

How Difference Makes a Difference

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The tendency to universalize human experience, particularly when differences are encountered, requires particular scrutiny in psychology and psychotherapy. In this essay, I discuss some of the ways therapists universalize experiences that decrease their awareness of themselves and of the clients with whom they work. I also suggest some ways therapists can become more self-aware so that difference becomes an opportunity for growth for both partners in the therapeutic enterprise.

Norms and the Social Construction of Meaning

American legal scholar Lani Guinier (1994) defined the winner-take-all majority rule as a form of majority tyranny characterizing U.S. democracy. The numerically more powerful majority or dominant choice completely prevails over the minority choice. For Guinier, “the problem of majority tyranny arises when the self-interested majority has few or no checks on its ability to be overbearing” (p. 4). The notion of an overbearing, self-interested majority with few checks on its power to be overbearing is relevant to U.S. psychology as well. In U.S. psychology, the term *norm* is not simply a statistical entity representing the most common numerically. Rather, when applied to research and practice, the term *norm* has a more historically situated and qualitative meaning. That is, the norm is the point of reference against which all else is measured, and it has historically been situated with White middle-class men. Lorde (1984) wrote that in the United States, the norm is “usually defined as White, thin, male, young, heterosexual, Christian and financially secure” (p. 116) and that those characteristics are associated with higher status in the social hierarchy. On the basis of this norm, the needs of many consumers of psychological services have been overlooked (at best) and harmed (at worst). Women, people of color, people with disabilities, members of sexual minority groups, and people who are poor have all been unfairly stigmatized and have suffered to a greater or lesser extent because of the way psychology has defined what is normal. In psychotherapy and institutional mental health, “normal” is associated with being healthy and more desirable.

Psychology in the United States has also traditionally delivered psychological services with certain assumptions that were based on dominant cultural paradigms, as if they were objective and normative, and that failed to take their own subjective cultural positioning into account. Subsequently, there was a failure to critique social pathology. Instead, pathology was viewed as something located within the individual or within certain minority groups to greater degrees than in members of majority groups (Comas-Díaz, 2000; Strickland, 2000). Individual or group pathology was then used to explain why those individuals or groups were in lower, marginalized positions in the social hierarchy. The invisibility of social privilege was maintained.

In the early stages of multicultural training, a multicultural approach to the practice and teaching of psychology often meant little more than being conversant in the values and practices that distinguished one ethnic minority group from another and the characteristics that distinguished those groups from the dominant culture. It also meant understanding those distinctions from affirmative rather than deficit perspectives. Hence, multicultural initiatives concerned themselves primarily with a focus on ethnoracial issues, ethnic minority groups, and their members.

As a result of that important initial work, there has been significant growth in the psychological literature in the study of the roles not only of ethnicity but also of gender, age, socioeconomic class, disability, and membership in other socially disadvantaged groups from affirmative perspectives. Feminist theoretical perspectives defined new ways of understanding women's problems as having their origins in social inequity, not in women's inferiority to men. There has also been a parallel increase in the psychological literature exploring lesbian, gay, and bisexual (LGB) sexual orientations from affirmative perspectives that are concerned with examining the effects of membership in these groups on the psychological development and coping mechanisms of their members. These perspectives are also concerned with the role of institutional racism, sexism, heterosexism, and other oppressive ideologies in the development of psychological theories and paradigms explaining and interpreting human behavior and in the application of those theoretical paradigms in psychotherapy and psychological assessment (Greene, 2004). The degree to which racist, sexist, heterosexist, classist, and other forms of biased thinking are embedded in theoretical paradigms and research in mental health and their subsequent effects on training and practice has slowly become a more visible focus of attention in the psychological literature (Greene, 1997, 2004) and is reflected in the creation of practice guidelines in these areas.

