

# Location of Self: Opening the Door to Dialogue on Intersectionality in the Therapy Process

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*This article describes the evolution and current practice of a model of location of self, a process in which the therapist self-discloses her or his social locations and invites a conversation about how the intersection of the identities held by the therapist and family may be beneficial and/or limiting. It invites thoughtfulness and dialogue in recognizing and addressing explicit and implicit ways that experience, with its associated privilege or subjugation in the world, can operate in the therapy room. It signifies that the therapist is open to exploring how these issues influence clients' lives outside of therapy as well. The conceptual foundations for location of self, along with its clinical development, are discussed, including the social justice perspective in which it is firmly embedded. Clinical benefits and challenges in its use are also noted.*

*Keywords: Therapist's social location; Intersectionality in therapy; Social justice in therapy*

*Fam Proc 49:405–420, 2010*

Location of self is the name of a process in which the therapist initiates a conversation with a family about similarities and differences in their key identities, such as race, ethnicity, gender, class, sexual orientation, and religion, and how they may potentially influence the therapy process. Implicit in this communication is the idea that these identities are meaningful and embedded in the work. In extending this invitation to the family to reflect and discuss the intersection of their identities, the therapist lays the groundwork for these issues to be raised throughout the course of therapy. The therapist signals a measure of comfort with going into the experience of social location in relationships inside and outside of the therapy room. Location of self begins with the therapist engaging in self-disclosure, but the process goes far beyond what is typical in the use of therapist self-disclosure.

## CONCEPTUAL FOUNDATIONS

### Challenging the Standard Bearer—White, Middle Class, Heterosexual, and Male—To Move Over

The conceptual foundation for the location of self process rests with key developments in the field of therapy in general. One shift involved the recognition of the role

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of various identities of culture, ethnicity, gender, race, class, and sexual orientation in understanding and working with families/clients. Not surprisingly, these issues were initially pushed into saliency by professionals with one or more marginalized identities. Mental health professionals of color challenged the assumption of White middle-class culture and values as the standard bearer by which all others could be evaluated, and often be found wanting, and explicated our own cultural identity frameworks (Boyd-Franklin, 1989; Boyd-Franklin, Franklin, & Toussaint, 2000; Comas-Diaz, 1987; Cross, 1980; Duran, 2006; Inlan & Hernandez, 1992; Jones, 1979; Korin, 1994; Sue & Zane, 1987; Watson, 1998). Feminists (Goldner, 1988; Hirshman, 2006; hooks, 2004; Walker, 1992; Walters et al., 1988) critiqued patriarchal assumptions and forced the issue of hierarchy and power in therapy. Other therapists addressed the issue of power in relation to race (Pinderhughes, 1989) and in relation to culture, race, and gender (Waldegrave & Tamasese, 1993). LGBT therapists asserted their sexual orientation as among the normative, examined relational issues among same sex couples, and elevated the bicultural, outsider perspective to one of value (Brown, 1989; Roth, 1989).

The idea of therapists developing a working knowledge of the ethnicity-related culture of various groups (McGoldrick, Pearce, & Giordano, 1982) gave way to the idea of getting to know the meaning of cultural identity in a case by case manner, including identities beyond ethnicity (Falicov, 1995) and the idea of using both approaches (Dyche & Zayas, 1995). Feminists introduced the concept of *intersectionality*, the confluence of multiple identities in each individual, as well as social location, the elevation, and subjugation associated with the identities (Combahee River Collective Statement, 1977; Crenshaw, 1994). Though much of the therapy field now acknowledges the import of these identities, models of therapy vary a great deal on the extent to which they are addressed.

### **Privilege and Subjugation: Front Row and Center in Therapy**

Approaches that address issues of oppression as central to the therapeutic process represent a second influential context for the location of self, a tool in the service of the same goal. These include the Cultural Context model (Almeida, 1998) and other critical consciousness approaches (Dolan-Del Vecchio, 2008; Hernandez, Almeida, & Dolan-Del Vecchio, 2005); the Validate, Challenge, Request model (Hardy & Laszloffy, 2005), “Just Therapy” (Tamasese & Waldegrave, 1993; Waldegrave, 2009), feminist family therapy (Carter & Peters, 1996), some versions of Narrative therapy (Madsen, 2007; Weingarten, 2000; White, 1995), models that address historical trauma (DeGruy Leary, 2005; Duran & Duran, 1995), and the Invisibility Syndrome (Franklin, 2004). Undoubtedly, there are additional therapies with this focus that bear no particular model name, but have been influenced by and influence others. In addition, given the cross-fertilization of models utilized by therapists, it is difficult to speak in terms of approaches being pure in terms of family therapy models. Though the above approaches agree that oppression is pervasive and a mental health issue, they vary in methodology and in the extent to which the self of the therapist is examined and utilized in the process.

### **Self of the Therapist**

The term, *self of the therapist*, is often used in two different ways. One is in reference to the personhood of the therapist, including the legacy of cultural, oppressive, and familial themes, meanings, and patterns of interaction that inform

her or his psychological and relational being. In some family therapy models, this awareness of self of the therapist is considered essential in managing family of origin issues that can get triggered in therapy. A second usage refers to the therapist using her/himself as a vehicle by revealing a reaction to something that transpires in the therapy, or sharing an experience of her/his own that seems germane. Both meanings reflect the view that therapists have a professional and personal presence in the therapy process, but the former meaning focuses on the therapist's awareness of his or her own family/culture of origin baggage, and the latter speaks to therapist self-disclosure (TSD). Self of the therapist is the third body of thought and practice that informs location of self.

