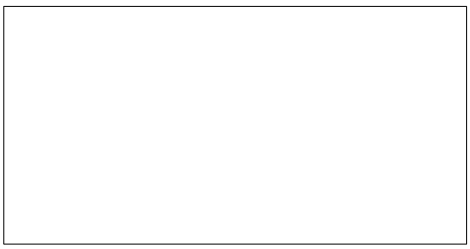

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Corresponding Author: Nicholas P. Sarantakis, Doctorate
York Saint John University
York, North Yorkshire, UNITED KINGDOM

Corresponding Author's Institution: York Saint John University

Abstract

Challenges and opportunities for psychologists and psychotherapists in respect to explicit and implicit discrimination issues in therapy are explored, both from the side of the therapist and the client. Furthermore, personal reflections on such issues are discussed drawing on examples of indirect discrimination on the basis of race and sexual orientation. It is suggested that a combination of professional anti-discriminatory guidelines, a willingness to understand deeply the client's frame of reference and self-reflection can guard against such phenomena that can harm ethical and constructive psychotherapy.

Introduction: Cognitive vs. social/interpesonal discrimination

It is generally accepted that social discrimination is the unequal and unfair treatment of people that belong to a certain minority group, based on a prejudice against this group, or the unfair treatment of individuals, who are just different in some way from the 'discriminator'.

However, discrimination is also a fundamental cognitive function associated with categorisation (essential for our survival and adaptation to a complex environment) which, as many other cognitive functions, processes information both at a conscious and at an unconscious level (Kaye, 2010). Cognitive discrimination serves important psychological and pragmatic needs of people and therefore it would probably be unrealistic to expect people to be totally free from any kind of cognitive discrimination and thus also from any kind of social discrimination. In fact, social psychology has investigated cognitive discrimination in the research of inter-group relations and has demonstrated the presence of biased judgments for members of the perceived as opposed group ("out-group"), a phenomenon that is typically interpreted in two different ways: either as a means for enhancing individual self-esteem (especially when the identification with the "in-group" the individual belongs to is robust), or

as a result of competition between groups for 'limited resources' that are important for their members (Tajfel, 1982). Thus, expecting from human beings to be totally devoid of any kind of cognitive, or other discrimination, would practically mean expecting from them to be deprived of their ability to choose partners and friends, define their identities by belonging to specific groups and not others (e.g. family, professional bodies, etc.) and to ultimately evade all their legitimate 'psychological defences' (Freud, 1937) serving the validation of their confidence and self-esteem.

Psychotherapists could not be the sole exception to that, however they do need to be especially sensitive to such phenomena and to be able to identify their occurrence in therapy and minimise their possible detrimental effects to the therapeutic relationship and outcome.

Challenges and tensions for Psychologists and Psychotherapists

In current psychotherapeutic practice, it is vital for mental health professionals to be competent with discriminatory issues. For example, Counselling Psychologists are explicitly expected to 'recognise social contexts and discrimination and to work always in ways that empower rather than control and also to demonstrate the high standards of anti-discriminatory practice appropriate to the pluralistic nature of society today" [British Psychological Society (BPS), 2001]. Thus, adopting an anti-discriminatory and culturally sensitive stance is a useful general guideline, however practitioners are sometimes faced with complex challenges and dilemmas that need further reflection: For example, therapists on the one had may endeavour to build a therapeutic relationship/alliance by demonstrating their unconditional positive regard for the whole experiencing of their client (Bozarth, 2013) and therefore for all their views and judgments for themselves and others. On the other hand, the therapists' 'congruent selves'(Grafanaki and McLeod, 2002) could feel discomfort with some content of their clients'narrative (which might be embedded in prejudice).

Thus, being open about this discomfort could compromise their unconditional positive regard for the client, while not being open could compromise their own congruence and eventually the quality of the therapeutic relationship. How could then a practitioner reconcile these two equally pivotal values and work productively with that tension?