One Person, Many Identities: Challenges to Practice

In December 2000, the American Psychological Association (APA) published "Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients" (APA, Division 44/Committee on Lesbian, Gay, and Bisexual Concerns, 2000) and in May 2003

the APA published "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists." Each document attempted to provide guidance to practitioners on the basis of the emergence of data in and the overall explosion of the psychological literature on the different needs of group members and individuals in psychotherapy and other psychological services. These documents directed practitioners to explicitly consider the role of the cumulative effects of negative stereotypes on members of distinct socially disadvantaged groups and on the thinking of practitioners, research scientists, and theoreticians. Understanding the role of the cumulative negative stereotypes of marginalized group members on the thinking of clinicians and the ways that biased clinical thinking and judgments perpetuate rather than expose or critique the distortions those stereotypes represent has also gained greater prominence. It is rare, however, that these analyses concern themselves with the complexity of these issues when a person is a member of more than one of these groups and therefore different in many ways simultaneously. In this context, the field of multicultural psychological assessment and treatment is challenged to begin to explicitly incorporate an understanding of the interactive effects of these combined group memberships or identities (across an individual's life span) and their effects on individual functioning, psychological research, and the delivery of psychological services.

Multicultural psychology challenged the discipline of psychology to acknowledge the diversity among cultural and ethnic groups and between dominant and nondominant groups and to explore the ramifications of those differences. In the 21st century, however, the challenge to multicultural teaching, research, and practice in the understanding of difference is infinitely more complex. In the tradition of moving the discipline toward greater inclusiveness, psychologists are now challenged to begin to incorporate an analysis of the diversity within those groups as well as the diversity between them. All individuals have multiple and overlapping identities; however, those who are members of more than one socially disadvantaged group have historically been invisible to U.S. psychology, including ethnic minority, LGB, disability, and feminist psychological paradigms, as well as to multicultural initiatives (Greene, 2000b, 2003, 2004). These identities are inherently messy conceptually, and it seems that psychology has not quite figured out what to do with individuals who do not neatly fall into dichotomous categories. Perhaps because of the competition for resources, attention, and appropriate inclusion in the discipline, paradigms put forth by marginalized groups themselves have been somewhat silent in addressing this multiplicity of identity and therefore multiplicity of oppression as well.

Failing to understand the more complex nature of the life experiences of such individuals will limit psychologists' understanding not only of specific phenomena associated with their group memberships but also of human identity development more generally, because all human beings have multiple identities. When working with members of multiply marginalized groups, however, psychologists are insufficiently equipped to understand the multiple layers of effects of social disadvantage

that such members must negotiate psychologically. The absence of these considerations obscures therapists' understanding of how identity is affected when individuals belong to a mix of disparaged and privileged groups simultaneously. Psychology has much to learn about how the development of any one of those identities affects the others.

Studying Gender, Race and Ethnicity, and Sexual Orientation

Feminist psychology, in worthy attempts to document the reality of gender subordination for most women, has been assailed for its failure to reflect the full spectrum of diversity among women (Brown, 1995; Greene, 1994a). An analysis of gender and women's issues that was discerned and articulated primarily by privileged, well-educated, predominantly heterosexual, White, middle- and upper-class women does not generalize to the life circumstances and needs of all women. Such an analysis does not appropriately consider the interlocking and complex nature of racist, classist, heterosexist, and gender oppression for women of color, older women, lesbians, bisexual women, religious women, poor women, and women with disabilities (Hall & Greene, 1996). In attempts to address these inequities, studies about gender have been challenged to better discern how sexual orientation, ethnicity, other forms of social status, and discrimination transform the meaning or affect the salience of gender oppression for a wider range of women. Contemporary feminist scholarship reflects theoreticians' attempts to become more inclusive.

Just as feminist psychology has not represented the diverse range of women's concerns, lesbian, gay, and bisexual psychology has failed to reflect the full spectrum of diversity or difference among LGB individuals in an integrated fashion. In a similar way, ethnoracial research rarely explores the gender coding of race or the heterogeneity of sexual orientation of group members. Psychological studies that focus on ethnicity or members of ethnic minority groups rarely, if ever, acknowledge that all of the ethnic group's members are differently sexually oriented, classed, aged, and abled and are otherwise diverse within each of these categories. In much of this research, the heterosexuality of clients and research participants is either presumed or ignored, and their homogeneity is emphasized over their diversity (Greene, 2004). Sexual orientation, class, age, disability, and other identities may be deemed particularly irrelevant if they are not the focus of the research. Sexual orientation, for example, is an active component in the development of human identity and as such may transform other aspects of individual identity and behavior, whether the focus of the study is on sexual behavior or not. In a similar way, class transforms the meaning of ethnoracial and gender identity. When the focus of the research is on the ethnicity of the members of a specific group, all group members should not be regarded as if they all share the same experience of their ethnicity.

