her parenting. But the therapist does not pick up on the client's effort to clarify the centrality and importance of values she learned from her parents. The client continues to produce and reify what are presumed to be Canadian values and norms in opposition to parenting values from her home country, which are superior

to how kids are “here” in Canada (turn 76). Thus, while the client was initially recruited or called upon to position herself as a foreign other who has acculturated to whiteness by stating her belief in Canada and in marriage of choice, she reframes her status as an other as superior, rather than subordinate, with regard to whiteness; she learned the superior values toward education from her foreign mother.

Even as the client actively negotiates her position within whiteness, the therapist continues to assert whiteness as an unmarked norm until the client complies with this point of view. Toward the end of this excerpt, in turn 89, the therapist explicitly presents a Western value of an individuated and independent self as a norm to the client, who in turn responds with what looks like an endorsement of these values in turn 90. Considering the power dynamics in therapist-client interactions, the client, who at first seeks to explore her understanding of the family disapproval of her marriage as a source of her current suffering, ultimately relinquishes to the therapist and verbalizes her agreement with the therapist’s assessment with “Yes.”

In this case, we argue that by directly questioning the practice of arranged marriage, the therapist (*a*) expresses her disapproval of this practice as not normal or desirable, (*b*) requires the client to show her agreement with the therapist’s negative perception of arranged marriage, which (*c*) leads the client to assure the therapist of her appreciation for “this foreign country” (Canada). This excerpt illustrates how this therapist, through asserting the dominant ideology of romantic partnership and marriage, produces whiteness as the unspoken norm in Canada. Furthermore, this production of whiteness led the client to reify her subjectivity as a foreigner within Canada.

CASE EXAMPLE 2: STRUGGLING FOR POWER—WHEN CLIENTS RESIST THERAPIST’S WORLDVIEWS

This client (Client 1), who is in her early 40s and whose primary language is Spanish, emigrated from Mexico to Canada about 3 years ago with her immediate family, consisting of her husband and three children. The client voluntarily entered therapy because of problems with her 17-year-old daughter, her second child, whom the client says missed school, ran away from home on a few occasions, used marijuana, and engaged in promis-

cuous behavior. The client explains her feelings of fear over the daughter's behavior as related to the loss of the client's own deceased brother, who was murdered as a young adult. From her perspective, her mother had been in denial about his unsafe life style (e.g., drug abuse and selling) and did not intervene early enough to help him out of this risk.

The therapist (Therapist 1), who was in her late 30s, identified her racial and ethnic background as Anglo. She had about 10 years of post-MSW clinical experience at the time of data collection and reported "occasionally" working with racially diverse clients. This therapist worked in a community family counseling agency and estimated the treatment with this client as a brief therapy, approximately 12 sessions. The recorded therapy sessions adopted a solution-focused therapy approach (Berg-Kim 1998).

During the initial sessions, which were video-recorded, the client often speaks of how different her childhood in Mexico was from Canada, and she relates this to how her daughter is not respectful to her and her husband. The client also talks about economic stress, as she and her husband are underemployed in Canada. Underemployment of immigrants, particularly racialized immigrants, is an important social issue in Canada; immigrants are more likely to be impoverished despite higher levels of education than native-born Canadians (Reitz 2001; Man 2004; Li 2008). Structural inequalities may contribute to suffering in their lives and augment fear for their children's future. In this vignette, the client voices her fear that her daughter will also face economic hardship if she does not follow the advice of her parents and teachers to complete her schooling. The following vignette took place during the third session of this case.

Vignette 2

105. C: And I know it for experience. I cannot get a be:tter job IN Ca:
nada, not in my country,
106. T: Right
107. C: here becau:se I don't have the diplomas si:gned by Ca[nadian
108. T: [Right]
109. C: in:stitutions].
110. T: So, >from where you're sitting, you know that from experiences?<
111. C: Exactly.
112. T: She >mi:ght have to yet learn from experience and you said that
she is capable of learning from experience<.

