

PSYCHOTHERAPY, RACE, AND RACISM IN BRAZILIAN CONTEXT: EXPERIENCES AND PERCEPTIONS OF BLACK WOMEN

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ABSTRACT. The belief in racial democracy in Brazil has been deconstructed by various indices of social inequality and violence victimization. Although more than 50% of the country's population is black, Brazilian scientific production on racism and mental health is not significant. The subject of race relations is, in general, invisible within the *psi* sciences. This situation raises the question of how this portion of the population is served in the mental health system, specifically in the psychological clinical service to the black client. The objective of this study was to collect narratives of black persons who had white psychotherapists, regarding their experiences of racism in daily life, as well as to how they were listened to in a biracial dyad in psychotherapy. Seven women took part in the study. Four thematic categories were identified: (1) Reason to seek psychotherapy; (2) Psychotherapeutic process; (3) Associated therapeutic factors, and, (4) Psychotherapist specific training to serve black people. The most important issues, presented by all the interviewees, were the interracial transference in the therapeutic process and the lack of training of the psychotherapist to serve black clients.

Keywords: Racism; mental health; black woman.

PSICOTERAPIA, RAÇA E RACISMO NO CONTEXTO BRASILEIRO: EXPERIÊNCIAS E PERCEPÇÕES DE MULHERES NEGRAS

RESUMO. A crença na democracia racial brasileira vem sendo desconstruída por vários índices de desigualdade social e de vitimização pela violência. Ainda que mais de 50% da população do país seja negra, a produção científica brasileira relativa a racismo e saúde mental não é significativa. O tema das relações raciais é, em geral, invisibilizado dentro das ciências *psi*. Esta situação desperta a pergunta sobre como essa parcela da população é servida no sistema de saúde mental, especificamente na clínica psicológica de atendimento a clientes negros/as. O objetivo deste trabalho foi coletar narrativas de pessoas negras atendidas por psicoterapeutas brancos/as, sobre suas vivências de racismo no cotidiano e sobre como se deu a escuta na terapia em díade birracial. Sete mulheres participaram do estudo. Foram identificadas quatro categorias temáticas: (1) razão para buscar psicoterapia; (2) processo psicoterapêutico; (3) fatores terapêuticos coadjuvantes, e, (4) formação do(a) psicoterapeuta para atender pessoas negras. Os temas mais importantes,

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apresentados por todas as entrevistadas, foram a transferência inter-racial no processo terapêutico e a falta de formação do(a) psicoterapeuta para atender clientes negros/as.

Palavras-chave: Racismo; saúde mental; mulher negra.

PSICOTERAPIA, RAZA Y RACISMO EN EL CONTEXTO BRASILEÑO: EXPERIENCIAS Y PERCEPCIONES DE LAS MUJERES NEGRAS

RESUMEN. La creencia en la democracia racial brasileña viene siendo deconstruida por varios índices de desigualdad social y de victimización por la violencia. Aunque más del 50% de la población del país es negra, la producción científica brasileña relativa al racismo y la salud mental no es significativa. El tema de las relaciones raciales es, en general, invisibilizado dentro de las ciencias *psi*. Esta situación despierta la pregunta sobre cómo esta porción de la población se sirve en el sistema de salud mental, específicamente en la clínica psicológica de atención a clientes negros/as. El objetivo de este trabajo fue recolectar narrativas de personas negras atendidas por psicoterapeutas blancos/as, sobre sus vivencias de racismo en el cotidiano y sobre cómo se dio la escucha en terapia con profesionales de pertenencia racial diverso del suyo. Siete mujeres participaron en el estudio. Se identificaron cuatro categorías temáticas: (1) La razón para la búsqueda de la psicoterapia; (2) Proceso psicoterapéutico; (3) Factores terapéuticos secundarios, y (4) Formación del psicoterapeuta para atender a las personas negras. Los temas más importantes, por haber sido presentados por todas las entrevistadas, fueron la transferencia interracial en el proceso terapéutico y la falta de formación del psicoterapeuta para atender a clientes negros / as.

Palabras clave: Racismo; salud mental; mujer negra.

Introduction

Systems of racial domination have been justified strictly based on phenotypical differences, which dictated the moral, psychological, intellectual, and cultural qualities of different human groups, with one of them as a reference. Today, by the conclusion of human biology itself, there is no scientific reason to believe in the existence of biological race and the impossibility in operationalizing the concept is clear (Munanga, 2003). The current understanding of race, therefore, is not based on biology but on ideology that hides a relationship of power and domination. It is in this sense that race is understood here: a socially constructed category, a tool for dominating and excluding, a sociopolitical marker of inequality.