Marginalized members of an ethnic minority group may experience their group identity, as well as their marginalization within and outside of their ethnic group, very differently than dominant members of the same group. However, questions about differences and similarities in those experiences may not arise if clinicians and researchers give no thought to the inclusion of other identities as salient. The degree to which sex, sexual orientation, class, or disability transforms or codes the experience of ethnicity is rarely explored. For example, LGB men and women and ethnic minority group members share historical and contemporary social discrimination and disadvantage in the United States. People who belong to both groups must negotiate double and triple layers of discrimination and hostility as part of their everyday lives, but clinicians and researchers lack an adequate understanding of the social tasks and psychosocial stressors that are a component of gay and lesbian identity formation for persons with multiple identities. The vicissitudes of racism, ethnic similarities and differences in same-gender couples, and the effects of these variables on their relationships are also neglected in the narrow focus on heterosexual couples found in the literature on ethnic minority clients and the equally narrow focus on predominantly White couples in the gay and lesbian psychological literature (Greene, 1994b, 1996, 2000b; Greene & Boyd-Franklin, 1996).

Multiple Identities and Competing Alliances

The tendency to partition identity into isolated parts and then organize them into hierarchies leads people to assume that they should view the constituents of multiple identities hierarchically as well. Indeed, Walker (2002) observed that in U.S. society, being different usually implies having power over or being overpowered by someone. Another assumption is that different identities or groups compete with one another or that one identity must be considered more important than others across the life span. Socially marginalized groups do compete with one another for political resources and power. However, in clinicians' attempts to understand the nature of the individual client's experience, these assumptions make it more difficult for them to understand more complex experiences as well as the dynamic nature of identity and the differential importance of different identities across the life span. Such assumptions also make the task of healthy psychological adjustment infinitely more difficult for those who manage the ill treatment that is accorded people with multiple identities when those identities are socially disadvantaged (Greene, 2000a, 2000b). However, there is a tendency for members of socially disadvantaged groups to engage in the practice of marginalizing other disadvantaged identities when they view other socially disadvantaged groups, just as do members of the majority (Moncayo, 1998). In reality, any given dimension of a person's identity—their gender, ethnicity, sexual orientation, or class—may be more salient or prioritized in one setting and less salient or prioritized in another. Likewise, an aspect or aspects of an individual's

identity may be more salient at certain developmental junctures than at others. In a similar way, current events in the environment and political landscape may differentially affect an individual's awareness or feelings about certain aspects of their identity; recent examples include the beating of Rodney King, the O. J. Simpson trial, the homophobic beating and murder of Matthew Shepard as well as gay public figures like San Francisco supervisor Harvey Milk, and the Clarence Thomas–Anita Hill Supreme Court nomination hearings. The history of domestic terrorism against some of these groups may heighten individuals' sense of vulnerability. For example, African American clients who grew up in the South or other parts of the United States when lynchings were a prominent form of terrorism may experience more heightened feelings of vulnerability when similar events take place in the present than African American clients who did not experience the direct or vicarious trauma of such events in their personal histories. Depending on the event and the nature of the individual's previous experiences, such events may heighten the person's sense of pride, shame, vulnerability, or awareness of selective aspects of his or her identity.

The tendency for a clinician or researcher to launch an exclusive focus on gender, sexual orientation, or ethnicity with no sense of the ways that they overlap or interact can be a serious hindrance to an understanding of these phenomena and to the therapy process. Furthermore, successfully understanding and disarming racism, sexism, heterosexism, and other forms of institutional discrimination and oppression require an understanding of how they are connected to one another, how they mutually reinforce one another, and how an exclusive focus on any one as the master oppression can in fact facilitate rather than mitigate their oppressive impact. In the mad scramble to claim most-oppressed status, divide-and-conquer behavior among marginalized groups usually emerges. The result is that privileged group members flourish, and always to the continued detriment of their disadvantaged counterparts.

