

RAPPORT, EMPATHY AND OPPRESSION: CROSS-CULTURAL VIGNETTES

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This narrative focuses on cross-cultural vignettes from the author's practice in New York City during three periods in his professional life: (1) while working at a group home and studying for his BSW in the late 1970s, (2) as an MSW student in his first year placement in a child psychiatry setting, and (3) ten years later while working in a union-based social service program and teaching a course on oppression at Fordham University. The narrative explores cross-cultural social work by focusing on the themes of rapport, empathy and oppression-awareness.

* All names have been changed.

Vignette One: "Let the Music Play"

We called them the kids, although in many ways they were wiser in the ways of the world, and of the streets, than we would ever be. We were the staff, the "crash pad counselors," who lived two of every six days and nights with this group of ten primarily African-American and Puerto Rican adolescent boys and girls who resided in a settlement house-operated short-term group home. As the only white staff person, I was told by Robert, the Director, that I was hired because in all their lives these young people may never have met a white representative of a societal institution who was anything but an enemy in their eyes. He hoped I could be otherwise.

I was trying, but it was the noise that bugged me the most. On one end of the long, narrow basement living room the radio played at maximum volume, while at the other end there was nearly always someone transfixed in front of the television. When we went upstairs for the night, the radio went with us and stayed on all night in the boys' room. This routine went on for quite some time after I began working there. Since this was the practice with the other two shifts as well, there was little I could do without setting myself up as the bad guy.

Finally, I raised it in a staff meeting. I said that I felt that it was bad mental health to have constant music, and that to have the television and the stereo playing created a cacophony inconsistent with the kind of quiet atmosphere needed for residents to study, or just to have a

quiet conversation. I didn't even get to first base.

One night after bedtime the radio was extra loud and one of the residents shouted to turn down the radio. That did it: I walked in and shut off the radio, and said as far as I was concerned the radio would be put on automatic shut-off so that it turned off one-half hour after bedtime. I would bring it up in the staff meeting the next day, I said. Terrence complained in a hurt tone, and I told him that the mind and ears needed a rest and that was what sleep was for. The next day I went straight to the director and told him that we simply had to provide some structure with regard to the radio, and he agreed with me. In the staff meeting, we agreed to formulate a new policy of no radio and T.V. at the same time, auto-shut-off at night, and volume never higher than number seven except with permission. Finally, we had a little peace of mind. I was pretty satisfied with myself.

Then one hot summer evening we were all sitting around. Angel had gotten a job, and everyone else was depressed because they couldn't find summer jobs. "Do you want to play some spades?" someone asked. "Naaa", everyone said. Finally, William got up and went over and turned on the radio, way up loud. He looked over at me, and I nodded my consent. I just sat there and listened to the music. I thought maybe I would try to understand the words for once. The big hit of the month came on: "Let the Music Play," by Barry White. The words repeated, "Let the Music Play..." over and over, then finally: "Let the Music play/I

just want to dance the night way, here, right here, is where I'm going to stay, all night long. Let the music play, just until I feel this misery is gone, keep the music on, let it play on, let it play on, let it play on. Please! Let it play on."

One brief refrain from a disco album taught me more than I had learned so far in almost two months of working there. One line from the lyrics illustrated the tremendous gulf that existed between my world view and theirs. For the residents, oppression was not an abstract concept; it touched every aspect of their lives. For them, the music represented a brief respite from the constant reminder of their plight: no homes, no jobs, no one person in their lives who really cared, and little hope of a turn for the better except that maybe one of the permanent placements would turn out to be not so bad.

I realized how far I had been from seeing the depth of this oppression. For regardless of the rightness or wrongness of my thinking about the music policy, something else was responsible for the intensity of my discomfort with the music. And that something was that I hadn't really completed the process of learning to empathize with the kids; I hadn't yet connected fully with the residents. And the reason I wasn't really able to empathize fully with them was that I hadn't yet understood the enormity of the suffering they were going through, and the differences between our situations.

