Reflections: My Career in Clinical Social Work

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Abstract: This article presents the author's reflections when she closed an independent clinical social work practice in a small northeastern city. She discusses how the intersectionality of her social identity and her transition from working-class roots to professional status influenced her personally and professionally. She highlights intersubjectivity, multiculturalism, and social justice as theoretical frameworks that guided her practice, and she illustrates with practice examples.

Keywords: social class, intersectionality, social justice, multiculturalism, intersubjectivity

Introduction

At the end of 2016, I closed a 24-year independent clinical social work practice in a diverse small city in the Northeast. I have been a clinical social worker since I graduated from Columbia University School of Social Work in 1976. I held clinical, supervisory, and administrative positions in New York in schools, hospitals, and community mental health before opening an independent practice in collaboration with my husband, a family practice physician, to provide "a holistic approach to patient care" that integrated mental health services and primary care medicine in one practice location, making services accessible and less stigmatizing because "the services were accessible in the familiar health care environment" (Lesser, 2000, p. 119).

The practice opened in Holyoke, MA a mid-size, ethnically diverse, northeastern town. Most clients had managed care insurance plans, Medicare, or Mass Health, which enabled them to seek treatment not otherwise available in an independent practice setting. Additionally, many of the clients were new to counseling services, and the location of the practice within a medical building/practice setting eased the transition to mental health services (Lesser, 2000). My goal was to make private mental health services available to a wide socioeconomic range of clients and provide them with a choice that many disadvantaged and marginalized clients may not have always had. I was able to do this by becoming a provider for most insurance plans, including Mass Health, which provided opportunities for a treatment option generally afforded only to the middle and upper classes (Cooper & Lesser, 2015). Over time, I expanded my solo practice into Pioneer Valley Professionals; a multidisciplinary community-based independent group practice with a commitment to therapy for clients who were generally underserviced in private practice.

I worked with children, adolescents, adults, and the elderly from different races, ethnicities, social classes, countries of origin, abilities, and religions. These included white ethnic Polish, Italian and Irish Americans, French Canadians, Puerto Ricans, Latino immigrants from the Dominican Republic, Africans from different countries, Hindu and Muslim Indians, Holocaust survivors and their descendants, Jewish and Christian refugees from Russia, veterans of several different wars, and aging survivors of World War II. Some of the children and adolescents were under the guardianship of the Department of Children and Families. Several were

first-generation Americans with a bi-cultural identity who were referred by the courts, schools, parents, doctors, mental health professionals, and insurance plans. I saw clients with trauma histories, mental health disorders, physical disabilities, neuro-developmental challenges, mood disorders, cancer, and a wide range of psychiatric and situational problems.

As I reflect on my years of clinical social work practice, I realize I have been strongly impacted by "a powerful identification with my class of origin and structures of experience" (Botticelli, 2007, p. 122). The consciousness of class was part of my earliest life experience growing up in a small Italian American neighborhood just south of Greenwich Village, the towering arch of Washington Square, and the sprawling buildings of New York University. Although an avenue (Houston Street) separated my family and neighborhood from "The Village," it represented such a class divide that my parents, who were born in the United States, referred to those living north of Houston Street as "The Americanas." I attended neighborhood Catholic schools through high school and graduated from City College in 1974. I was awarded a National Institute of Mental Health Training Grant to attend Columbia University School of Social Work.

I crossed a major class boundary when I went from City College to Columbia University, where I began to appreciate the complex significance of my internalized class representation (Russell, 1996). The intersectionality of my own social identity—race and ethnicity (White Italian American), religion (Roman Catholic), gender (female), and sexual orientation (heterosexual)—has impacted my self-concept, demonstrating the "profoundness of internalized class relations" (Botticelli, 2007, p. 124). I also came to appreciate and subsequently support my clients in recognizing that class identity is the result of the institutional structures often based on privilege and disadvantage (Kim & Cardemil, 2012). Not surprisingly, class has been the variable most subject to countertransferential challenges as I transitioned from a working-class identity to a professional identity. I remember struggling in my work with a professional African American woman who came from a working-class background similar to my own and was able to access the kind of college education that was not within my reach. In this instance, I recognized that despite some advantages this client had, her struggles with ongoing racism as a black woman and my privilege as a white professional woman were constants (Cooper & Lesser, 2012).