When individuals have multiple identities, some of those identities or characteristics may place them in privileged groups while others place them simultaneously in disparaged groups. However, people are usually more comfortable focusing on the locus of their disadvantage rather than their locus of privilege. They may be oblivious to their locus of privilege. In the study of ethnic minority groups in the United States, there is an appropriate focus on the racism that disadvantages group members. An exclusive focus on racial disadvantage, however, overlooks the ways that some ethnic group members may be privileged or disadvantaged along dimensions other than ethnicity when within-group analyses are made. Hurtado (1996) explained this in her work on gender privilege. She argued that subordination and oppressive processes are not static and that oppression per se does not apply to all members of an oppressed group equally. Rather, she observed, such processes are relational in nature and as such may prove difficult to pinpoint. She wrote that if oppression and domination are relational, they are not the property of individuals

but are contextual. Therefore, the very idea of differences based on race, sexual orientation, gender, and so forth exists only because people give them particular meaning, a meaning that shifts with time and place and that depends on contextual circumstances.

For example, African Americans are a diverse group of persons. There are many differences among group members, such as in socioeconomic class, sexual orientation, gender, skin color and hair texture, educational level, and other factors that contribute to the wide range of diversity of experiences of ethnic identity within the group. Along with that diversity come the hierarchies of privilege and disadvantage that exist within the group, often mirroring those in the broader society. One example is the privilege that has historically been accorded members with lighter skin color and straighter hair textures and the corresponding disadvantage for darker skinned persons (Greene, White, & Whitten, 2000). Despite the discomfort that accompanied acknowledging the existence of skin color hierarchies, not just among members of the dominant culture but among African Americans themselves, it was considered important to do so. This acknowledgment was considered important to eliminate the conflicts such hierarchies produced and to better understand their effects on the dynamics within all kinds of interpersonal relationships as a manifestation of internalized racism and as a factor in self-esteem among African Americans. Discussions about heterosexual privilege have been far less forthcoming, perhaps owing to the discomfort of openly acknowledging the existence of LGB group members in families and communities and to the historical ambivalence about acknowledging any kind of sexuality that departed from dominant cultural norms (Greene, 2000a). Ignoring the salience of sexual orientation in the study of ethnoracial groups ignores the presence of heterosexual privilege among members of these groups in communities of color as well as the degrading treatment accorded LGB men and women of color in both the dominant culture and among people of color in their communities.

It is important to acknowledge that although social privilege and disadvantage stand at opposite ends of the conceptual continuum, in reality they intersect with one another, and each individual operates at the nexus of these intersections. Wildman (1996) and Rothenberg (1988) observed that each person is embedded in a matrix of categories and contexts in which he or she is privileged in some contexts and disadvantaged in others, and each category or context interacts with the others. One form of social privilege can moderate a form of disadvantage, simultaneously, just as membership in a disadvantaged group may negatively moderate a locus of privilege in an individual (Greene, 2003, 2004). No person fits into only one static category; rather, each one exists at the nexus of many groups or categories.

There is always the potential for oppressive behavior in anyone who holds societal advantage or privilege and the power that accompanies it. That potential is not limited to members of the dominant group in the United States. Therefore, members of an ethnic or other minority group should not avoid exploring the

realities of forms of privilege and disadvantage that some members of the group may have, as well as forms of disadvantage that may be pertinent to other groups. Because of the potential for oppressive behavior in all people, it is important in psychotherapy to determine where along the spectrum of social disadvantage and power the client resides on multiple identity axes. Perhaps more important is determining where along that spectrum, on those dimensions, one is located as the researcher, therapist, supervisor, or teacher and, when the multiple identity axes are viewed together as they act in concert and in context, what they mean.