The words to that song made me realize that I had failed to understand why they needed to hear that music. From that point on, whenever I became irritated, I tried to remember the source of the strong forces which were saying to me: don't get involved, stay away from that suffering. Today, when I want to be reminded of that, I listen to Richie Havens sing "On the Turning Away," from his *Wishing Well* album: "No more turning away, from the weak and the weary...no more turning away, from the coldness they feel."

I was reminded by recently participating in the Undoing Racism training of the People's Institute for Survival and Beyond (www.pisab.org): only by understanding clearly the nature of racism and the way it permeates our institutions and shapes our attitudes and

perceptions can helping professionals maximize our effectiveness in providing service to people in need and also work together with poor people themselves to make fundamental changes in the system of economic exploitation, which is at the root of the oppression our clients face.

Setting Two: Field Work at Inner City Hospital

As a first year student in the direct practice track of the Columbia University MSW program, I was thrilled to be assigned one of the coveted psychiatric placements. But it soon became apparent that I had a lot to learn. For instance in one case I was assigned early on, I was clueless as to the cultural significance of death and the fear of death in the African-American families I worked with at Inner City Hospital. During one of my sessions with a particular client, I finally came to understand the high illness and death rates in the black community. Given the higher infant mortality and reduced life expectancy, I realized this must have influenced the way my client's fear of death was being picked up on by the six year old grandchild she was raising. This was instilled fear in the child that she would lose her grandmother, just like she had lost her mother when she was two years old.

Seen retrospectively, this realization came during what has been called a "present moment" within an intersubjective dyadic or group experience (Stern, 2004). As such moments are considered in retrospect, clients and workers come to new understandings of themselves and their present relationships, as well as of past moments in their personal and professional lives. Because of our longstanding practice of writing the kinds of process recordings on which this narrative is based, social workers have long given attention to such moments. The realization I came to in this case was the equivalent of my realization of the significance of music to the group home residents. In each case, the discovery of the culturally-specific meaning of a universal human experience (death and music) helped to deepen my empathetic responses to the client population.

As the following vignette from my field work at Inner City Hospital shows, cultural unfamiliarity adversely affected my practice with Mrs. G., a 35-year-old African-American mother of four living in a housing project in central Inner City. Her eldest son resided with relatives in the South; her youngest son, who was born with a severe cognitive impairment, died at age five in November 1977. Her household consisted of herself, her ten year old daughter Patricia, and her eight year old son James. James was referred to the Inner City Hospital Child Psychiatry by his school in May, 1978, following the school's decision to hold him back in the second grade for academic problems and immature behavior.

Mrs. G. reluctantly assented to weekly sessions, which is agency policy for all parents. She was extremely depressed and withdrawn, rarely leaving the house except to fulfill household responsibilities. While there were indications that she never fully adjusted to her move to the North from South Carolina in 1965, her isolated behavior was exacerbated by the death of her mother in January 1977, her uncle in July 1977, and her son in November 1977, all following on the heels of separation from her husband in November 1976.

She did have a number of relatives in the New York City area who took the children frequently on weekends. She also had a boyfriend who was a subway motorman; he visited frequently, but did not take her out socially. She had several girlfriends who regularly urged her to go out, but as of the beginning of the sessions she had not done so. Mrs. G.'s behavior in the first several interviews was rigid but cooperative. She sat erect with her pocketbook in her lap and said as little as possible. She willingly talked of James's problems, and demonstrated an extreme negativity towards him, both verbally and non-verbally. She steered away from any discussion of her life until the end of the second interview when she described her separation from her husband. Little rapport was established in the first two interviews.

In a subsequent interview, I awkwardly suggested that I would like to get to know her a little better rather than talking only about

James. She asked me what kind of questions I would like to ask her. Embarrassed that she framed it as an interrogation, I redirected the question and said there might be some questions I would like to ask, but did she have any questions. She said that Dr. W. had told her James would see the doctor and she would see the social worker. "I saw her once," she said meekly, referring to the African-American chief social worker who had done the intake, Miss G. I softly asked her what she had spoken to Miss G. about. She said she had spoken with Miss G. about the deaths in her family and her separation from her husband. When she stopped talking, I asked her if there was anything else she talked with Miss G. about, and she would continue. Finally, she said it had been a difficult time for her. I said I could see why it would have been, and asked her if she found it helpful to talk about these things and she said— first hesitantly and then with conviction—that it did. I said I was available to talk with her about whatever she wanted, and said, "You understand, I'm a social worker and that's my job." She appeared to accept that I would be the social worker, although I did not address her apparent desire to see Miss G.