Gently confronting a client that judges and discriminates against himself, given that this is implemented in an empathic and accepting manner, could have a healing power and it could also be perceived by the client as genuine care. The situation will be rather more challenging when clients judge and discriminate inappropriately against others and they do feel strongly about their beliefs. In such cases, it would probably be preferable to invite the client to explore their deeper emotional needs from which their prejudicial beliefs (or judgments for others) emanate, rather than to challenge directly their beliefs or values, as this could be perceived by clients as challenging their core identity, or even discriminating against them, because they hold such beliefs (for example, 'my therapist sees me as a racist!'). Thus, the focus of therapy would be on facilitating the client to understand better themselves, instead of judging them or demanding from them to change.

There will be occasions where clients will be dogmatic and highly defensive about their discriminatory beliefs and not willing to explore them openly. This can be a considerable barrier for the practitioner and for the therapy, since such clients' beliefs could involve issues that the therapist also feels strongly about them and thus this could prevent the latter from feeling and demonstrating a genuine unconditional positive for the client. This issue could become even more intense when the client discriminates – implicitly or explicitly – against a social minority that the therapist belongs her/himself. Therefore, being able as a therapist to 'contain' (Ogden, 2004) not only the unconscious dynamics that underpin the client's prejudice, but also their own beliefs and feelings and being able to engage in the

therapeutic relationship - despite of these - can certainly be a major challenge. Deciding (as a therapist, or as a client, or collaboratively) not to proceed with a certain therapeutic relationship (due to such difficult dynamics) could be the best option in some cases. However, should the therapist choose to work with a client where such value clashes exist, they would need a high level of self-awareness, resilience and empathy to be able to metabolise such dynamics to an eventually productive journey. Thus, before a therapist engages in the exploration of the clients' discriminations and prejudice, they need to become more aware of their own, of the impact that others' discriminations have upon them and find effective ways to manage them.

Despite the prominent nowadays discourse of 'evidence-based practice', the value of the 'therapist's use of self' (and therapist's personal experiencing) is increasingly acknowledged for any therapeutic relationship (Rowan and Jacobs, 2002) and moreover their ability for critical reflection on this aspect of the therapeutic process is now recognised as a pivotal competence (e.g. HCPC, 2012). In other words, what matters for the practitioner as a person, matters for them as a therapist as well and thus self-awareness on such issues can indeed facilitate and enrich their ability to connect with clients, both with these ones suffering discrimination and oppression and these one expressing discriminatory views. Furthermore, if there is substantial truth in the classic dictum that 'it is [the therapist's] own hurt that gives the measure of his/her power to heal' (Jung, 1951, p. 116), then it is also the therapist's own reflective experiencing of discrimination and oppression that helps them to be empathically attuned and explorative with their clients' relevant experiences.

Example no 1: The silence of 'race talk' and different cultural contexts

Next I shall draw on two more specific aspects of discrimination and oppression that are relevant to therapeutic practice and which are based on actual past experiences of myself. The first one draws on the aspect of cultural context and the second one on my experience of being a member/client in group therapy. The importance of both these aspects are highlighted in the relevant literature, as on the one hand Thompson's *Personal-Cultural-Structural model* (Thompson, 2012) emphasises the importance of cultural context and on the other hand there seems to be a shortage of client reports on such phenomena in therapy (Worthington, Soth-McNett, & Moreno, 2007). The two examples are offered here only as anecdotal exploratory points.

The first example is one that emanates from the comparison of my relational status with the black community at two different cultural contexts: Within the first one (Boston, U.S.A.) I observed that close social interaction between white Europeans (such as myself) and the black Americans was quite rare. Within the second context (Glasgow, U.K.), I observed that interactions between white Europeans and the black community (British or of other ethnic origin) were quite common and not much qualitatively different than any other cross-cultural interaction. The above example could be viewed as highlighting that discrimination is not only an interpersonal matter, but it is also critically influenced by the – more or less implicit – concurrent political, ideological and cultural milieu within such cross-cultural interactions take place. That means that racial attitudes are often not 'black or white', namely that the cultural context may trigger the 'discriminatory' or 'anti-discriminatory' self of the individual. Therefore, individuals probably possess contradictory 'configurations of themselves' (Mearns, Thorne, & McLeod, 2013) and their context may facilitate one or the other to be expressed at a behavioural and social level.