The twentieth century witnessed an effort to address the history of racial injustice and oppression in various areas of knowledge (Carter, 2007). One of the areas that most recently considered race relations was psychology and, even later, clinical psychology. Outside Brazil, the race/ethnicity factor and its influence on the process of psychotherapy became subject of study since the 1970s and received increasing attention from 1980 on (Parham, 2002). It is remarkable the rich research production on the subject in several countries since then, especially those which have in place an immigration system. In short, countries whose population is diverse and not just white.

According to Carter (2007), a 2001 US government report, found that non-white populations in the United States have less access to mental health services, are less likely to receive the necessary care and, when they do, it has lower quality than the host population. Minorities, in their historical and current struggle against racism and discrimination, have their mental health affected. Much has been studied about the social, economic and political effects of racism, but less is understood about the aspects linked to psychological effects on the target populations and the psychological reactions they develop (Carter, 2007).

Williams & Priest (2015, p. 127) point out that in the UK, even where the most complete health data for blacks and other immigrants are found, ethnic-racial health disparities are evident and include “[...] less life satisfaction and less subjective well-being, as well as higher rates of life-long morbidity and mortality, with such disparities present in all social strata”. In low-income countries, the topic of ethnic-racial health disparities has been much less considered in the empirical literature than in high-income countries. When there is any data, the disparity remains, for example, in South Africa, India and Brazil, where indigenous people, black people and mixed races present several very low health indicators (Williams & Priest, 2015).

The lack of data, a consequence of racism in Brazil, begins with the capture of the question on race in the censuses and extends to completing registration forms in general. From birth to death, racial identity is attributed by agencies’ professionals, according to the categories: white, brown, black, indigenous and yellow, practiced by IBGE. Despite the improved quality in filling out these forms, many racial identities are ignored. Also, the resistance of professionals to record racial self-declarations generates inaccuracies; in addition to the fluidity of boundaries between the groups, classification still depends greatly on the eye of the beholder (Schwartzman, 1999). This lack of data initiates the formalization of invisibility.

In Brazil, being racism structural and structuring, it has ingrained in every tissue of society, from the individual to the epistemological. Data are ignored from demographics, which avoids confronting concrete reality, to academic production of black intellectuals, also with the aim of avoiding the discussion of that reality. On the one hand, black knowledge is concealed, based on the argument of black production is unscientific, as if it did not even exist; on the other hand, the access to white knowledge is promoted, protected by a biased filter considered universally applicable.

Gouveia and Zanello (2018) verified the low indexed Brazilian scientific production regarding mental health and racism in the period of 15 years, from 1999 to 2014. Most of the production is from social psychology, being the production in the clinical area next to zero, and the exchange between the two areas equals zero. The theme is invisible within the *psi* sciences in general. Almost half of the 19 studied articles adopted the historical approach regarding either the incorporation of racism in psychological/psychiatric theories or the affirmation of psychiatry as science in Brazil by means of eugenics and scientific racism. Twelve articles have psychology professionals as first authors and only one of them reported the experience of racially contextualized clinical intervention (Gouveia & Zanello, 2018).

These insignificant numbers appear within the narrow criteria of indexing to a database. Black production in the 2000s is not negligible compared to the whole previous history. Excluded from the survey were the production of dissertations, doctoral theses, books, the production within social movements that have particular means of disseminating their production, and certainly much more. Indexing becomes then another method of

silencing, suppressing the dissemination of knowledge about the black by the black. It makes invisible what Oliveira and Nascimento (2017, p. 230) called “[...] analyses that inaugurated the formal debate of psychology from a new look that emerged from the 2000s [...]” across the country.

In this ‘lurking hole’ of knowledge persists, however, a plethora of scholars of race relations in psychology, not identified in the indexed literature of the country. Still in the twentieth century, three black women, psychoanalysts, were pioneer in addressing race relations in psychology and psychoanalysis in Brazil. Virginia Leone Bicudo, defended in 1945, a pioneering master’s thesis on racism in Brazil and, in 1955, developed in São Paulo, within the scope of UNESCO’s anti-racist agenda, a study of attitudes in primary school students related to the color of their peers (Maio, 2010). Neusa Santos Souza, inaugurated, in 1982, the research on the emotional life of blacks and, with Fanonian inspiration, exposes the omission of the psychoanalytic theory about it. She dissected the emotional cost of subjection, the negation of one’s own culture and one’s own body; the discarding of one’s own identity - concrete and symbolic - would be the price paid by the black for their social rise. In 1998, Isildinha Batista Nogueira hypothesized the black person’s development of a characteristic psychic configuration as a result of the historical-social reality of racism and drew attention to the fundamental role of the elaboration of the meanings of racism in modifying the black condition.