Since "identities are complex, contextual and situational" (Lesser & Pope, 2011, p. 22), class knowledge requires an understanding of its interconnectedness with other diversity components such as race, culture, gender, and ability. The connection between race and class is very powerful in America because the vast majority of the working poor and unemployed are persons of color (Kochhar & Fry, 2014). Class contributed to my understanding of the double jeopardy of being a person of color from a working-class background when a single, female woman shared the numerous microaggressions she suffered through the years in her work as an administrative assistant. When she protested, she was silenced and her valid concerns were minimized with the "pejorative stereotype of the angry black woman" (Ashley, 2014, p. 27). This woman came to therapy with symptoms of depression related to her years of struggling to prove herself as competent and worthy of a promotion, while she watched her less-skilled white

colleagues advance. She had worked hard to get herself through college and tried to win approval by overfunctioning and by working extended hours. Despite this, she remained in her administrative position with little opportunity for advancement and/or financial remuneration for her efforts. Bonilla-Silva and Baiocchi (2001) write that the significance of racism in the post-civil rights era is often minimized, which is exactly what occurred in this case. Therefore, treatment of this client's depression also focused on my giving voice to the discrimination she was experiencing as a black woman. I said: "It seems to me that you are being systematically discriminated against which is something important for us to talk about." It also involved dialogue about how she felt about working with me—a white woman—under the circumstances she was describing as well as how I felt about hearing what she disclosed and working with her—a black woman being discriminated against by white people like me. I continued: "Is this something we can discuss together? I'll share that it makes me a bit uncomfortable, but I think it's important because I know I have benefitted as a white woman in my career in ways that you have not benefitted as a black woman in your career." She told me it was the first time she heard this from a white woman, and it opened a dialogic conversation, which focused on her history of racial discrimination as a black woman growing up in the segregated South. Leary (1997) describes the significance of talk about race as an "intimate and enduring aspect of personal social identity" (p. 179) and not something to get past in therapy. Our conversations moved to my supporting her in filing a complaint with the Massachusetts Commission Against Discrimination.

Class challenged me to reflect on the intersectionality of class and race when working with clients who had class privilege but were from oppressed racial groups, such as highly educated students and professional persons of color. One African American student remarked on her surprise when she felt identification with her clients of color but realized that they did not necessarily feel the same sense of identification with her. She told me that these clients identified her more by her class than by her race, and she felt blindsided by this possibility. Collins and Arthur (2010) affirm: "Many clients hold multiple and sometimes conflicting cultural identities that impact their worldviews" (p. 219). I also remember a session with an African American man who shared his experience as a first-generation college student. He told me that when he first heard an African American professor refer to "persons of color," he didn't know "who the hell she was talking about, because when [he looked] in the mirror [he didn't] see a person of color, [he saw] a Black man." I suggested that race and class, which is what he was talking about, were pretty complicated issues: "With us, race difference is in the room, and perhaps with your professor, class differences were in the room." He thought about this and said: "I don't expect you as a white person to get who I am, but I expect more from my own people."

Class impacted my ability to understand and support white working-class clients to stretch and appreciate the profoundness of race in our society. A young, white, working-class woman shared: "I'm actually afraid to talk in my psychology class because I am afraid I will be told to check my privilege. I don't even understand this because I struggled so much financially." Within the framework of white identity development, my client's attitude was ethnocentric, as my own was as a young white woman from a working-class family those first days at Columbia,

when I had absolutely no idea where I fit in. I clearly was not one of the few students in the racial minority at the time, but I certainly did not identify with the financially and socially privileged middle and upper middle class white students (Sue & Sue, 2015); I used my personal experience to empathize with this young woman while also asking her "to consider the ways in which being a white woman struggling financially may be different from being a black woman struggling financially or being a black woman." I shared: "I also struggled to appreciate that difference in my young years, but that is exactly what white privilege is about, which is seeing the world through white eyes and assuming those are the only eyes." I added: "Considering the question enabled me to check my own privilege while also being self-compassionate about my own journey from a working-class family and identity."