Roberts (2005) points out in her review that models of family therapy have widely different positions about boundaries between clients and the therapist. Training settings also vary in the extent to which "self of the therapist" is a focus, and in the way this is addressed. In my own training at the Family Institute of Westchester, where Bowen's model formed the base, with issues of gender, race, culture, and life cycle newly added, self of the therapist was a required course. In presenting our genograms, we were asked to identify multigenerational themes and patterns of handling anxiety, and to consider how these could represent vulnerabilities in our work with certain clients. We did not, however, consider the ways in which oppression and privilege associated with our cultural locations had been woven into our themes and family patterns, and how that might interact with the location of clients.

Narrative therapists have a firm theoretical grasp on how power and social advantages tied to positions of presumed superiority can and does weave a problem narrative around disenfranchised groups. Their approach addresses the subjectivity issue of the therapist in therapy by a format that minimizes therapist prescription or definition, raises questions that facilitate the emergence of stories in which clients can perceive their strengths, and offers transparency about the source of the therapist's ideas.

In the experiential model, the use of self is well-regarded, though in my internship with a Whitaker-trained supervisor, I found its activation to be trusted to the intuitive rather than a structure. There seemed to be an assumption that moments of striking associations or emotional resonance for the therapist in relation to the family could have therapeutic value if shared authentically.

Aponte and Carlsen (2009) have developed a supervision tool that includes self of the therapist issues and can be used across family therapy models. However, neither it nor any of the above models routinely incorporate an explicit acknowledgement of the dimensions of power and privilege between therapist and client in the therapy process.

By contrast, feminist therapists, who have keyed in on interlocking oppressions, advocate strongly for therapists to locate themselves as part of addressing these issues in treatment (Greenspan, 1986; Simi & Mahalik, 1997). The underlying thought is that disclosure of the therapist's values, social location, and political beliefs can help to equalize the relationship and offer clients the information that allows them to make a different choice of therapist. Ziemba (2001) points out, however, that the latter rationale rests on a class assumption, given that poor families often do not have the social status position that offers choice.

TSD and transparency represent another dimension of self of the therapist, an increasingly salient one in therapy practice. TSD ranges from factual matters of training and education to personal identities and experiences. Used selectively, and

with certain provisos, TSD has been found to strengthen the therapeutic alliance and offer new possibilities for change (Katz, 2003; Roberts, 2005), and bridge gaps in social power between therapists engaged in cross-cultural therapy (Constantine & Kwan, 2003). TSD has also been found to be reassuring and normalizing to clients, who see therapists as more real and human, and in turn become more open in the therapy (Knox & Hill, 2003). Findings of positive effects of self-disclosure in the immediate therapy process have thus far been more consistent than those looking at its impact on therapy outcome (Knox & Hill, 2003). However, it is clear that research into this practice remains at an early phase and that such research would need to address the complexity of the self-disclosure process, including the range of content that can be included. While guidelines for engaging in this practice may vary depending on content, such as spiritual disclosure (Denney, Aten, & Gingrich, 2008), sexual orientation, and gender of therapist (Satterly, 2006), there is general agreement that there are risks and benefits associated with this process, and that care needs to be taken in choosing what and how to disclose (Knox & Hill, 2003; Roberts, 2005). Guidelines for disclosures noted by Roberts (2005) include that they are affirming and supportive of the clients' central concerns, that the therapist has some emotional distance from what is shared, and that therapists elicit from clients their experience of the disclosure.

While my work with location of self is informed by the progressive developments outlined above, my thinking has been greatly shaped by specific work of colleagues. The cultural genogram is one of the first instruments that attempted to get therapists to look at their own cultural legacies, including markers of oppression that they and their ancestors have lived through (Hardy & Laszloffy, 1995). This tool, along with the pyramid of power and privilege (Almeida, Woods, Messineo, Font, & Heer, 1994) became an integral part of my live supervision class with family therapy trainees.<sup>1</sup> These tools laid the groundwork for trainees engaging in location of self. The pyramid diagram displays positions of privilege organized by class status, with intersections of gender, race, and sexual orientation layered within class such that upper class, White, male, heterosexual occupy the top and poor, Black, female, LGBT, the bottom. Though the pyramid is static in its presentation, social location is relative to time and context (Hulko, 2009). That is, one's status of social elevation and marginalization is relative to a period of time, a particular place, and the people in it. Finally, Miguel Hernandez' work on privilege and power has been instrumental in widening my lens on these issues and strengthening my resolve to address them in training and in therapy.<sup>2</sup>

### CLINICAL EVOLUTION OF LOCATION OF SELF

The current format of location of self that I engage in has evolved over a number of years, and will continue to evolve. It began with a circumscribed concern and focus, clients of color with White therapists. As an African-American therapist with an interest in families of African descent, many of whom were not privileged to choose their therapists, I had concerns about how this might limit therapy, particularly in regard to experiences of race. How might their cultural differences become a burden to the clients, and how comfortable would a family feel about bringing up racism? It made

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<sup>1</sup>The version that I use is one that Almeida has used in workshop presentations, and is a modification of the one referenced.

<sup>2</sup>This occurred as part of my collaboration with him as faculty of color colleagues at the Ackerman Institute and in personal communications over a number of years.

sense for the field to begin here as well, once it became clear that racial and gender issues constituted substantive content and could not be treated as merely symbolic. Also, the predominant cross-racial scenario was and continues to be White therapist-clients of color, though thankfully, not as dominant as before.

The approach at the time consisted of asking clients to share how they felt about having a White therapist. The therapist might then acknowledge that while s/he may be ignorant of certain cultural meanings or practices, s/he would be open to and eager to be “educated” by the client. The question of how the *White therapist* might otherwise feel about working with a person of color was generally avoided. I cannot recall a single discussion at the time about the Black therapist-White client relationship, and right up to the present, articles about cross-cultural, cross-racial therapy are overwhelmingly focused on White therapists with clients of color.