113. C: Yeah, but why to fall, if somebody's telling you, 'THERE'S A ROCK.'
114. T: I know isn't t[hat]-
115. C: [*Ha!*] *Hhh*
116. T: [isn't] that the diff(h)icult aspects of parenting a tee:n. Ye:ah. Isn't that –
117. C: And she knows, she's even laughed with me together. 'Mom, what do I have to learn once I fail?'
118. T: Uhummm.
119. C: At least, sometimes, that's why I told you, 'She surprises me.'
120. T: Uhummm.
121. C: Because sense comes into her mind and says, 'Why did not I listen to you?'
122. T: Right.
123. C: 'Why do I have to learn with pain?' ↑
124. T: Because that's-that's her TASK right no:w. That's the task [of]
125. C: [But in that way,]
126. T: [this age]
127. C: [she can get deeply hurt.]
128. T: [Right]
129. C: And another very deep concern I have> like yesterday <when I was seeing this commercial about >genital herpes<,
130. T: [Right]
131. C: [And I go like], 'Oh, I added it to my list'.
132. T: [Right.] >OK<. And THAT is the-that is the challenge when you are parenting teens is that this stage that they're in they-they expose themselves to LOTS of ri:sky situations, to a lot of risks. And, you know, and that's what they thrive on is doing risky things. And so it's ho:rri:fyng for us to si:t back and know the risks that are potentially facing them.
133. C: 'That's not going to happen to me. Oh, ye:ah RIGHT. You have the power
134. T: [Right]
135. C: [because you're saying it]'
136. T: [Being 18]
137. C: [Above ALL power is surrou:nding YOU.]
138. T: [But that's being 18] is believ:ng that you're invincible, right?
139. C: *Ha*, I wa:s so fearful. That's why I-in-in that aspects-that aspect↑, I canno:t rappo:rt,

140. T: Right.
141. C: build a rapport because I was so not like that.
142. T: Right. OK.
143. C: And in my times, the greatest fear was to just get pregnant.
>Forget about syphilis. Forget about AIDS<.
144. T: Right. OK. Have you thought about the parenting group? ↑
145. C: Ye:ah, I've-I thought about it. I do:n't-I'm not sure if I'm going
to be able to—I want to, but I have to build like some, ah, sche:
dule routi:ne in my work.↑

Conversation Analysis: Turn-by-Turn Analysis of Language Use

In this vignette, the therapist and client engage in a discursive struggle. The therapist changes the focus of the conversation and dismisses the client's talk, the client repeats the talk, and both speakers talk over each other (illustrated by brackets in turns 107 and 108, 114–16, 124–27, 130–32, and 134–38). In turns 110 and 112, the therapist changes the focus from the client to the daughter to discuss the daughter's developmental issues from a Westernized perspective of parenting that fosters the development of individuality and independence (turns 124, 132, and 138). The client resists the change in focus by over-talking, and she continues to discuss her understanding of parenting from her own upbringing (turns 139, 141, and 143). This example of over-talking indicates a disjuncture of dialogue, or disengagement at the moment. In a clinical setting, therapists are trained to actively listen, and over-talking can signal a power struggle to dominate the conversation (who gets to speak and be heard). Another indication of disjuncture is the practice of dismissing the other's talk, which is shown through interactional asymmetry. In turns 112–17, the client expresses her affective frustration and fear of her daughter's ignorance and anticipated pain (and possibly her frustration with the therapist) at the same time that the therapist focuses on informing a cognitive, psychoeducational perspective of parenting (turn 132). The last example of disjuncture occurs in the client's repetitive talk, in turns 139, 141, and 143. The client repeats the word "fear," emphasizing how dissimilar her experience was from her daughter's. The repetition indicates that the client does not feel heard or understood and, therefore, needs to repeat herself to get her point across to the therapist (Tsang, Bogo, and Lee 2011). The therapist's suggestion that the client take a parenting class as possible treatment selection in turn 144 dismisses the client's previous talk. These examples illustrate

how disjuncture is evident in conversational dyads, through struggles in turns, timing, focus, and lexical choice of talk.