Over the course of my social work education and beginning years as a clinician, I moved toward the stage of dissonance, when I was more directly in touch with being privileged as a white person in spite of economic hardships (Sue & Sue, 2015). This was an emotionally uncomfortable time, especially working with diverse clients who were in their own subjective stages of class and racial identity formation. I moved to a stage of introspection where I had to explore what being white in America means, including my own implicit racism, in order to truly engage with clients in dialogic conversation about privilege and oppression as it impacted their lives and my own (Sue & Sue, 2015). My own white identity development enabled to me to discuss and validate this client's personal history and struggles and empathically support her in enlarging her class-based perspective to appreciate the myriad ways in which race overshadows class in our society (Stracker, 2004). This is especially significant in contemporary America, where racism is minimized and dismissed as no longer a major factor in determining opportunities in America (Bonilla-Silva & Dietrich, 2011; Bonilla-Silva, 2012, 2015, 2018; Kochhar & Fry, 2014).

Watts-Jones (2010) discusses how the therapist's self-disclosure of social identity can be used to address identity differences in the therapeutic relationship as well as outside of it. She challenges therapists to consider the location of self-interactions, asking: "How does a White therapist say to clients of color that s/he fears unknowingly saying something racist," or "How does a Black therapist say to a White client, I wonder if you will be able to take me seriously given the history of racism in this country?" (Watts-Jones, 2010, p. 409).

I used many different theoretical frameworks to guide my practice with clients over the years, including psychodynamic, cognitive behavioral, narrative, solution focused, and internal family systems, among others. However, multicultural theory, intersubjectivity, and social justice were the metatheoretical frameworks that contributed to my becoming a culturally competent social worker.

Intersubjectivity Theory

Intersubjectivity is a postmodern, metapsychoanalytic theory that examines the subjective relatedness between the therapist and the patient. The components of the therapist's and the

patient's subjectivities are the emotional conclusions that each has drawn from lifelong experience of the emotional environment. Although the therapy is always for the patient, the emotional history and psychological organization of patient and therapist are equally important to the understanding of any clinical exchange. Personal history shapes and limits a therapist's capacity for empathic introspective understanding because it influences the emotional availability to any given patient (Stolorow, Brandchaft, & Atwood, 1995; Natterson & Friedman, 1995; Benjamin, 2004). As Natterson and Friedman (1995) write: "The therapist's subjectivity plays a continuous role in shaping the therapeutic process" (p. 4). "What we inquire about or interpret or leave alone depends upon who we are" (Natterson & Friedman, 1995, p. 9).

Bowles (1999) describes the concept of the third space in the theory of intersubjectivity as the interactional field created "when the subjectivities of the therapist and the patient come together, allowing both to practice new ways of interacting with another" (p. 359). I engaged in many third-space conversations with my clients that involved the different intersectionalities of our social identities (Benjamin, 2004). I did not leave my working-class background behind when I moved into a middle-class professional space. It evolved in the work I did with countless clients over many years as I listened and grew alongside them. This is what both solidified my roots and enabled me to coalesce the identity I now have. Liu et al. (2004) describes class as being fluid and relational, resulting in a shift in perceptions, feelings, and experiences related to our class identity. I developed a class competency that, according to Strier (2009), includes: "knowledge, skills, theoretical approach, and critical awareness required to effectively help clients oppressed by class structure" (p. 240).

Intersubjectivity theory recognizes that the therapist is never able to be completely anonymous. There are inevitably self-disclosures as the therapist and the client communicate with each other both verbally and non-verbally. Natterson and Friedman (1995) address this when they write about the therapeutic relationship: "This is the reality of a relationship, and in this context a huge array of beliefs, memories, values, ideas, and expectations in each person become knowable to the other, and innumerable influences upon each other occur" (p. 70).