The first suggestion that I widen my lens beyond White therapists with families of color came in a workshop with Ken Hardy many years ago. And as soon as I began to consider how I as an African-American therapist might approach this with a White client, it became clear that there was another reason why I did not start there, and probably why the field skirted the issue of the White therapist’s feelings. It is much harder to do location of self yourself than to ask someone else to do it. Nor do I put these two pairings on equal footing. The White therapist is doubly empowered by race and therapist position with families of color, while the Black therapist is empowered by only the therapist position. Admittedly, this is a two-dimension comparison, a subset of a larger number of dimensions in operation, which would further qualify this, but still not create parity.

### **Leaving the Comfort Zone**

How does a White therapist say to clients of color that s/he fears unknowingly saying something racist, or that s/he is anxious about Black families getting too angry if they talk about racism?

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?

I recalled tackling the racial difference once during my psychology training in North Carolina, the first time I had worked with White clients, Southerners at that. I felt I had to address it somehow, even without supervisory input. I asked one client how it was for him to have a Black therapist. His response amounted to a declaration that he was not racist. I stalled right there. I simply had no ideas about how to maneuver from there, and could not provide any ease with what was clearly edgy territory. Even when I approached this issue with White clients again, years later, I usually did so in terms of cultural/ethnic differences and not race.

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 a therapeutic relationship. It is no wonder that both therapists and clients alike will often cooperate in keeping this exploration a skimming operation. But I have found that the more the therapist can be comfortable with and clear about the importance of such a discussion, the more likely the client will feel at ease giving it consideration and participating in a meaningful dialogue.

The location of self process that I utilize in my private practice and in training has evolved into one that is routine, and not specific to any particular combination of

identities present in the therapy room. It has been a gradual process of experimentation and expansion. At the base of its development rest three assumptions. The first is that therapists need to have a certain degree of comfort about any issue in order to be free to go into it and to create an atmosphere in which clients feel safe enough to explore it. So, for example, a therapist who does not feel comfortable asking a middle- or upper-class couple about their specific income (it often seems easier when they are poor), will be limited in hearing and addressing money issues in their relationship. S/he will also be constricted in understanding and addressing how the power of money may be operating in the couple relationship (Carter & Peters, 1996; Shapiro, 2007).

Developing comfort requires practice, including the practice of talking about identities and relative privilege and subjugation. Training is the place to nurture this comfort, by making it routine to consider and talk about intersectionality as personal and in the room, and not simply as a theoretical construct. Over the course of working with location of self I have been aware that some identities of difference between therapist and clients, other than race, seem harder than others, and that this can be related to a number of contextual factors. Socioeconomic class is one that I continue to feel less fluid in addressing. While some discomfort is necessary for any new venture, and I have pushed myself and others, I also respect the need to examine the particularities, and to move forward within a modicum of discomfort.

### **The Explicit and Implicit Embedded in Identities**

The second assumption is that identities matter in the therapy process, particularly those associated with social advantage and power. Our identities represent an additional lens through which we understand the world, including the world of our families. Assumptions are embedded in our identities, and while we may aspire to be aware of them, many are implicit and out of our consciousness. Thus, as a social worker at the time in an OB-GYN perinatal clinic, serving a largely poor Black and Latino population, I had no recognition of an implicit assumption I held—that there was no issue around managing children and a household after a Cesarean section (C-section) delivery. It was an assumption of omission, which could also be called ignorance, a more benign term which can undercut the significance of this factor. My assumption of omission was based on my identity as a middle-class Black mom who had experienced a vaginal delivery. It was not until I had my own Cesarean, and realized how much I needed the help my mom provided for me and my family, that I recognized my assumption of omission.

I began to wonder, did all of the women in the clinic have family members who could take time off from their jobs or lives to come stay with them for a week or two? My mom, a professor, had the privilege of negotiating this and flying to New York. She did not lose any pay. Nor had any woman ever asked me about getting help after delivery. Maybe they too had never had a C-section before, but I still wondered if they had, would they have inquired. Socioeconomic class shapes a great deal the degree to which people feel entitled to ask for, let alone, demand services. And so, a new question emerged in my work with women who knew they would be delivering by C-section, would they have help at home afterwards? I began to call DSS to provide homemaker services for those who did not, and to ask the OB-GYN doctors to provide medical documentation for this.

### **The Question About Oppression is not If but How**

The third assumption is that no one escapes the influence of oppression, given its infusion into systems of thought, associations, and values, implicit and explicit, and institutional and cultural practices. This means that issues of oppression are always relevant to some degree in therapy. The manifestation of its influence in the psyche and in relationships is shaped by many contextual factors. These include the intersectional mix of identities and their historical legacies, lived experience, and conscious work on overcoming internalized oppression and the use of privilege in ways that collude with injustice. This suggests that we as therapists need to be curious about how oppression shows up in every family, and not simply those who present with discrete trauma, or those who come in identifying the second shift as a source of conflict (Hochschild & Machung, 2003). In this framework, good therapy includes a lens for seeing the legacy of wounds and entitlements that run underground as well as those that surface in relationships, and a space for witnessing and healing these.