In this interview, I missed a perfect opportunity to discuss frankly her apparent desire to see the black social worker. I reacted out of fear that she might actually state a preference. Were she to have done so, I would have been presented with an ethical dilemma as to whether and how to raise her request with the agency. One alternative would have been to help her see that I had been assigned and that this could not be easily changed. Instead, I denied her the opportunity to express or clarify her feelings. In Gitterman and Schaeffer's terms, I failed to struggle to close the gap of social distance and unknownness. As they pointed out, to avoid the pain is to avoid the humanness of the situation (Gitterman & Schaeffer, 1973, p. 158).

Clearly, rapport was slow to develop in my work with Mrs. G. As the counseling proceeded, she slowly began to open up verbally, but rapport was still limited. However, empathy is not the same as rapport. Rapport is typically defined in terms of the presence of

empathy, harmony, and compatibility, whereas empathy itself involves understanding and responding to the feelings of another (Barker, 2003). Empathy is seen as enabling the empowerment of a client and moving beyond class and other social distance (Keefe, 1978; Solomon, 1976). Pinderhughes also said that empathy "neutralizes the client's powerlessness" (1979, p. 316). Clearly, empathetic communication is important to achieving practice effectiveness across cultural boundaries. But as these narratives suggest, empathetic communication may be possible even when some aspects of rapport are limited due to cultural differences.

As work continued, "treatment" was geared towards building a supportive relationship to encourage her to get out of the house. When this began to happen, her new behavior reinforced itself and by the third month she entered a job training program. Finally, there was a significant lift in her depression, although her symptoms returned shortly before termination. By the last interview she had entered driver's training and had joined a friend's social club. Although Mrs. G. had expressed occasional insights and sorrow about the deaths in her family, she continued her reluctance to share personal information and feelings in general. While there was trust, there was not the comfortable and unrestrained atmosphere seen as part of rapport (Vontress, 1976).

As the termination proceeded with Mrs. G., I anticipated that she might express gratitude for my work with her, and I tried to prepare myself for how I would handle that given my overall problems with accepting praise. There was a basis for my anticipation, for when I had visited Mrs. G. during a brief hospital stay she had begun talking about how she had never met a man like me, etc. In the next to last interview, Mrs. G. asked me if she could ask me a question. I said sure, anticipating she might ask me to stay in touch after termination. She asked me if it would be okay if she got me a little something, not too much. I said of course it would, and she said it was the thought that counted, not how much, and I agreed. She said that I had been very good to her; I nodded and muttered "thank

you." She continued by saying that I was "so interested in people and it was from the heart." I was going to turn it back to focus when she said, "It just goes to show it's not the color of your skin which counts. It's that you care about people. I can see it in your eyes." She said she told her daughter Tanya this, and that she said, "Oh Mommy, he's just a man doing his job." She said she told her, "You know you're right, but there's something different about him." I thanked her again.

As the above account shows, Mrs. G. perceived an empathetic response on my part, even though rapport was never fully established. This observation is valuable for understanding the potential of cross-cultural relationships. Cultural unfamiliarity may produce awkwardness which inhibits the compatibility seen as part of rapport. But the shared recognition of the caring attitude of the worker, one rooted in an understanding of the impact of oppression, dehumanization and exploitation on the life of a client, can go far towards producing an effective working relationship. In other words, mutual recognition of cultural differences and even difficulties in verbal communication can be overcome by the transmission of empathy, which is largely non-verbal. The implications of this observation are discussed further in the concluding section.