However, within an intersubjective framework, the therapist also consciously, deliberately, and judiciously uses self-disclosure. The therapist makes specific decisions about self-disclosure based the meanings of such disclosures for the patient and therapist, and whether such disclosures are likely to facilitate or obstruct the therapeutic process (Natterson & Friedman, 1995). I made a conscious decision to let Jane, a devout Roman Catholic with a tendency to be obsessional about confessing her sins, know that I am Roman Catholic. I gently told her: "I appreciate your devotion to confession and absolution because I was raised in that tradition, but I think it might be important to consider the ways in which scrupulosity is actually interfering with your desire to feel spiritually connected." She felt understood and was able to then engage in identifying when this occurred, taking small steps to reframe her thinking and actions. Maroda (1999) writes about mutual recognition and the importance of the therapist "following the patient's lead regarding what he needs at a particular time" (p. 480).

I also shared my Roman Catholic religious tradition with a woman who had been sexually abused by a Roman Catholic priest and felt guilt about disclosing what occurred and seeking justice. She initially felt that I was not able to understand the power of the priesthood or her allegiance to the church and was relieved when she learned that I could meet her in a particular transitional space related to a shared worldview. Ganzer (2007) refers to this as when "the therapist's use of self becomes an interactive, subjective, and empathic means of furthering therapeutic action and portending a positive outcome to the treatment" (p. 119). I cautiously and purposefully left my own comfort zone related to spiritual self-disclosure in this exchange with my client, considering Watts-Jones' (2010) cautionary words: "It is not easy to figure out how to foray into these issues at the level of depth that they often operate and maintain the possibility of therapeutic relationship" (p. 409).

Foster (1999) introduces the concept of "cultural countertransference," the "clinician's own culturally based life values; academically based theoretical beliefs and clinical practices; emotionally charged prejudices about ethnic groups; and biases about their own ethnic self-identity" (p. 270). Cultural countertransference is a concept that can be extended to multiple identities including class, ableism, gender, sexuality, education, and faith, among others. Therefore, the entire range of racial, sociocultural, and political identities and subjectivities the therapist and patient bring to their relationship, including issues of oppression and privilege, are all topics for challenging and growth-enhancing conversations for both the client and the therapist (De Lourdes Mattei, 1999).

Natterson and Friedman (1999) believe our work with clients is to some extent always influenced by the patient's psychological life as well as our own. They write: "An interpretation is always an intersubjective event" (p. 79). In my work with a client suffering from metastatic cancer, I recognized the depths of despair I felt each time I sat with her and how it was clouding my ability to listen attentively and remain empathically attuned. Listening to her story brought me back to my own father's death at age 54 from cancer when I was just beginning my graduate studies in social work. I distanced from that pain by immersing myself in my work, but now, years later, I had a chance to do things differently. I regrouped and listened to this man talk about preparing his will and saying good-bye to those he loved before he was no longer able to do that. I replied: "I see how important it is for you to get your affairs in order and be able to say good-bye to your family while you feel you are able to." In order to be able to construct an interpretation, I had to be open to my own pain so that my attention could focus on the patient's subjective state, informed by the new insights I achieved about my own relationship to pain. As Noonan (1999) shares: "The patient feels understood when the therapist feels understanding" (p. 127).

I worked with a young woman who had lost both her legs as a child in a horrific accident. I had to reach into myself to truly listen to the daily struggles she faced when she woke up, when getting out of bed and dressed required a great amount of effort. "Don't try to get me to talk about what I went through after I lost my legs," she would yell at me. "I won't have my legs no matter how much I talk about it. All I want is for you to see that I can't find a job no matter how

smart or educated I am because people don't want to hire someone with no legs. Do you understand that?" I felt her anger and then said, "I am beginning to understand why you get so angry at people because they, like me, in these sessions with you, just don't really get it, and I'm very sorry about this." After I owned my limitations in being able to really understand and/or appreciate what my client was struggling with on a daily basis, she was able to be more authentic with me as we worked on "co-creating subjectivities as a critical component in fostering this new relationship" (Katz, 2010, p. 314). In numerous therapy sessions, the intersectionalities of our social identities mixed and mingled as we dialogically created a third space that included her experience of a discrimination that I would never know, and I worked to create a space to talk about it. Katz (2010) describes the therapeutic relationship as providing a "new interaction" that enables the therapist and patient to engage in "new relational possibilities" (p. 314). I supported this client in filing a civil rights complaint against a previous employer and helped her address her impulsive, angry, and often-inappropriate responses to people, which contributed to her interpersonal challenges. Gasker and Fischer (2014)note: "Relationship is central to a social work understanding of social justice" (p. 51).