The space in this paper is limited to mention the achievements of other researchers, but it is valid, however, to cite their names as Brazilian authors who inaugurated the discussion of race relations in clinical psychology, already in the XXI century: José Tiago Reis Filho (2000), Regina Marques de Souza (2003), Maria Aparecida Miranda (2004), Maria Conceição Nascimento (2005), Maria Lucia Silva (2005), to name a few.

Two important studies investigate the path of race relations in psychology. Schucman and Martins (2017), in drawing the constitution of the thought, history and positioning of Brazilian psychology regarding race relations, mention psychologists, black women, such as Neusa Santos Souza, Edna Roland, Edna Muniz, Maria Jesus Moura, Maria Aparecida Silva Bento, Isildinha Baptista Nogueira, among others, as responsible for the insertion of the theme of race relations and racism, since 1980, both in the production of psychological knowledge, as in the debates with the category, as well as in the work of psychologists. Another important study is the analysis by Oliveira and Nascimento (2017, p. 239), about the omission of psychology concerning race relations, the uncritical attitude of clinical psychologists regarding both their practice and the subjectivity of black and indigenous populations. The authors investigated race relations in psychology and concluded that “[...] the psychologists who study the Brazilian society in its psychological manifestations within race relations are provided with a small but strong family of ancestors”. The current boom in scientific production in the area, which began in the 2000s, is promising, and seems to point to a decentralization with the probable development of geographic research axes, namely, the Southeast and Northeast regions.

The Brazilian black population represents 54% of the total population (Instituto Brasileiro de Geografia e Estatística [IBGE], 2015). Its history is marked by a long period of criminal slavery and by an abolition that benefited the whites and the whiteness. Brazil has 519 years of history, 388(3/4 or 75%) of which were under black enslavement, supported by society, politics and religion. The 1888 abolitionist law did not provide for land distribution, education or any other form of compensation or promotion of citizenship, which is reflected in the poor access of the black population to education, the labor market, health, housing, urban infrastructure and to material goods in the country. The astonishing disparities

between the two groups in Brazil persist; inequalities remain according to a bipolar (Heringer, 2002; Schucman, 2010, 2012), racialized and racist logic.

Racism remained on other grounds: if before, i.e. during enslavement, it was overt, later it became insidious and pervasive, much stronger and much harder to grasp. However, not being seen and/or named does not make racism less effective, less harmful, less sickening. Carter (2007), for example, associates the experience of racism with Post Traumatic Stress Disorder (PTSD). However, he does not use the nomenclature 'disorder', which would indicate something originating in the own person; instead it names the state as "[...] race-based traumatic stress injury" (Carter, 2007, p. 25) to indicate a condition due to environmental causes. Another example is the literature on cultural psychiatry (Ngui, Khasakhala, Ndeti, & Weiss, 2010), which associates the position of disempowerment, particularly of marginalized, stigmatized and discriminated people - as is the case with the black population - with common mental disorders.

Affected by psychiatry or not, the fact is that psychology was and remains absent from the scene when it comes to race relations. As early as 1962, Wrenn had introduced the concept of the psychotherapist who is 'culturally encapsulated' into his monocultural worldview, to speak of universal applications of psychotherapeutic concepts and goals to the detriment of culturally specific views (Sue, 1981). Psychology is criticized for reproducing the power relations of colonialism, using hegemonic theories, based on the culture and functioning of the white population, for the white person, but as if they were theories of universal application (Sue & Sue, 2003).

Brazilian racism has a *sui generis* way in its development and functioning: the myth of racial democracy has delayed the national debate on racism and public policies to combat it. With the unmasking of the Brazilian racial paradise, the questioning of the existence of a racial democracy, came the affirmation of a persistent and prevalent racism in the country. One specificity of this racism is that among Brazilians one admits the existence of racism in the country, but without acknowledging their own role in it, a racism whose range of penetration is immeasurable.

The relevance of racism and its impact on the mental health of the black population is undeniable. It is necessary to think about this impact and how this population has been assisted by health services provided not only by the State, but also privately, as is the case of most part of clinical psychology care in Brazil. Taking this into consideration, this study aimed to listen to black people who underwent psychotherapeutic treatment with white psychotherapists. It was intended to collect narratives about their experiences of racism in daily life and about how listening in therapy occurred when the professional had a racial belonging different from the client.

Methodology

This research followed the norms and principles established by National Health Council Resolution nº 466, of 12/12/2012 and was approved by the Ethics and Research Committee of the Institute of Human Sciences of the University of Brasilia (CAAE: 68033617.8.0000.5540), under opinion number 2.094.292.