### **CURRENT MODEL OF LOCATION OF SELF**

In my work with families, as a clinician and as a training supervisor, I make use of Karpel's (1994) model of marital evaluation, except in the case of the need for immediate crisis intervention. Families are informed about this format either before the first session or at its outset, in the training context. In the first few sessions, I attempt to elicit as broad an understanding of the presenting issues as possible. Following this, I offer feedback that includes some of the strengths I believe they bring to the process, how I see the problems they are grappling with, and how I think we might work on these. I elicit their thoughts and reactions to my feedback. Does it make sense? Have I left out something they feel is important to address? Is there something we should add or subtract? Out of this discussion, a treatment plan is negotiated. I have found it to be a natural place to introduce location of self at this juncture in treatment planning, as it fits in with establishing the treatment structure. In addition, I think allowing a few sessions before addressing this dimension increases the chances of comfort in the room and for meaningful engagement. For families entering therapy for the first time, involuntarily, or with an unsatisfying prior treatment experience, allowing this time to establish a good connection before location of self may be particularly important. It is important to note, however, that others who engage in their own versions of location of self introduce it earlier in the therapy (K. Hardy, personal communication, June 2004), including the first session (M. Hernandez, personal communication, October 2000).

Before the session in which I do this, I give thought to any concerns I have about similarities or differences in the identities the client(s) and I occupy creating a limitation in therapy. So for example, if my clients are African Caribbean, I may have a concern about how my experience of race, racism, and patriarchy may differ from theirs and could limit or overdetermine my therapeutic input. I will also consider if there may be benefits to our combination of identities. Thus, I tend to see being a parent as an asset when I am working with parents.

The following is a typical way that I introduce the process of location of self to clients.

Before going forward with therapy, I also like to share a bit about myself. I do this because I believe that my training is only one of the lenses that helps me to understand and work with problems and families. My personal experiences also inform my vision, what I see and don't see. And so I like to

think about how my personal identities might be helpful or a limitation in our work together, and get your thoughts about this. I think it's important to be able to talk about this now and throughout therapy if either of us thinks we may have hit a roadblock or pothole related to this.

I then proceed to identify myself as African American, Black, middle class, a mother of two grown children, divorced, heterosexual, and with a spiritual practice that draws from Buddhism, Ifa, and Dagara spirituality (West African), and Native American spirituality. At times, I say I am African American and African Caribbean but identify with the former because that is how I was raised. I take the lead in sharing my ideas first as I think in the privileged position of therapist I should bear the initial vulnerability in this conversation and not the client. Also, while differences tended to be the major concern early on in this process, it became increasingly clear that similarities can also pose limitations. Some therapists have noted more difficulty working with clients of similar ethnicity, and while I will usually say that I tend to see my ethnicity/race as an asset in working with those of African descent, I will also say that it could be a liability if I assume that I know their experience, or overlook differences.

Often, I will already have some knowledge about many of their identities, including their spiritual practices, although even if I have an idea of their class position, I will ask them in the discussion how they identify themselves class-wise.

In working with families, the feedback, treatment planning, and location of self is done initially with the parents, and depending on the age of the children, some abridged version of location of self may occasionally be done when the treatment planning expands to include the children.

My experience is that clients are surprised yet quite interested in this turn of the therapy process. As I have grown more assured in the value of this conversation and in the practice of such talk, I have found that families have offered a greater range of participation in this process. Potential benefits do seem to be easier for both clients and myself to bring up, as opposed to drawbacks. I have, however, had couples raise concerns related to my marital status, and to my gender and social justice perspective. For example, in couple's therapy with several different couples, concern about my ability to either help them save their marriage (because I did not save my own) or interest in helping them save their marriage has been expressed.

Being transparent about such identities can force one's clarity of thought about the therapeutic process in ways that are often not put on the therapy table. So, for example, most therapists have had no practice in sharing that they are in therapy themselves or in addressing the question of how we can help someone if we need help ourselves, a common way of making meaning of this. As a divorced therapist, I have to be clear and able to articulate that saving my or anyone's marriage depends on many factors, that every marriage is different, and that I do not see my ability to help them as dependent on my marriage having worked out. I also have to be able to say that I hear that the fact that I divorced raises concern about my commitment to helping them stay together. I need to provide reassurance that this is my intent, that I see strengths that support their goal, although ultimately I cannot guarantee the outcome.

There is therapist vulnerability in this conversation, and it can feel very odd at first and at times, depending on how it goes. One could examine this example and say that by disclosing my divorce status, I have raised anxiety where there was none. That is true. That does not mean, however, that my divorced status might not operate as a limitation at some point in the therapy, unbeknown to me or the client at different

points. Making identities transparent is an invitation to clients to participate with the therapist in being mindful of how our mix of experiences may at times create tension, misunderstanding, or frustration and to talk about it. It extends the collaboration.

## **Two Case Examples**

### *Peter and Jose*

An interracial gay couple in their mid-30s presented in therapy in crisis after it emerged that one was considering sex outside of the relationship. Peter was White and grew up in the southwest, while Jose came to the United States as a young adult from Costa Rica. They had a history of infrequent sexual intercourse, conflict around their different cultural and individual rhythms (spontaneous vs. planned, emphasis on we vs. I, high vs. low order) and around managing the experience of Jose's additional subjugation as an immigrant, gay male of color.

In the location of self discussion I shared my thoughts that it could be a benefit that I am a person of color in relating some to Jose's experience, although clearly there were differences. I also expressed concerns about what it might be like for Peter having two people of color in the room. Jose thought it could be helpful and Peter voiced no concern about how this might become an issue. I also shared my concern that as a heterosexual therapist with little experience with gay couples, as opposed to lesbians, I would likely be ignorant of some of the unique dimensions of their lives and sexuality, and that I think that could be frustrating for them. Here I drew on and shared my own experience of frustration with often being burdened with explaining aspects of the Black experience to Whites. At the same time, I shared that I do try to inform myself about the impact of heterosexism on the gay and lesbian community, and to be aware of my own privilege, but that inevitably I would likely fall short. Both Peter and Jose expressed some relief to have a therapist who considers these issues and agreed that they would bring up any experience of feeling alienated in regard to them. Jose went on to say that he had recently found an article about the unique difficulties gay men of color have in finding a home community, and offered to bring it in. I gladly accepted.