Another observation that strikes me is the fact that in Boston racial differences were almost a taboo discussion topic, which was certainly not the case in Glasgow. Indeed, 'silence' can express a widespread social awkwardness for a historical - and maybe still

present – discrimination that is much 'louder' than words. In fact, Sue (2015) emphasises how such 'loud silences' are in reality rather counter-productive, despite their stated intention to eliminate discriminatory language. Thus, he promotes open 'race talk' and specific strategies that can actually help overcome such phenomena.

Arguably, his suggestions could be fruitfully applied to the 'psychotherapeutic space' as well. Such dynamics might become present in therapy when the practitioner and client may not truly accept specific aspects of each other's personality. Hence, a conscious endeavour from the therapist's part to meet and accept the 'whole person' (Mearns and Cooper, 2005) of the client (thus acknowledging both the client's aspects that are easy *and* difficult to accept, without over-emphasising the latter) may open up the potential of an authentic psychological contact, which has been diachronically proven to be vital for therapeutic change to occur (McLeod, 2013). Simultaneously, addressing openly racial or other cross-cultural issues (as Sue proposes) could also facilitate such psychological contact, as long as they are introduced sensitively by the therapist, so as they are not perceived by clients as a conditional (instead of an unconditional) positive regard.

Example no 2: Exploring sexual orientation in therapy

The second example derives from my participation in group therapy, as part of my training in psychodynamic therapy. I remember very clearly the following incident since it struck me as a daunting example of implicit oppression and patronising practice: one of the female group members shared with the group a few of her recent night dreams, where she had sexual encounters with another female. The therapist felt that he needed to reassure her that 'she is not a lesbian'. For one thing, this group member had never asked for such reassurance, but even if she had, it would have to be her own journey of 'subjective knowing' (Rogers, 1964) about her sexual orientation, according to the fundamental in current psychotherapy values of agency and non-directivity (Levitt, 2005).

It is likely that this psychoanalytic therapist/psychiatrist adopted the 'authority role' he assumed for himself and trusted his 'clinical judgment' that this client needed reassurance for her (presumed) worry about her sexuality. However, as this example shows, there can be a whole chain of assumptions by the practitioner leading to a statement that can entail an (implicit) oppressive content and most likely an adverse therapeutic outcome. At the same time, these very assumptions can dismiss from the therapeutic process areas of potentially great significance for the client. In this example, such areas could be 'how do I experience my sexuality', 'Can my sexual fantasies be accepted/contained by others as an open aspect of myself', or 'is it really important for me to explore my sexual identity, or not?' On the contrary, 'shutting down' this window of discussion actually deprived the client from possible areas for self-exploration, or even conveyed the implicit message that this aspect of her identity cannot be acceptance and therefore it has to be hidden.

Considering this and other similar examples, one might think that such – implicitly - oppressive practices are associated with the psychoanalytic theoretical origins, where the development of sexual identity was exclusively conceptualised within a patriarchal family model (Freud, 1905), which was predominant at Freud's historical time. Nonetheless, I would argue that discrimination cannot be linked to any particular modality, but rather to the therapist's possible unawareness of the ideological (and inevitably subjective) grounds of all discourses about sexuality and a 'blindness' to their own reluctance to 'enter' and understand the client's frame of reference. From that perspective, an anti-discriminatory stance is pan-theoretical and indeed Freud himself, more than a hundred years ago, certainly did not attach the stigma of illness or mental disorder to homosexuality (Freud, 1905), while more recent

developments within the psychoanalytic/psychodynamic tradition have elaborated on models of gay/lesbian affirmative psychotherapies (Hicks & Milton, 2010; Shadbolt, 2004).

A therapist must understand and embrace diversity, but does it actually matter whether the therapist's sexuality is the same as the client's? In fact, suggesting that a match of the therapist's and the client's sexuality is always preferable would presuppose that people with similar sexualities tend to be similar in most other aspects of their identity and hence more able to connect with each other, an assumption which is doubtful (Hicks and Milton, 2010). Even more, there are arguments emphasising that if a gay client is working with a heterosexual therapist, this can offer the former the chance to explore and understand better the heterosexual world (Milton, Coyle, & Legg, 2002). Shadbolt (2004) argues that empathy is more important than having the same sexual orientation with the client, although there will be some cases where this 'resonance' will be of special importance. However, in such cases, the therapeutic contract will have to address to what extent lesbian/gay therapists are willing to disclose/share personal information and how this is likely to be beneficial for the therapy.