Although Mrs. G. said there was something different about me, I would ask this question about that: how many times in her life had she had the opportunity to sit with a white person and really talk? If she had had that opportunity, if a white person had had that opportunity to relate to her, if segregation and racism had not prevented previous intimate contact with a white person, might she have long ago come to the conclusion that "it's not the color of your skin?" This is precisely why it is so important for professional social workers to study cross-cultural social work, because so many of us have been denied the opportunities for cross-cultural social living.

Setting Three: Union-Based Social Work Program

After I graduated, I spent 10 years practicing social work with multicultural client populations in New Orleans, New York, and

Philadelphia. Actually, my clients were not just clients, they were members of several different trade unions, and I was literally "their" social worker, since their union contracts provided for my services. In several positions, I was a program director doing advanced generalist practice (casework, groupwork, supervision, program development, policy advocacy, community organization.) But now I was working full-time as a caseworker in a union-based social work program, and loving it! In most of my positions, my experience had primarily been with a very culturally diverse group of predominantly male union members. Suddenly, most of my clients were women: African-American women in particular. Not since my work at Inner City hospital had I worked primarily with black female clients.

My work seemed to be going well, but after a few months I was assigned the case of a member who was in job jeopardy. She was in danger of losing her job due to absenteeism and showing up under the influence of alcohol. She was also at risk of eviction for being behind in her rent. The "presenting problem" was her wish for a referral so that she could get public welfare funds to prevent eviction. But our policy was to do a full psychosocial assessment and see if we could address any other problems. Accordingly, I felt it was my responsibility to engage her and refer her to treatment for any alcohol problem she might agree that she had, in addition to helping her access the public welfare funds. But this wasn't a formal employee assistance program in which the referral is often made by a supervisor. So we had no leverage from that standpoint. The only leverage we had was the unit's policy to do our best to engage members about any serious personal problems which might precipitate the need for eviction prevention funds or any problem with job jeopardy.

But I was having a hard time getting to first base with this client, who we'll call Shanice.¹ Shanice was denying the severity of her job jeopardy, saying that it was an unsympathetic supervisor who was the problem and that, yes, she had come back from lunch one day after having had a glass of wine, but that she didn't really have an

alcohol problem. She said it wasn't her fault that her child was sick a lot, and that she needed time off from work. She had needed money to attend a funeral in North Carolina when her aunt passed away, and this had also resulted in a few missed days from work. And she's been sick a lot herself, she said. I didn't try head on to address the clear expression of denial.

I explained that given the presenting problem, my role was to refer her to the public welfare eviction prevention program, but that our policy was to complete an assessment prior to making the referral in order to ascertain if she had any other service needs. She could, if she wished, apply directly to the program, I pointed out. But if she wanted us to broker that referral and if necessary advocate for her, we'd need to spend a couple of sessions completing the assessment process. And I pointed out that we were also there to help members with any other issues they might wish to address. Our services were one of her union benefits, I reminded her, and so she might as well take advantage of them. We agreed to a follow-up appointment.

However, the second interview didn't go very well. I was able to gather some basic information about the nature of her current living situation, and I suppose we could have completed the process and made a referral to the eviction prevention program. But I felt that I hadn't been able to help her, and that no real rapport had been established. I would be selling her short if I were to just refer her. Besides, I explained, it wasn't an emergency, since we had a week or ten days in which to do this before action might be taken to evict her.

Still, I could see she was worried we wouldn't help her with the eviction. I explained to her that it seemed to me that we were in fact going to be able to refer her to the eviction prevention program, and that we did have time. But I directly addressed the problem. I said that I felt I hadn't been able to help her in the way I was accustomed, and I felt that perhaps it was my own inability to work effectively with her. I said I was wondering if we could have one more session prior to the referral, but that first I wanted to get some advice from my supervisor about how to be of better help

to her. We made an appointment for later in the week.

At the time, I was teaching part-time at Fordham University in addition to working full-time at the union. I was teaching a course, *Oppression of Diverse Populations*, and dealing with the many problems encountered in diversity and oppression education (Garcia & Van Soest, 1999). In that course, I was trying to find ways of making the course content more relevant to practice concerns, and to bring the discussion of theories of oppression down to a more micro level. But I had found very little literature that got at the actual feelings that people experience at the moment of acts of oppression, as this was before the advent of the now substantial literature on everyday racism (St. Jean & Feagin, 1998).