This was a qualitative research with mixed interviews (free and semi-structured). The participants' recruitment was done through advertising on social networks for black collectives on the campus of a Brazilian public university, as well as the help of colleagues who also announced the research to their friends. The interviews were held in private places, chosen by the participants, so as not to incur travel expenses and to preserve confidentiality.

The inclusion criteria used were (1) self-declaration as a black person and (2) having gone through or being in psychotherapeutic treatment with a white professional.

Seven women self-identified as black were selected and interviewed. Although not an exclusion criterion, no males expressed interest during the call for participation in the research. Racial parity was a resource utilized for the interviews: black woman interviewer interviewed the participants (all black women) in order to avoid introducing disturbing elements (gender and race of the interviewer) in the interview situation and to avoid potential resistance, common in dyads of diverserace/ethnicity. Racial parity is also justified because we are a racialized country, where not always explicit tensions between whites and blacks are present; it contributes as well as “[...] to facilitate free speech” (Carone, 2003, p. 21). The average duration of the interviews was 01 hour. To keep their identities confidential, we took care to replace their real names with names of gems they have chosen (Ametista, Esmeralda, Pérola, Turmalina, Quartzo Rosa, Diamante and Serpentina).

The age of the interviewees ranged from 22 to 30 years (average 25 years); four self-declared as brown and three as black; three as heterosexual and four as bisexual. Four women are from the Federal District, one from Goiás and two from Minas Gerais. The education level was between undergraduate (5) and master (2); the marital status of four women is single, one is married and two live in stable union. Four women are students, one is a civil servant, one is self-employed, and one is a professor, and their incomes range from R\$ 1,500 to R\$ 15,000, with an average of around R\$ 5,000; four women earn from one to five minimum wages. As for mental health, two of them have been diagnosed with depression and have been medicated; the duration of psychotherapies ranged from one to ten years. All reported having a support network, and five of them reported having this resource in religion. Only three women had or have black psychotherapists.

Participants were invited to freely tell their story: (1) Tell me a little about yourself, your life, your personal experience, your experience with psychotherapy, from when you started it to today. During the narrative, resources (such as paraphrase, affirmations, and other stimuli) were used to direct speech content around psychotherapy experiences with white professionals. The semi-structured interview was guided by the following questions: (1) In your opinion, how should be the contact between client and psychotherapist in an interracial psychotherapy, for this to be the most successful possible? (2) Do you think the psychotherapist's and client's skin color have any impact on the therapeutic process? Could you describe your experience in this regard? (3) Do you recall experiencing any uncomfortable situation in psychotherapy, the origin of which you imagined or imagine was your race, ethnicity, or skin color? Please describe your thoughts, feelings, and actions in that situation. (4) Do you address ethnic-racial issues in therapy? (5) Have any psychotherapists addressed ethnic-racial issues in therapy? What posture did she/he demonstrate? What is/was your reaction/posture? (6) Do you think there may be psychotherapy for minorities?

All interviews were recorded and transcribed, and from these texts content analysis was performed. Two researchers separately read the interviews in full, and after analyzing and gathering the themes, they met to decide on the categories constructed, which will be described below.

Results and discussion

By means of the content analysis four categories were listed, namely: (1) reason to seek psychotherapy; (2) psychotherapeutic process; (3) associated therapeutic factors, and

(4) psychotherapist's training to serve black people. Each category was composed of themes, which will be presented below.

In the first category 'Reason to seek psychotherapy', we grouped the various reasons given for seeking psychotherapy or the trigger that caused the action of seeking help from a psychotherapist. These included themes such as suffering for love, loss of loved ones, and life passages, which could be entering a new environment, as a change of school, or entry into university or work world. Some participants presented more than one theme in their motives for seeking psychotherapy.

The reason related to loving suffering was found in five women and can be illustrated by Pérola's statement: "[...] I searched for it because I was trying to end a relationship [...] very abusive. A lot of psychological violence that I didn't know how to get out of [...]". Quartzo Rosa also declared this trigger. Although in denial as to why she sought therapy, Serpentina mentioned the breakup of a love relationship. Suffering for love also appeared because they were related to men who, despite their involvement, did not accept them for a stable and committed affective relationships, as was the case with Diamante. Also Ametista brought an undefined relationship with a white man: "I had an undefined boyfriend, [...], upper middle class white man, psychology student [...] I said boyfriend, something like undefined relationship, because it was always in anon-place; it wasn't a dating, but it was; but he was with me, but he wasn't, he never took me on".