The gradual infusion of multicultural perspectives in psychology has resulted in changes in psychological perspectives on socially marginalized, underserved, and poorly served group members and in the delivery of psychological services to them. APA's "Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients" (APA, Division 44/Committee on Lesbian, Gay, and Bisexual Concerns, 2000) were published more than 25 years after the association adopted a resolution that LGB orientations per se imply no impairment of judgment, stability, reliability, or general social or vocational capability (APA Committee on Lesbian and Gay Concerns, 1986). The APA leadership recognized that the implications of that resolution had yet to be fully implemented in practice and set forth guidelines to provide practitioners with an appropriate frame of reference for treating members of this population and with basic information and references. In a similar way, APA's (2003) multicultural guidelines reflect the continuing evolution of the study and practice of psychology, changes in society at large, and emerging data about the different needs of particular individuals and groups who have been historically marginalized or disenfranchised within and by psychology on the basis of ethnoracial heritage and social group identity or membership and, largely, their difference from the "norm." The guidelines also reflect the knowledge and skills professionals need in the midst of the dramatic sociopolitical changes in U.S. society and the needs of new constituencies. I would argue that many of these constituencies are not new; rather, they have been invisible to psychology, often rendered invisible by the profession and generally ill served by its professionals.

The APA guidelines are designed to suggest and recommend specific professional behaviors, endeavors, and conduct for psychologists and are intended to facilitate the highest level of professional practice. All psychologists are urged to proceed not simply with descriptive knowledge of marginalized group cultures, although this is important. Rather, they are to move in the direction of gaining knowledge about themselves and their own multiple cultural heritages and varying social identities and examining the meaning of those identities to themselves as well as their clients. It is imperative that psychologists clarify their own subjective cultural positioning and its effect on their perspectives and clinical judgment as well as the subjective cultural positioning of the discipline and its paradigms. Although many graduate programs now require specific coursework in cultural diversity or seek to enhance their students' cultural literacy, striving for a standard of cultural competence

becomes meaningless if there is no way to define, measure, and require competence in this area. Cultural competence is one area in which credentialing bodies are increasingly compelled to assume a more proactive stance in incorporating these competencies into the full meaning of being ethically competent to practice psychology and into the regulation of that practice.

The Context

My analysis of psychotherapy with socially marginalized people and of the issue of difference takes place in the context of a belief in the meritocracy myth and of some of the dynamics that are intrinsic to historical and contemporary social injustice. Mental health institutions exist as a part of a broader culture that verbally espouses pride in its “melting pot” of different cultural groups while practicing cultural insensitivity and denigration of group differences (Strickland, 2000). Acting in accordance with the practices and values of the dominant culture, institutional mental health in the United States has historically conceptualized differences from the dominant cultural norm as deviant and pathological. Only recently have psychological paradigms come to view human development and behavior as something that can have many different trajectories that are not inherently pathological simply because they are different from those of dominant cultural groups. These ideas formed the core of the development of multicultural and diversity initiatives in contemporary psychology and psychotherapy.

Diversity and multiculturalism are terms used to denote the study of ethnoracial, gender, sexual orientation, age, disability, and other cultural differences between groups, as well as the descriptions of those differences. In this essay I contend that the meaning that is given to those differences is socially constructed: What this means is that the ethnoracial group that one belongs to has particular meaning and may be located at a particular position in the social hierarchy depending on the broader social context rather than on the specific properties of those dimensions alone. It is the social context that makes these differences important enough to make decisions about people based on them (Greene, 2003). Furthermore, in the United States these particular aspects of human diversity are not just descriptive; they are also treated as if they explain and justify the positions people hold in the social hierarchy. In psychotherapy and the delivery of psychological services, clinicians must always be asking how much of a difference these differences make in peoples' lives, how that difference may change across the life span, how these differences are understood or perceived by the client and others, and how these differences inform the client about who he or she is as an individual.

Understanding the client therefore requires the therapist to conduct a contextual analysis that leads to questions about how these relative statuses in and of themselves may contribute to the client's position in the social hierarchy and, particularly, about

what the client must do to negotiate social barriers associated with the subordinate social status that comes with having those identities. Naturally, this examination also raises questions about the effects of the theoretician's or clinician's position in that hierarchy, because hierarchical relationships are relational in nature. How does the clinician's or theoretician's subjective social positioning and cultural lens, as well as his or her awareness of or obliviousness to them, affect his or her conceptualizations about human feelings and behavior? Furthermore, how does the clinician or theoretician feel not only about his or her place in the hierarchy but also about the social hierarchy itself? When one considers the potential responses to any of these issues, one must ask what is reenacted in the therapy process itself when the clinician is a member of or strongly identifies with a privileged and dominant group and the client is or does not. I contend that there is the potential for the normative social power relationship characterized by dominance and subordination to be reenacted. The very differences between the client and therapist themselves can be a source of unnecessary tension that can interfere with conducting therapy in ways that benefit the client.