### *David and Joan*

David, a pediatrician and Joan, who worked a few hours a week outside the home, came for therapy for help with their pattern of conflict and prolonged distance, usually over their differences in parenting. They were so cautious about approaching the nature of their problem that it took much longer than usual to get a basic grasp of it. David felt he had acquiesced in his parental input to avoid Joan's anger. Joan felt that David often relied on her emotionally without acknowledging it or taking a position about what he wanted from her, and in regard to limits for their two adolescent boys. This couple was in their late 40s, White and Jewish.

In locating myself with them, I shared my thoughts about how my gender might lead David to feel outnumbered in terms of a male point of view, and also my wonder about what it might be like for them to have a Black therapist. I usually contextualize the latter with a normalizing statement about Whites typically having less exposure to Blacks as help providers than the other way around. Both shared that while all of their prior therapists had been White they did not feel that our racial and ethnic differences would be an issue. In addition to locating myself, I also shared that my way of working is attuned to issues of oppression, like racism, sexism, heterosexism, classism, and how

they show up in relationships, and to my belief that these influences undermine health. This has become a routine part of my direct clinical work, a sort of informed consent practice.

Joan viewed my sensitivity to sexism as an asset, but also voiced concern about my being separated (at the time), saying she did not want that for them. David voiced concern that he not “be the brunt of your anger at men,” and fear of being “dismissed because I am an oppressor.” I expressed appreciation for their sharing of concerns and offered reassurance to Joan about my commitment to their goal of staying together, and encouraged David to bring up in session if he felt dismissed, ganged up on, or the brunt of what he identified as my anger at men. In the 2 years that we worked together, this couple did some tremendous work. And in fact, David did bring up feeling dismissed at a time when therapy was shifting from exploring the interactional pattern connected to his difficulty asserting himself to Joan’s experience of being unappreciated. We were able to talk through his feelings and eventually expand the work into looking at ways that sexism had contributed to the wedge between them.

With practice in location of self, I have gained greater confidence in addressing experiences of discomfort that I have in therapy when I suspect that racism or sexism is in play in the therapeutic relationship. I have found it helpful to witness my experience and to dialogue around it. For example, a White client I had been seeing for some time in one location during the day (in her vastly White, middle- and upper-class neighborhood) was going to begin coming to another office of mine in the suburbs in the evening. She asked me if it was safe around there. That question lingered in a disconcerting way. I wondered if it was because I was Black. I tried to imagine her asking a White therapist the question, but an image of this seemed hard-pressed. Near the beginning of the next session, I shared with her my experience of that question and how I wondered if she would have asked the same question of a White therapist. She did not appear defensive and said she would like to think about it. In a subsequent session, she said she was not sure but she thought that race had likely been a factor in her question. I let her know I appreciated her willingness to look at this, and that I think this is often how racism operates, in subtle forms, and that I think we were all impacted by oppression.

Undoubtedly, the ease with which this conversation transpired had to do with a number of factors, the solid therapeutic alliance, the work we had already done about the impact of classism in her life (her sense of inferiority about not having a college education, though she made much more money than I did), and a prior exploration around her use of the term “girl,” to describe her adult cleaning woman. Nonetheless, even in instances where the alliance remains new and little work dealing with privilege and subjugation has gone on, I find it essential to clear the therapeutic channel by raising these experiences for witnessing and exploration.

While the discussion of location of self has tended to focus on certain identities, it is important to note that depending on the family involved, other locations can be included. For example, in my live supervision class, one trainee felt it would be important for her to locate herself not only as having been raised in a working class home but also one with a single parent.

## Challenges

I have encountered certain challenges in this work, and I will identify three. As previously noted, some location of therapist’s identities relative to those of clients are

easier to share than others. I have found this to be true for family therapy trainees and for myself, and it is useful in each case to examine what informs this relative difficulty. This sometimes has to do with the vulnerability of the therapist sharing a subjugated identity that is not overt with clients who are privileged in that identity. In teaching location of self to family therapy trainees, sexual orientation, parental status, and religion have emerged as creating more of a dilemma at times than other identities.

Certain religions may be marginalized or devalued. A therapist who practices Wicca or Vodou is likely to be marginalized or feared. One trainee, a Jehovah Witness, was very reluctant to locate herself on this dimension. A gay or lesbian therapist may or may not be “out” in many sectors of his or her personal life. Even if s/he is “out,” s/he may fear alienating or losing heterosexual clients in being “out” as a therapist with them. Russell (2006) speaks to the complexity of disclosing the therapist’s sexual orientation. While parenting is not necessarily a socially privileged position, therapists who are not parents often feel they will be disadvantaged by sharing such information when working with parents. In handling these situations, I have tended to press trainees on disclosing their status of not having children, and honored the substantial discomfort of the Jehovah Witness and LGBT therapists. Underlying the difference in my approach is my feeling and thought that therapists with covert subjugated identities need to be in charge of whether to name or forego naming these identities in their location of self with families. I will, however, press them to consider what would need to be different for them to feel ready to take such a leap.

In regard to my own spiritual practice, I recognize that it may present a liability in working with those who may have a strong aversion to practices outside the Judeo-Christian tradition. As with other identities I occupy, my spirituality shapes what and how I understand, and thus belongs on the table for discussion of concerns or welcoming. More so, I often will draw on ideas from my spirituality in the course of therapy, always referencing their source and that they are one way of looking at an experience. I have in a couple of instances, involving Jehovah Witnesses, voiced concern that our difference in this identity could potentially create a limitation in understanding. While we agreed to bring up any feelings of difficulty around this, neither gave voice to any concerns up front. I suspect that this could be more of an issue in working with families whose practices are orthodox or fundamentalist. Some clients, whose spiritual practices have been similar to mine, or outside the mainstream, like Reiki, have expressed feelings of comfort about this intersection.