The loving suffering in black women is mediated by the cultural construction of affective refusal of men (white and black) towards these women. Not surprisingly, there has been a growing debate around the issue of black women's 'loneliness' - understood as a result of the affective rejection in their relationships - and its impacts on their mental health (Pacheco, 2013; Zanello, 2018). This ultimately creates a greater identity vulnerability among them: if there is affective refusal, when they are 'chosen', many end up accepting and enduring greater and/or more situations of abuse, violence and neglect.

The loss of loved ones also turned out to be the theme for Diamante in the category, "[...] my cousin passed away [died murdered], [...] was the cousin everyone thought that I was going to marry him [...]", as well as in Esmeralda, who accumulated with the loss of a close person elements of another order(s), which disoriented her: "[...] I felt as if life was running over me, you know, as if things were happening far beyond my ability to understand them [...]".

The third theme in the reasons for seeking psychotherapy, namely life passages, was shown in the speeches of two women. When Esmeralda first sought therapy, she was motivated both by the loss of a close family member and by the stress with the undergraduate completion added to other academic commitments. Turmalina also experienced adaptation to a new environment when she was transferred from school at the age of 13. Note that 'passage' experiences can be threatening situations in general for anyone. However, they can become even more challenging for black people, due to the racism experienced cumulatively in various environments, such as schools, universities and the labor market.

In the 'Therapeutic process', two themes were identified: (a) glass wall and (b) inter/intra-racial transference and/or therapeutic relationship. 'glass wall'³ refers to the

³ The term 'glass wall' correlates with the concept of 'glass ceiling' that emerged in the 1980s to designate the point from which women could not progress to higher hierarchical positions, or leadership positions, in the organizational world, due to sexism. The concept has evolved to describe this illegal barrier to the progress of qualified and deserving employees, which is due to prejudice: age, ethnicity, political or religious affiliation, and/or gender. The term 'glass wall' as elaborated herein applies to the invisible but real barrier through which the next step or level of advancement in the psychotherapeutic process can be seen, desired, expected but not achieved.

process of stagnation of psychotherapy, presented by the seven interviewees, and which develops in different ways. Stagnation can take place because: (a) the professional is oblivious to racial issues, reason for not addressing them in psychotherapy, or because (b) the professional ignores, minimizes or universalizes when the interviewee brings up the subject, or because (c) the interviewee did not raise the issue for fear that the professional would not be able to 'handle it'. Thus, first the patient's frustrated expectations - who cannot get what she is trying to or is not even trying because she does not believe in the professional's ability - as well as, second, the psychotherapist's inability both factors participate in the constitution of the 'glass wall' for these women. This experience appears to be independent of the psychotherapist's race/color.

The glass wall presented in many forms. Ametista, who wanted to deepen her experience of the difference in the psychotherapeutic process, reported experiencing the sensation of limit when she realized that her universe confronted the psychotherapist's universalism. Diamante needed some time to decide on the termination of psychotherapy, and even requested other functions (coaching) to the professional. But she knew that they would no longer continue and found herself pointing out to the professional "[...] all I tell you is because I'm black". Serpentina also experienced the sensation of limit. Esmeralda experienced the psychotherapist's unfamiliarity and disorientation in the face of her life issues. Pérola gave up the process already at the intake session, when she clearly realized from the professional's behavior, that she would have nothing to offer. Quartzo Rosa, in her experience with the white psychotherapist, found a compromise solution to the professional limitation, avoiding the unpleasant, and preferring, as she stated, to use her psychotherapy time with subjects that could flow. Quartzo Rosa pointed out limits regarding the black psychotherapist as well; according to her assessment the black professional was devoid of the knowledge on her own history and subjectivity. Turmalina also chose not to speak of racial issues when faced with the insurmountable barrier, for fear of losing the motivation and abandoning psychotherapy, which partially met her needs.

Following are some phrases from the lines of these women, which show the feeling of stagnation of the psychotherapeutic process: (a) "[...] I got a feeling that I had reached the limit [...]"; (b) "[...] we had the professional-client connection. But there came a time when there was a limit [...] so it didn't progress anymore"; (c) "[...] I reached a limit with her [the psychotherapist] [...] I saw a wall, you know? [...] It won't flow here with her more [...]"; (d) "[...] I don't know if [the psychotherapist] can't or doesn't care; it's like talking about it with her would be something she can't grasp, can't help me, can't guide me [...]"; (e) "[...] coming to the office and talking about an experience of fucking violence like that, which is obviously racial, and the person just delegitimizes and, I don't know, says that you are exaggerating, that you are crazy, that it is in your head, or it is some kind of persecution complex [...]"; (f) "[...] a racially trained person who can handle some things that I take there [...] I would very much like the feeling of not having to be explaining, because I think that professional training is up to the professional, not the client [...]".