Multicultural Theory

I was initially trained as a psychoanalytic psychotherapist, and over the years, I realized the importance of not privileging that particular theoretical framework. I studied cognitive behavioral and mindfulness therapies as well as distinct models of trauma informed psychotherapy, among others, recognizing how different theoretical lenses influence our clinical assessments. Multicultural theory supports the use of different theoretical models and clinical practice skills to be effective with diverse clients (Sue & Sue, 2015). Selecting the most appropriate theoretical lens is an important aspect of multicultural practice, but it is not the only aspect that merits attention. Multicultural counseling competencies have expanded beyond those for specific populations. Greater attention is now given to the intersections of racial, socioeconomic, class, age, religious, spiritual, gender, sexual orientation, ability identity, and cultural context of clients and communities, especially for those from a historically marginalized status and a social justice scholarship base (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Collins and Arthur (2010) recommend a conceptual framework that includes an appreciation of cultural factors, personal identity factors, contextual factors, and universal factors, including differences in experiences between dominant and non-dominant groups in society.

A multicultural model also stresses the importance of the therapist's own engagement in cultural identity development, recognizing the helping relationship as a significant interpersonal context in which culture must be discussed. Cultural sensitivity and cultural competence require this type of relational engagement, building on cultural strengths and tailoring treatment to cultural values (Kaplan, 2004; Santiago, Kaltman, & Miranda, 2013). I worked with a number of middle-aged Latina women who expressed gratitude for the help they received by cooking and baking samples of their ethnic foods. I always accepted these gracious gifts and often took a first bite during the session to show my appreciation.

Yan and Wong (2005) suggest a multicultural perspective that shares some similarities with the theory of intersubjectivity and recognizes that "one's understanding of one's own culture is always developed through interaction with others" (p. 186). Both the clinician and the client engage in "intersubjective reflection, which is a dialogic process in which both worker and client interactively negotiate, understand, and reflect on their cultures with reference to their understanding of the problem presented by the client" (Yan & Wong, 2005, p. 186). This includes social justice-oriented inquiry about community and societal being, including "oppression, stigma and other abuses or violations of human rights" (Cooper & Lesser, 2015, p. 46). Each learns from the other in ways that provide new experiences and contribute to change.

Social Justice

The value system underlying the social work profession is social justice. The Code of Ethics of the National Association of Social Workers (2017) lists social justice as a core value and "the challenge of social justice" (p. 5) as an ethical principle. Therefore, psychological accounts of painful personal history should not necessarily be privileged over narratives where individual experiences may be caused by sociopolitical issues. Bell (2007) reminds us that diversity and multiculturalism are also tied to unequal power differences among different groups in society. Dietz (2000) affirms: "In order to challenge oppression, social workers must support [their] clients in naming their experiences of oppression" (p. 503). We, as therapists, have to understand when a problem stems from racism or bias in others so that clients do not inappropriately personalize problems.

Clinical practice and psychotherapeutic solutions should include socioeducational dialogue that communicates an understanding to clients about the impact of social and historical forces on their personal psychological development. Appio, Chambers, and Mao (2013) discussed the significance of "validating clients' experiences of institutional barriers" and supporting them to "actively challenge oppressive institutional practices and work towards social change" (p. 160). Gibbons (2011) also writes about this type of empathic connection: "An enhanced feeling of power grows out of the healthy interaction with empathically attuned others, contributing to the capacity to act in the environment with a sense of self-efficacy and purposefulness" (p. 245). Therapy can then include supporting individuals to take steps in the sociopolitical arena on their own behalf as part of their recovery from traumatic experiences. We can enable participants to develop a critical consciousness that is fundamental in moving from a position of powerlessness, internalized oppression, and self-blame to one of empowerment toward individual and social change. I worked with many young clients who had behavioral problems that were related to undiagnosed conditions such as ADHD, dyslexia, and anxiety. These children and adolescents were academic underachievers with compromised self-esteem. Advocating for appropriate educational testing often resulted in individual education plans that focused on providing the type of assistance needed for these youngsters to have academic success, which decreased negative behaviors. Clients need encouragement to explore options and make informed decisions about actions to pursue (Appio, Chambers, & Mao, 2013).