Critical Discourse Analysis: Resisting Whiteness as the Norm

Through these discursive strategies, the therapist tries to recruit the client to comply with her view of developmental norms. These norms center on adolescence as a time for turbulence and pursuing independence, and they are grounded in a Western and Eurocentric understanding of adolescence. In Bradford Brown and Reed Larson's (2002) discussion of parenting norms in India and the Philippines, they write, "the negotiation of autonomy, which has been seen as central to Western adolescence, is not a central motif in these cultures" (2). Cross-cultural scholarship on adolescence also questions the Western epistemology of adolescent psychology as an inherently Eurocentric enterprise (Nsamenang 2002). As such, the therapist relies on common understandings of adolescence as a turbulent period, reflecting Western constructions that, we argue, remain invisible as a specific sociocultural perspective, as shown above. To illustrate, in turns 112, 124, 132, and 138, the therapist asserts the adolescent's opportunity to overcome challenges through personal experience, while dismissing the clients' reference to her cultural background. As expressed by the client, adolescents are supposed to defer to their parents' advice and parents are supposed to protect their children from pain they have endured. In contrast, the therapist suggests that adolescents must learn from their own experience. As indicated by discursive patterns of over-talking and dismissing the other's talk, it is evident that the client is not passive but actively resists the therapist's attempts to impose her own narratives. Nonetheless, the client's narrative does not penetrate the therapist's notion of what adolescence should be.

Critical Discourse Analysis: Dismissing Structural Determinants of Suffering

Given the initial talk by the client in turns 105–9, and in addition to dismissing the client's knowledge around parenting, the therapist disregards underlying issues that may contribute to the client's suffering. These include personal history (the loss of her brother) and structural factors (e.g., economic insecurity and underemployment) that contribute to the client's credible fears that her daughter will face continued marginalization, underemployment, and financial insecurity in Canada. Rather than listening

to the client, the therapist deploys discursive strategies to emphasize her point that teenage years are for “learning from experience” even if this involves making mistakes that are painful. Thus, the therapist recruits the client to accept Western constructions of adolescence as a turbulent period of individual development rather than exploring how parental stress may be exacerbated by the client’s immigration and settlement and related marginalization in Canada.

DISCUSSION

Using critical and poststructural theories of discourse, this article describes how patterns and structures of naturally occurring talk in therapeutic encounters can reproduce whiteness as a powerful organizing principle. We identified episodes of cross-cultural dialogue between white female therapists and immigrant clients in order to explore how speakers use language to position themselves and to produce and resist whiteness within the same clinical interaction. This analysis provides a window to examine how institutional and interpersonal dynamics of marginalization and dominance become apparent in conversational behavior between white therapists and their racialized clients. In examining the discursive features of cross-cultural dialogues, we find that even seasoned and well-intentioned therapists, like those who participated in this study, may perpetuate clients’ marginalization and dominate the therapy process by asserting and maintaining whiteness as an unmarked standpoint in clinical encounters (Weinberg 2006). In particular, the findings illustrate (a) that therapists assert Western values as the cultural norm in clinical assessment and treatment options; (b) that they use discursive strategies to recruit clients to assimilate to unmarked normative values of whiteness (i.e., to get clients to agree with the therapists’ assessment of presenting issues and suffering and treatment recommendations); and (c) how clients both resist and comply with their therapists’ worldview by positioning themselves within or resisting a discourse of whiteness.

Considering the power dynamics between the client and therapist, we argue that the production and maintenance of whiteness functions as a dominant lens that filters the clinical encounter such that therapists and clients miss opportunities to meaningfully engage with each other, in turn disrupting the therapeutic process. In particular, (a) when the therapist dismisses the client’s perceived source of suffering, she misses an oppor-

tunity for healing; (b) the client's move to demonstrate a good subject within whiteness (e.g., as in case 1, "I believe in this foreign country") distracts from her initial exploration of pain stemming from her parents' disapproval of her marriage; and (c) the therapist's failure to see her own Western perspective (in both cases) obscures her capacity to remain client-centered.