Inter/intra-racial transference, a sub-theme of the 'Psychotherapeutic process', would already exist unconsciously when the interviewee sought help. With a white psychotherapist it is already assumed that she 'will not deal with it'; when the psychotherapist is black there is a hope of empathy, which would come from shared racial experience, but this empathy has not always been confirmed. In fact, psychologists may have had experiences that made them aware of racial issues. However, the training is lacking. Thus, at least at first, it seems to make a difference to have a white or black psychotherapist, but that does not seem to be a determinant of therapeutic efficacy. It is also necessary for the psychotherapists to

abandon their obliviousness, their alienation from racial issues, which begins, according to Helms (1990), by becoming aware of themselves as a racial being, and having as well the proper training that considers specificities.

All interviewees manifested one type of transference or both: fantasy of a racial partnership with the black psychotherapist and fear of being misunderstood by the white psychotherapist. Esmeralda, for example, restrained herself from bringing her experiences of racism to psychotherapy: “[...] I will not even discuss this with her because she [white therapist] will not understand me”. Quartzo Rosa also stressed her care in raising the issue with the white psychotherapist for fear of being misunderstood.

It was also pointed out the fear of not seeing their experiences and perceptions legitimized. This fear even arose with the black psychotherapist: “I have noticed several times during therapy with both [therapists, one white and one black] that I will avoid saying certain things that I just don’t think they will understand” (Quartzo-Rosa). Turmalina presented idealization of the black psychotherapist in her second experience, even if in the first, at age 13, her psychotherapist was black and the ‘bigger’ work, according to her report, was with her self-esteem and control of negative thoughts, with no racial perspective: “[...] I think if she were a black woman, maybe I would be able to approach [race issues] by the sense of experience, shared experience”.

Besides the inter/intra-racial transference experiences, the interviewees brought details of the therapeutic relationship set with their psychotherapists (white and/or black), regarding the management of racial experiences. Ametista, for example, very critical of psychology in general, stated: “But all the experiences [with psychotherapists] I have ever had have confirmed the criticism [that psychology could not deal with the specifics of racial experiences]”. When she brought situations of suffering racism to therapy, her white therapist tried to convince her that “[...] we are all one, that we are all the same [...] it seems that people did not hear what I was talking about and affirmed a universality of experience”. Diamante, in turn, assessed that the unfamiliarity with black experiences, perpetuated by training, precludes any comprehension efforts by white professionals. Pérola, regarding her first experience with psychotherapy, prior to her racial awareness, assessed the failure to address racial issues as incompetence: “[...] today I think it was terrible”. From her second experience she also presented some idealization of the black professional’s ability based on her supposed racial experiences.

Facing the almost nonexistence of an approach to racial issues in psychotherapeutic care, there were ‘Associated therapeutic factors’, i.e. auxiliary treatment factors located outside the office. These are Afro religion and support groups such as family and black friends, as well as family or self-activism, circles in which racial experiences can be and actually are discussed. Such support networks point out that these women are not in ‘solitude’ as such; the potentiality of group belonging, of the relations of black groups, remains unaffected by the loving disregard they experience.

In the category of ‘Psychotherapist training to serve black people’, two themes emerged: academic instruction and empathy, which is also a skill that can be acquired and trained. Six women addressed issues related to academic instruction, sometimes simultaneously with empathy.

One of the aspects highlighted was the violence caused by the universalization of Euro-American theories adopted by psychotherapists, who take white as the universal human model. The speech of Ametista exemplifies this suffering: “[...] I could not narrate myself from the perspective of the difference, ‘ah, but this is human’[...] it did hurt me so much; every time I heard that, I wanted to die. The ‘human being’ [...] There is no ‘human

being', there are groups and groups and diverse groups; it does not include me, it is my corporeality, it is my affective experience, it is my territorial experience, it is all different".

In this sense, the lack of specific training in racial issues was highlighted as a limiting factor for the effectiveness of psychotherapy, "[...] many times we get there, and the therapist does not have this training" (Quartzo-Rosa). As Diamante clearly pointed out, there are people who struggle and can become ready on racial issues, but training is lacking, as in the case of her psychotherapist: "She is the kind of person who tries to make an effort but has no training [...]". About the role of the white psychotherapists, Pérola emphasized the possibility of sensitization on racial themes in their training, so that the client does not need to explain where racism is in the reported experience.