Theoreticians and clinicians get their information about people who are similar or different from themselves from the same places that clients get that information. People's beliefs about themselves and others are shaped by many complex socio-political variables that may have little to do with locating the true nature of their own or others' identity (Greene, 2003). The way one conceptualizes and understands the differences that are the focus of this essay may be used to serve other than descriptive purposes in a larger system of dominant–privileged and subordinate–marginalized relationships; they may serve as explanations as well. Consider when the word *trash* was used to refer to impoverished White Americans. The use of such an unmistakably disparaging word to distinguish poor White persons from other White persons communicates more than just who poor White people are. In a most insidious fashion it implies why they are poor and situated on the lower rungs of the social hierarchy. Placing the blame on poor White people and not systemic inequity preserves the meritocracy myth. Both clinicians and clients alike are affected by a cultural mythology that has been developed to explain differences in people's relative positions in the social hierarchy: the meritocracy myth. This myth has also been used to justify selective ill treatment of subordinate group members and to avoid the launching of an active critique of social as opposed to individual pathology (Greene, 2003, 2004).

According to the meritocracy myth, achievements by members of privileged–dominant groups are usually attributed to individual efforts or the presence of superior talents and abilities, and rewards for those efforts are seen as having been earned and deserved. Jordan (1997) observed that members of the dominant culture developed a myth of earned power and meritocracy to justify their unfair treatment of subordinate group members, usually people who were different from them in some way. When this myth is not questioned, whatever position people

have in the social hierarchy is seen as deserved. People who are in positions of power are seen as having earned it and therefore as deserving of their power over others. People who are powerless, disadvantaged, vulnerable, and exploited are presumed to be getting what they deserve as well, including blame, punishment, and contempt for their condition. Both client and clinician have a personal stake in these beliefs and may play a role in maintaining these beliefs about themselves and about one another.

The reality of life against a backdrop of dominant and subordinate relationships extends to the practice of psychotherapy, institutional mental health, and the development of psychological theories. Traditional U.S. psychological paradigms, for example, have been appropriately assailed for their limited definitions of a normal family or marriage as the Western nuclear, heterosexual model that equates structure with function; that defines normal psychosexual development as having only heterosexual outcomes; that focuses exclusively on the individual and on individuation, minimizing the importance of relationships and connections; and that fails to analyze the real, and not just symbolic, social barriers to social opportunities in a client's life as if they either have no effect at all on intrapsychic development and behavior or, at the other extreme, inevitably render the client a psychological cripple (Comas-Díaz, 2000; Greene, 2000a, 2000b, 2004; Strickland, 2000). These traditional formulations viewed people as if their culture was not a core piece of their psyche and only in terms of culture's symbolic and not realistic aspects. Multicultural analyses view the failure to name and critique social pathology and the interactive relationship between the individual and a hostile social milieu as a glaring omission from most mainstream psychological analyses of behavior (Comas-Díaz, 2000; Greene, 2000a, 2000b, 2004).

When psychotherapy paradigms legitimize the social status quo or fail to examine it critically, they become instruments of oppressive ideologies and ill treatment of those deemed "other" than the dominant group. In this context, people who step outside of their socially defined positions—for example, women who want to do jobs deemed appropriate only for men, persons of color who want access to the same social opportunities as members of the dominant group, and lesbians or gay men who wish to marry—they may be pathologized and even deemed dangerous to dominant group members. As an example, the current backlash against lesbians and gay men who wish to marry or be given exactly the same rights and social privileges as heterosexual couples is based on the perception that they pose a threat or danger to the institution of marriage.