Janie was a college student whose life was impacted by professors who were lax about safeguarding her confidentiality regarding her accommodations as a student registered with the Office of Disability Services at the college. She was sad, anxious, and disheartened by her college experience. An empathic therapeutic approach with this client included helping her address the anxiety and shame she felt as a result of these experiences. It also included opening a conversation focused on psychoeducation, guidance, and support in filing a complaint with the State Education Department's Office of Civil Rights. The result was a feeling of empowerment for this young woman when her complaint was validated and resulted in the college having to institute appropriate education for the college's Office of Disability Services as well as those professors who had violated her civil rights so that their actions did not extend to other vulnerable students. This young client and many others with similar struggles also taught me biases "about preferential teaching and learning styles, which are also embedded in the socio-environmental milieu" (Lesser, 2017, p. 2).

A step in supporting my clients to pursue social justice for traumatic injuries was to recognize and discuss how injustices and inequalities may be implicitly enacted in the therapeutic practice. An example of this occurred when I was repeatedly challenged by a patient with serious posttraumatic stress disorder who projected his sense of rage at the world onto me. I felt emotionally depleted and found myself suggesting that he might not be happy with me as a therapist and may want to seek a consultation. He challenged this and said: "Oh I see now you are using your power to get rid of me and you're doing it like you're doing me a favor, right?" I started to object but realized that was exactly what I was doing and responded: "You're right, I did do that. I was feeling frustrated and got angry at you." He calmed down and said: "Maybe I make other people feel that way also when I am always angry." I replied: "Well, I just want to say that may be the case and we can talk about it, but I still want to own that I could have handled things differently, and that's about me and not about you."

It is important to identify systemic barriers associated with sociocultural forms of oppression in order to establish more egalitarian therapist-client relationships that do not focus solely on the personal and the interpersonal (Strier, 2009). This particular client had suffered not only abuse by an alcoholic father but also the indignity and injustice associated with having a learning difference in an educational setting that did not recognize or assist him, and that contributed to profound damage to his young self-esteem due to discriminatory educational practices. His educational experiences led to a compromised ability to support himself with something other than minimum wage positions, which took a toll on him physically and psychologically. Addressing his anger included recognition of his value as a hard working, blue-collar man now faced with a self-perceived shame of applying for social security disability benefits. Although we shared working-class roots, I had the ability to achieve upward social mobility, which this client did not. As Ganzer (2007) notes: "The relational self of the clinician, as well as the patient, is acquired through and defined in the context of relationships; and these relationships operate in social, cultural, and political contexts" (p. 118).

What I found in my many years of practice in Holyoke, MA was that poor and working-class

people need economic opportunity. However, they also need clinicians who practice within a social justice framework, who want to inquire about and listen to the impact social forces have on their lives. They can then share feelings, reach for new goals, and do so within the "parameters of a safe interpersonal alliance" (Smith, 2005, p. 692). The social work literature would benefit from additional research in this area so that integrative models can be developed and practiced.

Summary

Noonan (1999) talks about the importance of the therapist's "affective needs, which include the need to feel valued and significant to another, and in the case of the patient, both as a therapist and as a person" (p. 39). I realize that my own affective needs include mourning the end of my practice and my relationships with clients I saw regularly and, in some cases, for many years. I was privileged to be trusted with painful memories and experiences. I worked with many clients to deconstruct trauma narratives, enabling them and myself to achieve personal growth because, in spite of differences, we were able to share the common human experience of connectedness (Sue & Sue, 2015). I felt empowered professionally by my ability to see people grow in self-esteem and self-assurance psychologically and, in many cases, socioeconomically. Each step in a client's growth was also a step in my own growth in self-esteem and self-assurance, psychologically and socioeconomically. I feel incredibly thankful to all of my clients for the opportunity they gave me to support their changes and to be changed by them minute by minute, hour by hour, in countless conversations over many years. During our final good-byes, many clients told me that I would always be with them, and I told them they would always be with me. I have deeply internalized each and every one of them, and for this I am eternally grateful.

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