These findings highlight how whiteness can interfere with therapeutic engagement and lead to misguided treatment recommendations, suggesting the need to pay attention to the ways in which systemic issues shape everyday clinical practice. Roger Worthington and his colleagues (2000) claim that the extent to which a therapist recognizes the socio-cultural factors influences on the client's presenting problems is positively associated with therapists' cross-cultural competence with racial or ethnic minority clients. The therapist's apparent unwillingness to acknowledge the client's sociocultural factors in life may indicate the therapist's cultural ignorance or lack of responsiveness. Several empirical studies report that the therapists who acknowledge and verbalize the sociocultural references in the clients' life are rated as "more culturally competent and more credible source of help" (Worthington et al. 2000, 461; for more details, see Fischer, Jome, and Atkinson [1998]; and Thompson et al. [1994]). As described in the vignettes presented in this article, the clients bring up various sociocultural factors (e.g., immigration, poverty, child-rearing practice, and arranged marriage). The therapist could balance the socio-cultural and psychological factors affecting a client through acknowledging the significance of the sociocultural factors and listening to the unique internalized cultural meanings of social cultural factors in a client's life, instead of attempting to assimilate them to whiteness as the norm.

Because multicultural education and diversity training among social workers are important, various scholars propose pedagogical approaches such as experiential learning, structured controversy, mindfulness-based critical reflection, anti-racism field assignment, and so on (e.g., Donner, Everett, and Basham 2004; Wong 2004; Lee 2012). In general, they seem to agree on the importance of promoting social workers' critical consciousness about their biases and prejudices based on their social locations as the main approach. However, what the present study illustrates is that whiteness norms (e.g., what constitutes normal family life cycles and intimate relationships) may be ingrained in our theories and practice models, and thus govern and legitimize social workers' assessment and treatment

planning, while residing outside of our consciousness. RoseMarie Perez Foster's (1998) concept of cultural countertransference captures clinicians' own limitations of the extent to which we can acknowledge and be conscious of our sociocultural being. Because we are often unaware of cultural countertransferences, Perez Foster asserts that they are often "disavowed by the clinician; [yet they] exert a powerful influence on the course of treatment; and though unspoken, are frequently perceived by the client" (253). Therefore, it is crucial for social workers to acknowledge the inescapability of prejudice and bias; social workers enact unconscious and disowned aspects of cultural countertransference and therefore should humbly accept their own vulnerabilities. In this regard, it will be important to create a practice environment that may counterbalance problematic and challenging moments in practice that are often outside of immediate awareness. Clinical supervision and peer consultation, where social workers feel safe and encouraged to reflect their own biases and prejudices, and close review of clients' dialogical responses to therapists' assessment and treatment on a regular basis may provide a space to make these moments visible, so that social workers have opportunities to be aware of and work through them.

This study also indicates how the context of whiteness is inextricably linked to the nation. We demonstrate that, even within clinical encounters, racialized clients, who are also immigrants in Canada, are positioned as outside the imagined and portrayed white racial identity of Canada. Thus, the clinical space, which is often recognized as a private and personal sphere, becomes a site where broader social investments can be enacted. In both cases, the therapist and the client take part in preserving white hegemony within a multicultural society (Moodley 1983; Bannerji 2000; Day 2000). David Nylund (2006) argues that critical multiculturalism and critical whiteness studies are needed in social work education and training to make whiteness more visible to therapists. We believe that an understanding of how the politics of race and nation-building in Canada are intertwined is to inform an understanding of how therapeutic encounters produce and reproduce whiteness. This study promotes the need to address how micro-interactions within clinical practice can produce, negotiate with, and resist structural oppression. We recognize the appeal of critical consciousness and reflexivity approaches as important methods for challenging the dangers of essentializing the cultural knowledge of others. These are certainly important starting points for training

social workers to be more reflexive of their social locations vis-à-vis their clients. Nicole Nicotera and Hye-Kyung Kang (2009) suggest that a range of teaching strategies is required to de-center privileged identities that play a role in maintaining oppression in social work practice. We further argue for the need to transcend the emphasis of change within therapists as the foremost means to change the individual and interpersonal sphere in the client's life. Therapy space is a microcosm of the outside world (Yalom 2002). We view the clinical encounter as a negotiated space within which both therapists and clients can engage with, resist, and challenge the dominant ideologies that contribute to oppression and inequality. This calls for renewed attention to how whiteness is embedded within the broader social context (i.e., national, regional, organizational, community), shaping how social work practitioners converse, listen, and perform.

NOTE

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