Luckily, in the process of compiling Volume Three for the School's Self-Study, consisting of a master bibliography of the readings in the School's course outlines, I came across a book I wasn't familiar with, *Direct Social Work Practice* (Hepworth & Larsen, 1990; Hepworth, Rooney, Rooney, & Strom-Gottfried, 2006). The authors emphasized the importance of enhancing empathy, and the role in that of understanding the words and affective phrases which described the feelings which emerged from people's experiences. They presented a list of more than 250 words and affective phrases, grouped into ten categories.

As the instructor I realized that as a class we might try to generate our own words and affective phrases related to oppression and the various kinds of specific oppressions we in the class may have experienced. Using 3x5 cards, which were written on by students and then handed in anonymously, we identified nearly 100 words and affective phrases - only six of which matched the text's list. This list has since been expanded and developed over the years by my students into a *Compendium of Words and Affective Phrases on Oppression, Dehumanization and Exploitation*. It was presented at a conference (Dover, 2006), and is now also available in published form (Dover, 2008). But at the time, it was just a list of words and affective phrases. For example, just from the B's, there are words like beleaguered,

belittled, blamed, and phrases like beaten down, being left behind, being used.

It had occurred to me during that second interview with Shanice that perhaps I should consider using the list, somehow, to help me get through to my client. I showed the list to my supervisor and pointed out I was failing to develop an atmosphere in which the client felt comfortable sharing what was really happening in her life. I proposed first explaining to Shanice that I wanted her to feel comfortable telling me more about the problems she may have experienced. Then I would relate to her that in teaching at Fordham I had been working with my students to develop a list of feelings that many people have, and would she like me to show her the list in case she had been feeling in any of those ways. We agreed that no harm would be done as long as I made clear this wasn't any kind of psychological test, that it was just a way to break the ice and get some communication going. The next day, I explained this to Shanice and she was actually eager to look at the list.

Pencil in hand, she started down the list, checking one word after another and becoming animated as she began to comment on some of them. This quickly led to a few probes on my part, asking her if she would like to tell me a bit more about when and where she felt this way. Soon, it was off to the races. She was raised by a single mother in an apartment above her uncle's bar. She was sexually abused as a child by bar patrons, and had begun drinking early in her teens. She knew she had an alcohol problem, but it hadn't caused her problems on her job, since she only drank at night after her child was in bed...until recently. After her aunt died, her drinking became worse: beginning at the funeral and continuing after she returned home. Yes, she had come to work having had more than one drink, and it wasn't wine; and it was in the morning, not after lunch. The reason she was behind in rent was in part the money she was spending on alcohol, which was considerable.

In this vignette as well, there was a crucial present moment: the very few seconds after she saw that list and realized it was okay to open up, even with this white guy in the button down shirt. This story had a happy ending.

We were able to make arrangements, not just for a referral for eviction prevention, but for the alcoholism treatment she needed. She was referred to one of the first programs designed for women substance abusers, and the program had a group for women who were also adult survivors of childhood sexual abuse. The union benefit fund paid for her detox and rehabilitation.

Conclusions

Solomon noted that in the black community, most referrals are the result of pressure from social institutions, such as the school in the case of Mrs. G. (Solomon, 1976). Thus, Mrs. G. approached the agency in a situation of relative powerlessness. Although Shanice came to her union-based program on her own initiative, she was clearly under pressure both from her landlord and her job. The group home residents, of course, were all involuntary clients.

Pinderhughes described the manner in which the concept of power relations is useful in stimulating discussion of cross-cultural relationships in social work education (Pinderhughes, 1979). Gitterman and Schaeffer also noted a power relationship (1973, p. 154): "Both parties perceive that the white professional has the upper hand." These views also dovetail with Solomon's central focus on empowerment of the black client (Solomon, 1976). Solomon pointed out that the client perceives the white worker as an extension of powerful institutions that devalue the client. In such an atmosphere it is difficult to establish the trust to engage in self-disclosure. Solomon pointed out (1976, p. 315): "Rapport is extremely difficult to achieve across racial lines." Vontress also pointed out (1976, p. 81): "White counselors find it difficult to establish and maintain adequate rapport with black clients."