As stated earlier, I believe that direct experience with a situation does provide a different level of knowing, and in fact that is what therapists and trainees fear in revealing that they are not parents—that this will disadvantage them in the eyes of clients who are parents. However, my approach is to include this as one of those possible limitations and explore with parents their thoughts about how this could potentially be a drawback or not. This requires the therapist to hold the view that while s/he may not fully appreciate some aspect of parenting, as a result of not having first-hand experience, this does not disqualify her or him as a capable therapist. Training and professional experience are part of the therapist’s competence, as well as an ability to acknowledge a potential limitation and address it productively if it indeed arises.

A second challenge is to engage in transparency about identities of privilege and devaluation in a way that does not shame either the therapist or the client. Class position seems particularly vulnerable to this. While I routinely locate my middle-class

status, sometimes identifying it as second generation, I have less comfort in sharing how I think it may be a limitation in working with those with marginal incomes as well as those of upper-class status. With practice, I have found it easier to talk about how I may be largely uninformed about certain financial realities such as prenuptial agreements as part of locating myself with those heavily endowed with money, or may be vulnerable to overestimating how much distress money can buffer. With clients of markedly less means and education, I have not yet reached a comfortable, fluid repertoire.

In one instance of experimenting with going further with class location with an African-American couple, the location of self discussion took an unexpected turn, and developed into one of the most extended I have had. Both members of the couple worked in mailrooms. Devon and Tanisha both had a year or slightly more of college. Both were quite intelligent and easily engaged. The discussion around my ethnic and race location revealed that they had wanted an African-American therapist and had “hoped it wouldn’t be too hard to get one.” They offered some reasons for this. Next, I moved to class, expanding from my usual “middle class” location to “second generation middle class,” and to elaborating on my understanding that class is based on education and income. I went on to say that while I did not know how they perceived their class status, I was aware that class does shape the experiences we have and that when I am working with those with more or less income and education than I have, I feel the need to try to be sensitive to those differences. Still, I could overlook or assume something because of that and wanted them to feel free to speak up if they felt it was happening.

What followed was a prolonged sharing on both their parts of their feelings of regret of not having gone further with school. They often reflected on this together, how they should have listened more to their parents, taken school more seriously, and realized that their struggles around money were related to the choices they had made. I initially was very concerned that my location around class had shamed them into explaining why they did not have a higher class position. I noted that they seemed to feel the need to explain and that this was not my intent in sharing my thoughts on class. They understood that but went on to say more about the context surrounding their choices. Tanisha had hoped to go away to college to study childhood education, as she would like to work with children, but her mother insisted she live at home and attend school. Tanisha had also been into partying and said that her mother’s ambivalence about Tanisha getting more education reflected the perspective of Jehovah Witnesses at the time, that is, that more education could lead followers away from the religion. Devon shared that his mom got her Associates Degree (A.A.) and wanted him to go further but said he had to make the decision for himself. Devon elected to go to work instead. I noted that they both seemed to be blaming themselves whereas there are often a number of reasons why people do not go on to college. I again reiterated the purpose—wanting them to feel comfortable to bring up anything they think I am not getting regarding their experience, and they both indicated they would. Tanisha voiced that it was their “guilt” that had led to their response.

For some time after, I remained unsure of whether I had triggered shame. Only after reviewing the tape many times, presenting it to others, and working with the couple for months did I begin to lean toward the idea that my location of self in terms of class had triggered their regret or “guilt” as Tanisha labeled it, and opened the door on an issue that was very alive in their relationship. Over the course of a year and a

half, we explored in depth their experiences in school, along with the family and social contexts, including trauma, in which they took place. This helped them to enlarge their perspective on how they ended up not going further educationally. Messages about class and experiences of shame and rage associated with classism were brought to the therapy table in ways that allowed them to examine these as reflections of a system of injustice and not a true reflection of their value and possibilities. They were also able to redirect some of the tension about their marginal socioeconomic position away from blaming each other to a joint effort to defy the dissolution of their relationship under the pressure.

Still, I continue to reflect on why the privilege of class seems more risky to locate with those who are devalued relative to the therapist on that identity, more than say heterosexism or even my experience of others locating themselves as White. For some reason, I have more concern about shaming in the case of this privilege. Perhaps it is related to the painful experiences I have witnessed around adolescents making “Payless” jokes about a peer’s clothing or my own quiet snobbishness about polyester, and fake leather. Clearly the words used are not the only factor in determining whether it is experienced as a one-up maneuver or an attempt to make space for navigating issues of social elevation and marginalization that could be alienating in therapy. The therapist’s demeanor—voice, body language, warmth, and ease—is another key influence in how this particular location of class comes across, and it has occurred to me that the use of the therapist’s voice and body is a neglected area in training.

I suspect that location of self in regard to class is more difficult in general, because the influence of class, the interpersonal sizing up, the markers, the presumptions, the quality of services associated with it are rarely acknowledged explicitly. Nor do we have the language to facilitate this across classes. I rarely hear people of limited means referring to themselves as “poor,” or “lower class,” the labels proscribed for them by those of more means. While racial struggle has been organized and quite public in this nation, class struggle, most visible in the labor union movement, has faded from view.

The particular identities that a therapist may find more difficult to talk about in relation to particular identities of clients are likely to reflect personal idiosyncratic factors and/or broader sociocultural ones. It is certainly useful to reflect on what goes in to relative ease and difficulty with talking about our identities.