But it seems that this lack of training occurs with both white and black psychotherapists. In the case of the latter, the similarity of certain experiences does not necessarily guarantee the quality of care and understanding of them. Serpentina, in her discovery process as a black woman, said of her black psychotherapist: "She is a black psychologist, but she doesn't point out racial issues from what I bring to her [...]". The same professional uses another possible involved aspect, which facilitates her to avoid addressing racial issues: "I am not in crisis because I am graduating, I am in crisis because I am discovering myself again [as black woman]". Also, Quartzo-Rosa points out the difficulty of her black therapist: "[...] she knows she's black, but she doesn't have a background in psychology that involves race as a fundamental issue in people's mental health, got it?". Diamante also stressed the need for the black psychotherapists to come to terms with their racial issues to lessen the risks of damaging the process and stressed that the black professionals can relive their own racial experiences in session with their client and that they (the experiences) need to be elaborated. Therefore, it seems that black professionals have not only failed to contact their historical condition at first, but consequently lack the elaboration of the meanings of racism (Nogueira, 1998) and their respective resignification.

Finally, on the theme of training, the possibility of an Afro-centered approach in psychology was pointed out: "[...] would be psychology with a reading of African spirituality: what is the mind, what is the conscious within African spirituality, [...] to see how to approach the black body and its black spirituality within therapy, within psychology [...]" (Pérola). African spirituality means the belief and practice of Brazilian religions of African origin. However, there are in Brazil, within the black community, multiple religious beliefs, belonging and practices; the population does not share the same exact creed. An Afro-centered approach as suggested by the interviewee would not apply *ipsis literis* in Brazil⁴. An Afro-centered clinical psychologist would be able to perceive needs and religiosities individually, without repeating the violence of imposing a single belief on all people in their diversity.

These themes have long deserved debate within the training of clinical psychologists in our country. Fanon (2008) indicated the limitations of existing (European) theories for understanding the impacts of racism on mental health. He was a fearless critic of psychoanalytic theory and had as unacceptable the claim that neurosis would apply to all cultures and would therefore be inherent to the human condition. For him, neuroses and all psychopathologies are expressions of a given culture. The problem of subjugated peoples is not exactly their psychopathology, not just their instinctive or subjective conflicts, but rather a problem of oppression and real conflicts between oppressors and oppressed. Nonetheless, both Fanon and Virginia Bicudo and Neusa Santos Souza, herself a drinker of the Fanonian fountain, are known in other fields (Oliveira & Nascimento, 2017), except,

⁴ According to the Brazilian Institute of Geography and Statistics (IBGE, 2010), 49.8% of people declared Catholic in the 2010 census also declare themselves black or brown.

or only minimally, in psychology. This is part of the pact of silence to quiet what is produced by blacks regarding blacks. Well, these are the genuine sources within psychology's reach, which will bring it a new, non-colonized look at the black psyche.

Also, outside Brazil, Fanon's thinking was expanded by multicultural psychologists, such as the brothers Sue, Arredondo, Charles Ridley, Ponterotto, Pedersen, Helms, Carter, etc. In the 1980s, the interest of psychology for the Afro-centered paradigm began to emerge, to challenge the Eurocentrism of psychology and its claims to universality, as Naidoo (1996) points out. Since that decade, there has been a significant increase in the number of books, articles, chapters, and instructional media resources that address the role of race in psychological theory, research, and practice (Thompson & Carter, 2012). This advance does not seem to have impacted the training curricula of clinical psychology professionals in Brazil, which are still the subject of debates of those who wish this change.

Empathy was mentioned by three interviewees as a key aspect. Ametista experienced empathy, even though her therapist was white. Diamante, in the idealization of the black psychotherapist, said: "I think if she were black, she would have been empathetic". Esmeralda expects the empathic ability from white and black professionals, believing that the latter supposedly would have greater empathic ability.

The term 'empathy' has been vulgarized, romanticized as a gift and lost its true meaning. Empathy is an attainable and trainable skill that is not just about saying 'I understand you' or 'uhum/aham' or agreeing with what has been said. Falcone (1999) defines it as a communication skill that would include three aspects:

- (1) a cognitive component, characterized by the ability to accurately understand another person's feelings and perspectives;
- (2) an affective component, identified by feelings of compassion and sympathy for the other person, and concern for his/her well-being;
- (3) a behavioral component, which consists of conveying an explicit understanding of the other person's sentiment and perspective in such a way that one feels deeply understood (Falcone, 1999, par. 4).