With the group home residents in this narrative, rapport was not as difficult to develop, in part because our ages were not so far apart, and in part due to my previous experience in group homes. But it took time for empathy to deepen. With Mrs. G., a higher level of rapport could have been achieved had there been a frank discussion of her desire to

see the black social worker from the outset. Her behavior resembled that previously noted for some black clients assigned to white workers during the 1970s, namely submissiveness, fear and distrust, accommodation, and secretiveness (Cohen, 1976). My behavior at Inner City Hospital was perhaps typical of novice social workers with limited experience in cross-cultural social work. But 10 years later, I still had difficulty fully engaging Shanice and establishing rapport in the first two interviews. Short-contact interviewing in which the presenting problem is the need for so-called "concrete" benefits always presents a challenge in terms of moving to address other issues.

However, all three vignettes also provide examples of the manner in which rapport and relational empathy are not always positively correlated. Empathetic communication may be the key to achieving practice effectiveness across cultural boundaries, even when full rapport is difficult due to compatibility-inhibiting cultural unfamiliarity on the part of either worker or client. Recent research suggests that rapport is an achieved therapeutic alliance that is established between the professional and the client, but that it is ultimately produced by the quality of empathy (Norfolk, Birdi, & Walsh, 2007). One implication of this research is that rapport isn't a prerequisite for empathy, but a product of it. This is consistent with Solomon's earlier observation that accurate empathy is highly associated with success in treatment (1976, p. 300). Solomon felt this involves clear communication between worker and client. More recently, Freedberg has pointed out that empathy is relational in nature (2007). In other words, like rapport, empathy arises in the context of a relationship.

The main conclusion of this narrative is that, although there can be limits to rapport when there is cultural unfamiliarity between worker and client, this doesn't necessarily prevent the establishment of relational empathy, especially if the helping professional is aware of the impact of oppression, dehumanization and exploitation on the client and the client's community. Clearly, there are limits on the ability of helping professionals to

overcome fully all the barriers posed by cultural unfamiliarity and institutional racism. For instance, Vontress recently pointed out how difficult it is for a helping professional to engage in effective cross-cultural practice with people from dozens of immigrant groups whose cultures differ in too many ways for the helping professional to comprehend. He advocated for renewed attention to "cultural common denominators that unify the human race," and for other "cultural similarities that they share with their immigrant clients rather than differences that separate them" (2001, p. 96). A return to recognition of the common human needs of all persons and enhanced attention to basic human needs within social work practice could also enhance empathetic understanding (Dover & Joseph, 2008; Towle, 1965[1945]).

Finally, increased awareness of the nature of injustice—theoretically and in terms of the words and affective phrases associated with the experience of three sources of injustice (oppression, dehumanization and exploitation)—can enhance our ability to establish empathy in our helping relationships (Dover, 2008). By understanding these feelings in ourselves and in our clients, we may be able to be more effective in our work with our clients. It also helps to write narratives and process recordings of those "present moments" in which we arrive at valuable realizations about ourselves, about our work with clients, about the lives of our clients, and about the nature of the injustice they face. I know it helped me. After all, as Bertha Capen Reynolds has pointed out (Reynolds, 1963, pp. 29-30): "We need to take exercises in being helped, as well as in helping. We must learn in order to give. Indeed, we must receive from those to whom we give, in order to give to them."

Author's Note: For a website copy of the Compendium of Words and Affective Phrases referred to above, please see: <http://www-personal.umich.edu/~mdover/>

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(Footnotes)

¹ Why call her Shanice? Clearly, I am seeking to give her a disguised name which may be used by African-Americans. For a fascinating account of the causes and consequences of distinctively African-American names, see Fryer and Levitt (2004).

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