A third challenge is related to the use of location of self in different settings. While I have been able to incorporate it routinely in my private practice and in my live supervision class, I find it more challenging to do so in agency clinical work. In one setting, location of self seemed impossible to keep up with, like paperwork, given the inordinate administrative and pressing clinical demands, and the obstacles to meeting them. As a result, I did not routinely engage in location of self. This is both ironic and sad because the potential value of location of self is heightened in these settings. Poor and working class families, who have less ability to choose their therapist, compared with those of more means, are predominantly served by public and nonprofit agencies. Class and racial differences between therapists and families are more pronounced than in private practice. Creating a space for thinking and talking about possible pros and cons to this intersection of identities would seem especially important. My approach to location of self became a selective one. Essentially, I would engage in it with families whose racial, ethnic, immigrant status, or nationality differed from mine or I had little experience with in therapy. I prioritized these because I tended to be more concerned about limitations arising out of our differences.

In another agency setting, a school-based clinic with adolescents, I also used location of self selectively, and in an abbreviated fashion. Therapy in that context had an informal, brief format with crisis-oriented family work. I utilized a similar principle as before in locating myself, but most often in regard to race, ethnicity, and sexual orientation. I made use of it more spontaneously, as issues related to these identities emerged. For example, in asking a female student if she had a boyfriend or girlfriend and getting a response of disaffection, I would inquire about it. I then shared why I asked that, including my desire to avoid actions that render the reality of gay sexuality invisible, and my awareness of this as a heterosexual. I more routinely identified my heterosexual location with LGBTQ students, and my ethnicity and Southern roots with Latino adolescents/families.

### CONCLUSION

Location of self is a tool in progress. More work is needed to ascertain the meaning and parameters of combinations of therapist–family locations that are experienced as most difficult, and to further refine the location process. Eliciting the experience of the families with this process, both at the time and at the conclusion of therapy, would also be useful. While I am unaware of any empirical research on its use, my experience is that it creates a space in therapy for addressing issues of privilege and subjugation, along with experiences of tension and alienation that can arise related to this.

Learning to locate one's self requires a willingness to go into places that most of us still feel uneasy about engaging, interpersonally and personally—race, class, sexual orientation, religion, and the associated power and vulnerability. Training and consultation with those using this approach are paramount in being able to entertain these aspects of our lives and work in the here and now and in some depth, rather than from the periphery or the revered domain of abstraction. Practice, continued consultation, authenticity, and patience with stumbling are needed to achieve greater ease and quality in this process. Location of self also requires time. With society and social service agencies focused on packing increasingly more quantity into time, we are challenged to use our knowledge, creativity, and advocacy in the service of quality in training and clinical work in a variety of settings. Madsen (2007) offers some suggestions on how to maintain a sense of collaboration and integrity in our work despite agency demands. Location of self is about integrity in our work, a way of developing greater skill with addressing issues of intersectionality inside the therapy room, and demonstrating an awareness and interest in how issues of social status—those positioned as superior and inferior, and their respective entitlements and losses—operate in the lives of clients outside the room. For those struggling with their subjugated identities it can signal a welcoming that can validate their experience. For those with little recognition of their privilege and its relational impact, location of self offers the message that these issues of relational injustice can be addressed to the benefit of relationships and the larger community.

### REFERENCES

- Almeida, R. (1998). The cultural context model, an overview. In M. McGoldrick (Ed.), *Revisiting family therapy: Race, culture, and gender in clinical practice* (pp. 414–431). New York: Guilford.

- Almeida, R., Woods, R., Messineo, T., Font, R., & Heer., C. (1994). Violence in the lives of the racially and sexually different: A public and private dilemma in. In R. Almeida (Ed.), *Expansions of feminist family theory through diversity* (pp. 99–126). New York: Harrington Park Press.
- Aponte, H., & Carlson, J. (2009). An instrument of person-of-the-therapist supervision. *Journal of Marital and Family Therapy*, 35(4): 395–405.
- Boyd-Franklin, N. (1989). *Black families in therapy, a multisystems approach*. New York: The Guilford Press.
- Boyd-Franklin, N., Franklin, A.J., & Toussaint, P. (2000). *Boys into men: Raising our African-American teenage sons*. New York: Dutton.
- Brown, L. (1989). New voices, new visions, towards a lesbian/gay paradigm for psychology. *Psychology of Women Quarterly*, 13, 445–458.
- Carter, B., & Peters, J. (1996). *Love, honor and negotiate, making your marriage work*. New York: Pocket Books.
- Comas-Diaz, L. (1987). Feminist therapy with Mainland Puerto Rican Women. *Psychology of Women Quarterly*, 11, 461–474.
- Combahee River Collective Statement. (1977). Retrieved November 29, 2009, from [www.buffalostate.edu/orgs/rspms/combahee.html](http://www.buffalostate.edu/orgs/rspms/combahee.html)
- Constantine, M., & Kwan, K. (2003). Crosscultural considerations of therapist self-disclosure. *Journal of Clinical Psychology*, 59(5): 581–588.
- Crenshaw, K.W. (1994). Mapping the margins: Intersectionality, identity politics, and violence against women of color. In M.A. Fineman & R. Mykitiuk (Eds.), *The public nature of private violence* (pp. 93–118). New York: Routledge.
- Cross, W. (1980). Models of psychological nigrescence: A literature review. In R. Jones (Ed.), *Black psychology* (2nd ed., pp. 81–98). New York: Harper & Row.
- DeGruy Leary, J. (2005). *The post-traumatic slave syndrome*. Milwaukee: Uptone Press.
- Denny, R., Aten, J., & Gingrich, F. (2008). Using spiritual self-disclosure in psychotherapy. *Journal of Psychology and Theology*, 36(4): 294–302.
- Dolan-Del Vecchio, K. (2008). *Making love playing power: Men, women and the rewards of intimate justice*. Berkeley: Soft Skull Press.
- Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other native peoples*. New York: Teacher's College.
- Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. Albany: State University of New York Press.
- Dyche, L., & Zayas, L. (1995). The value of curiosity and naivete for the cross-cultural psychotherapist. *Family Process*, 34, 389–399.
- Falicov, C. (1995). Training to think culturally: A multidimensional comparative framework. *Family Process*, 34, 373–388.
- Franklin, A. (2004). *From brotherhood to manhood, how black men rescue their relationships and dreams from the invisibility syndrome*. Hoboken: John Wiley & Sons Inc.
- Goldner, V. (1988). Generation and gender: Normative and covert hierarchies. *Family Process*, 27, 18–31.
- Greenspan, M. (1986). Should therapists be personal? Self-disclosure and therapeutic distance in feminist therapy. *Women and Therapy*, 5, 5–17.
- Hardy, K., & Laszloffy, T. (1995). The cultural genogram: Key to training culturally competent family therapists. *Journal of Marital and Family Therapy*, 21(3): 227–237.
- Hardy, K., & Laszloffy, T. (2005). *Teens who hurt, clinical interventions to break the cycle of adolescent violence*. New York: Guilford Press.
- Hernandez, P., Almeida, R., & Dolan-Del Vecchio, K. (2005). Critical consciousness, accountability, and empowerment: Key processes for helping families heal. *Family Process*, 44(1): 105–119.
- Hirshman, L. (2006). *Get to work: A manifesto for women of the world*. New York: Penguin Group.
- Hochschild, A., & Machung, A. (2003). *The second shift*. New York: Penguin Books.
- hooks, b. (2004). *The will to change: Men, masculinity, and love*. New York: Atria Books.