When any group is depicted as dangerous, the groundwork is laid for doing whatever is necessary to protect society from them, including violence against them. Hence, socially marginalized people, sexual minorities, women, ethnoracial minorities, and people with disabilities, among others, were given labels in the form of diagnoses that simply blamed them for their misery (Lerman, 1996). It is at this juncture that real barriers to social opportunity associated with race, gender, social

class, disability, age, and sexual orientation and, by inference, patriarchy, racism, sexism, ableism, and ageism not only are justified but also, if acknowledged, have their ill effects either denied or attributed to deficits in the groups' members (Harrell, 2000). The ill effects of having to negotiate social barriers on a day-to-day basis are not given the consideration warranted when assessing and explaining clients' psychological functioning. The failure to identify real, and not just symbolic, barriers also serves another purpose: It makes it less likely that members of socially marginalized groups will look outside of themselves for the causes of their misery and seek social change by challenging the status quo. In fact, they may internalize the malevolent explanations for their condition and blame themselves. Furthermore, their appropriate rejecting responses to social injustice have been cited as more evidence of their intrinsic pathology, evidence that is used to justify their continued scapegoating for other social ills and their exclusion from the social opportunities routinely granted to members of dominant-privileged groups. This process is facilitated when behavioral and cultural norms are organized around the dominant cultural group, which obscures both the pathology of the dominant group or majority and the socially constructed nature of one's placement in the social hierarchy.

Recommendations to Human Services Professionals

Social hierarchical positioning, whether based on race, sexual orientation, class, gender, or other variables, is maintained in part through an unwritten rule that it cannot be discussed in social discourse or in the therapy process itself; hence, the perception is maintained that difference per se is the problem. In human services contexts, professionals involved in training and counseling must assess their own feelings, fears, and fantasies about similarities and differences before engaging in such work. For example, it is important to consider the role of difference, social privilege, and social disadvantage in one's own life and its meaning. It is important to know what one is predisposed to do when one encounters people who are different and people who are similar. Clinicians can ask themselves the following questions:

- How does difference or similarity make you feel?
- What assumptions do you make when someone is like you (e.g., in ethnicity, sex, sexual orientation, dress, or social class)?
- Do you gloss over or need to deny differences? Are they anxiety provoking?
- What did it mean to you to be different or similar to others as a child?

People often presume that difference is a bad thing. For some people, however, such as individuals from large families, being different may have represented the only way they could get personal attention from overwhelmed adults because the difference made them stand out in the family "crowd." For other people, difference

or something that made them stand out may have made them a focus of unwanted or unpleasant attention. Being different may have resulted in family members distancing themselves from the client or threatening to do so. Other clients may have been forced to remove themselves from the company of a loved one who was different and whom the family disapproved of. Clinicians need to understand for each client what it means to stand out and what it means to fit in. The meaning differs in different contexts and is different for different people. Was it more important for the client to stand out or fit in, when, and what characteristics were involved? What does the clinician use to fill in the blanks when he or she encounters an unknown? Blaine (2000) argued that one's fears of difference are based not on what one in fact knows about others, but on what one thinks one knows and acts on without active inquiry and reflection. Clinicians must ask themselves how they came to know whatever they think they know about others and what they think this says about them.

Clinicians, of course, must consider that they also have many identities. It is incumbent on them to determine where they are located on the spectrum of social privilege and social disadvantage for each of those identities as well as relative to the person or persons they are working with. They must consider how those identities come together. The following questions may help in this endeavor:

- When were you first aware of differences among groups? Where did you get the information you have about what it meant to be identified with a particular group? How old were you? How did it make you feel about yourself, and did this change over time?
- When you encounter another person, what is the normative power relationship in society represented by your identities? How might this power relationship be recapitulated in your professional relationship with this person? How might it be helpful, as well as not helpful?
- Is there a discrepancy between your personal subjective identity and your social status? How do you explain and manage the discrepancy, internally as well as publicly?
- How do you feel when you are more and when you are less socially privileged than the person or persons you are working with? Is there tension, anxiety, guilt, or shame associated with these encounters? What do you attribute those feelings to, and how do you manage them?