Although not sufficient, it is a necessary attribute, not only for psychotherapists, but for any healthcare professional. Falcone (1999) proposed an empathy training program (PTE) developed with college students in a context of interaction, during 11 meetings of 2 hours each, in which both the verbal and nonverbal contents of empathic behavior were evaluated before and after training. The results indicated that the PTE was effective for the development of empathic behavior in students and for the transfer of the learning to the relational context. Other authors have reported similar results (Kestenberg, 2010; Rodrigues, Peron, Cornélio, & Franco, 2014), either in development or in the improvement of empathic skills.

Final considerations

This study analyzed the perception of black women in their experiences of psychotherapeutic care by white professionals. From their narratives it was possible to identify four thematic categories: (1) reason to seek psychotherapy; (2) psychotherapeutic process; (3) associated therapeutic factors, and, (4) psychotherapist training to serve black people. Women were discontent with the psychotherapeutic services, because racial issues and their experiences of racism as a source of mental distress, when and if reported in session, were generally not well received, considered or explored by the professional.

It was evident that, regardless of the psychotherapist's skin color, none of the professionals started the subject of race relations or used situations to start the subject: the approach was always made by the client. The continuity of the subject was not facilitated, being ignored, minimized, universalized, i.e., somehow discarded by both black and white professionals. Within the psychotherapeutic process itself, a 'glass wall' was established, the invisible obstacle to the progress of psychotherapy.

Perhaps the black psychotherapist cannot deal with it because of issues different from the white psychotherapist: the white because she cannot see or perceive due to her alienation regarding the black world and her own whiteness; the black professional, because the subject may address racial issues that touch her and that she may not have had the opportunity to access, name or elaborate for herself. The required training should therefore reach different failing areas: for the white psychotherapist to make race-based suffering visible, as well as to bring awareness of one's own racial identity; for the black psychotherapist to motivate her and lead her to work on her own racial questions.

Black women have a level of exposure to risk factors for mental health higher than white women or black men, due to the overlap of multiple stressors. These stressors synergize, which is inherent in the intersectionality of race and gender. Therefore, it is necessary to include race and gender bias into knowledge, studies and research.

The disguise that covers Euro-American, hegemonic, and universalizing psychological theories is another problem: it seems harmless and humanitarian, but in fact it does not provide specifics of knowing to support the clinical psychologist in listening to groups other than the white population. The expression 'this is human' ignores the violence that is the essence of racism; it is as if suffering had no race, gender, and social class. When we treat the different as equal, we incur a type of violence that is characterized, in this case, as institutional. The lack of approach to racial issues was felt by women as a limitation of the psychotherapist. Racial issues for these women are mostly dealt with in family and black friends with whom they have racial identity, groups that appear in an associated therapeutic role in coping with racially based stress.

In addition to the nonexistent and necessary racial theoretical contribution in undergraduate psychology courses in Brazil, it is important to require that trainees do their personal analysis/psychotherapy, which also does not seem to occur. In addition, we have generally seen that there is a demand for better training of helping skills, such as empathy. However, even if necessary, it alone is insufficient.

Another important aspect to be considered in the technical training of the psychologist is the therapeutic relationship, seen as a factor of effectiveness, involving both transference phenomena and the therapeutic alliance, which is the actual link between patient and therapist (Cordioli & Grevet, 2019). But if there is no adequate response or reaction from the psychotherapist to an affliction that specifically affect us, how can we develop such a bond? The therapeutic relationship is also treated as universal, not as specific, as an encounter between two 'human' beings. It was possible to verify here, both in the search and in the establishment of the therapeutic relationship, the presence of pre-existing transference that are racialized and that have important consequences in the psychotherapeutic process.

Despite the nonexistence of racial bias in the psychotherapies reported by the interviewed black women, there are two observations: (a) none of the women noticed racism in the therapeutic situation and (b) all reported some benefit, even minimal. On the other hand, it was also unanimous that there would be much more benefit if there was adequate training that considered racial relations. Here it should be emphasized that there is the action of racism in its insidious form: by not making visible issues that are fundamental to

understand our culture and the subjectivation of Brazilian people, clinical psychology ends up endorsing racism.

In short, the training of the psychologist in Brazil does not seem to include the necessary elements for the understanding and care of the specific population of the country. We are doing a colonized psychology: we treat the universal, we use the 'human suffering' argument, but not the human constituted here –mixed race, black, indigenous - and we do not treat the injuries caused by social diseases like racism. In psychology, one practices racism by omission, characteristic found in all reports of this research. It is urgent that "[...] psychological science recognizes and dedicates itself to the demands of the psychological suffering of the black population" (Oliveira & Lima, 2017, p. 145). We need to materialize the pain: it has sex, skin color, social class, age, etc. Hence, we must 'deuniversalize' clinical psychology in order to stop the one-size-fits-all approaches.

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