- Hulko, W. (2009). The time- and context-contingent nature of intersectionality and interlocking oppressions. *Affilia: Journal of Women and Social Work*, 24(1): 44–55.
- Inclan, J., & Hernandez, M. (1992). Cross-cultural perspectives and codependence: The case of poor Hispanics. *American Journal of Orthopsychiatry*, 62(2): 245–255.
- Jones, D. (1979). African-American clients: Clinical practice issues. *Social Work*, 24(2): 112–118.
- Karpel, M. (1994). *Evaluating couples: A handbook for practitioners*. New York: W.W. Norton & Co.
- Katz, J. (2003). Tales of a therapist: Unexpected self-disclosure in couple therapy. *Journal of Couple & Relationship Therapy*, 2(1): 43–59.
- Knox, S., & Hill, C. (2003). Therapist self-disclosure: Research based suggestions for practitioners. *Journal of Clinical Psychology/In Session*, 59(5): 529–539.
- Korin, E. (1994). Social inequalities and therapeutic relationships: Applying Freire's ideas to clinical practice. In R. Almeida (Ed.), *Expansions of feminist theory through diversity*. Binghamton: Harrington Park Press.
- Madsen, W. (2007). *Collaborative therapy with multi-stressed families*. New York: Guilford.
- McGoldrick, M., Pearce, J., & Giordano, J. (1982). *Ethnicity and family therapy*. New York: Guilford Press.
- Pinderhughes, E. (1989). *Understanding race, ethnicity & power, the key to efficacy in clinical practice*. New York: The Free Press.
- Roberts, J. (2005). Transparency and self-disclosure in family therapy: Dangers and possibilities. *Family Process*, 44(1): 45–63.
- Roth, S. (1989). Psychotherapy with Lesbian couples: Individual issues, female socialization and the social context. In M. McGoldrick, C. Anderson, & Walsh F. (Eds.), *Women in families, a framework for family therapy* (pp. 286–307). New York: W. W. Norton & Company.
- Russell, G. (2006). Different ways of knowing: The complexities of therapies disclosure. *Journal of Gay and Lesbian Psychotherapy*, 10(1): 79–94.
- Satterly, B. (2006). Therapist self-disclosure from a gay male perspective. *Families in Society*, 87(2): 240–247.
- Shapiro, M. (2007). Money: A therapeutic tool for couples therapy. *Family Process*, 46(3): 279–291.
- Simi, N., & Mahalik, J. (1997). Comparison of feminist versus psychoanalytic/dynamic and other therapists on self-disclosure. *Psychology of Women Quarterly*, 21, 465–483.
- Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist*, 42, 37–45.
- Tamasese, K., & Waldegrave, C. (1993). Cultural and gender accountability in the 'just therapy' approach. *Journal of Feminist Family Therapy*, 5(2): 29–45.
- Waldegrave, C. (2009). Cultural, gender, and socioeconomic contexts in therapeutic and social policy work. *Family Process*, 43(1): 85–101.
- Waldegrave, C., & Tamasese, K. (1993). Some central ideas in the 'just therapy' approach. *Australian & New Zealand Journal of Family Therapy*, 14(1): 1–8.
- Walker, A. (1992). *Possessing the secret of joy*. New York: Pocket Books.
- Walters, M., Carter, B., Papp, P., & Silverstein, O. (1988). *The invisible web, gender patterns in family relationships*. New York: Guilford Press.
- Watson, M. (1998). African American sibling relationships. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture and gender in clinical practice* (pp. 282–294). New York: Guilford.
- Weingarten, K. (2000). Witnessing, wonder and hope. *Family Process*, 39(4): 389–402.
- White, M. (1995). *Reflecting teamwork as definitional ceremony. Reauthoring lives: Interviews and essays*. Adelaide: Dulwich Centre Publications.
- Ziemba, S. (2001). Therapy with families in poverty: Application of feminist family therapy principles. *Journal of Feminist Family Therapy*, 12(4): 205–237.