The tendency to universalize human experience is usually engaged when one is confronted with discrepancies in social power between oneself and others that are not based on merit. Although universalizing may serve to superficially decrease interpersonal tension and associated feelings, in clinicians it hinders the ability to understand the client's dilemma. The need to see people as just alike, to deny or fear their differences, mentally removes one from the difficult tensions and feelings

that are a realistic function of these encounters. When this defensive distancing occurs, clinicians can maintain a false sense that social harmony and security exist between different groups as well as among different people within the same group. Avoiding this distancing requires the clinician to tolerate and understand the anxiety he or she experiences in encounters with difference that are organized around privilege and disadvantage. Most people grow up believing in the values of fairness and in the explicit assumption of the fairness of social institutions. When people are confronted with the ways in which their optimal development has been enhanced by factors that are based not on a simple function of ability, hard work, or fairness but rather on things they did not earn, they may need to avoid acknowledging that reality. Therapists are no exception. To acknowledge this reality may appear synonymous with minimizing one's own personal ability and effort—indeed, one's personal integrity. The denial of this reality, however, creates major obstacles not only to an accurate understanding of the client's dilemma but also to discussion of certain aspects of the dilemma. Therapists' failure to acknowledge and understand the broad and divergent role of societal privilege and social disadvantage in the meaning of social differences in client's lives ultimately undermines those initiatives whose goal is to celebrate the richness and complexity of human differences.

Understanding Difference: A Bridge to Empathic Connection

In considering the complicated nexus of sociocultural differences and similarities in any client, therapists are compelled to ask questions that go beyond their understanding of these variables as mere differences or similarities and that speak more directly to their meaning in the social power hierarchy. This essay has discussed people's tendency to avoid examining the meaning of differences in race, ethnicity, age, gender, religion, class, and sexual orientation, alone or in combination, and has attributed this tendency at least in part to the discomfort associated with examining the differentials in power and privilege that accompany these human distinctions and give them significance in people's lives. Pinderhughes (1989) discussed the importance of understanding the operation of systems of power in the broader society, especially how these systems privilege some and disadvantage others, and the role of power in the psychotherapy relationship and in the development of psychological paradigms. I have attempted to outline the salience of differences and social power and powerlessness in the life of the therapist as well as the life of the client when they come to work together in psychotherapy.

Walker (2002) wrote that psychotherapy's purpose is to move toward healing that takes place in the context of a relationship and an empathic connection between therapist and client. This healing is difficult, because professional practice is embedded in a culture where disconnection is valued over connection. It is made even

more challenging when differences in the dominant culture of the United States are usually managed by hierarchical, “power over” arrangements in which the reality of unequal and unfair distributions of resources is denied. Walker defined “power over” as a “cultural arrangement in which difference is stratified into dominant and subordinate, superior and inferior” (p. 2). She suggested that both client and therapist, who both have multiple identities, are “carriers of cultural disconnections” (p. 1) in this context. Other paradigms see differences as potential transferences and countertransferences that exist before the client and therapist ever encounter one another. Differences are implicit in the therapy process because they are an implicit aspect of people’s relationships in society and as such must be addressed as part of the therapy.

Walker (2002) used the concept of “shifting vulnerabilities” that are associated with those different identities as characteristic of the process of therapy. She wrote that these shifting vulnerabilities between therapist and client may evoke a need to avoid the feelings of vulnerability associated with certain identities that are bound to surface with attempts to connect across those identities. When this avoidance occurs, there is an impasse that blocks attempts to connect with empathy and mutuality. When avoidance does not occur, but the therapist recapitulates the relationship of dominance and subordination that is normative in the broader society, not only is connection blocked, but painful violation occurs. Therefore, connections, across differences as well as perceived similarities, by definition harbor the potential for conflict. Walker observed, however, that relational conflict across differences can represent either an end point of therapeutic and relational impasse or, in the negotiation of that conflict, a juncture that holds the potential for deeper connections. Walker credited her husband with creating a metaphor for cross-racial connection that I quote to describe the process of relating across all differences, particularly those associated with differentials in social power: Attempts to relate and bridge connections across differences may be likened to

being in a boat leaving a safe harbor to get to another shore. In the midst of the journey we find ourselves at sea encountering raging storms: storms of anger, guilt, humiliation, and sometimes despair. . . . If you don’t encounter the storm, perhaps you’re not in the boat. (Walker, 2002, p. 9)

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