Hence, discriminatory or oppressive practices can unfold and impact adversely on people or clients, even when they might not be meant as such, by those conveying them. Moreover, the above example show that such practices may be present even when they are expressed indirectly through the 'bracketing' of a certain aspect of human experiencing or identity. It is therefore important for therapists not only to be aware of their own ideological positions and how these affect their practice, but also to be open to exploring the effect that dominant cultural discourses may have on their clients' experiencing. From that sociological perspective, the social theorist and philosopher Michel Foucault (1979) demonstrated how gender and sexual identities can vary significantly across time and cultures and therefore they are much more socially constructed and reinforced through ideology, rather than biologically pre-defined. Therefore, psychotherapy could be the 'safe place' where clients can explore, 'construct' and own their identities, thus embracing an internal locus of evaluation and self-worth (Rogers, 2013).

Implicit or unintentional discrimination and oppression

Thompson (2012) emphatically acknowledges that discrimination can occur without the awareness or intention of the individuals conveying it and supports his argument with a broad body of relevant literature. Indeed, within the widely diffused ideology of 'political correctness' (Perry, 1992), it can be commonly observed in western societies that people either engage with an anti-discriminatory rhetoric, without actually committing against such practices, or they adopt a discourse and practice which assumes that these phenomena simply do not exist in society (thus in fact contributing to their perpetuation). Thompson (2012) clearly identifies such attitudes as dangers to a genuinely anti-discriminatory practice and stresses that such viewpoints reporting an 'exaggeration' of such issues and restricting their manifestation to the level of legislation can lead to complacency and neglect of such major matters. Among the remedies the author proposes is the relevant training of professionals that will make them more reflective practitioners and more aware of the disadvantages that certain minorities face in their everyday lives. Moreover, he advocates for an educative and convincing approach towards individuals and groups with discriminatory ideas, instead of 'bullying them' and thus reinforcing such dynamics.

Thompson suggests concrete steps that could be taken in order to minimise discriminatory phenomena, by utilising his *Personal-Cultural-Structural (PCS) Model*, which addresses the interaction between these three levels in discriminatory phenomena (Thompson, 2012). This is certainly a useful model to help practitioners identify the different levels at which discrimination and oppression may operate in society and be experienced by

clients. Thus, being aware of these different levels could critically facilitate a more holistic understanding of our clients.

While Thompson's model might seem somewhat abstract for applying it in psychological practice, Lago's and Smith's (2003) provide specific practice guidelines. These guidelines include avoiding the use of language/terms that might feel devaluing or hurtful for certain clients, not assuming that belonging to a certain minority is necessarily the 'issue' in therapy, reaffirming the clients' cultural identity and coping mechanisms, be knowledgeable about evidence that supports alternative to discriminatory or distorted views and be aware of support resources that might be available to particular minorities.

Nevertheless, Cocker and Hafford-Letchfield (2014) point out that the mere adoption of a set of standardised guidelines would not be sufficient: what is even more important is that practitioners endeavour to understand and take into account the heterogeneity and diversity of people's lives and experiences and that they do not assume that all minority groups or minority members are the same.

Beyond knowledge and practice guidelines against discrimination and oppression

Therefore, it seems that a genuine anti-discriminatory practice needs more than the knowledge of the relevant legislation (where significant advances have taken place, e.g. Equality Act 2010, Civil Partnership Act 2004, etc.) and the specific professional guidelines for understanding and containing the cultural dynamics between the client and their environment and between the client and the practitioner as well. What is further needed is possessing the competencies and the attitude that shall enable the delivery of an accepting and empowering therapeutic relationship, which has been shown to be the most critical common factor in therapy (Asay and Lambert, 1999). From that perspective, the notion of *cultural humility* suggested by Hook, Davis, Owen, Worthington and Utsey (2013) captures this attitude of not assuming (even implicitly) the superiority of one's own cultural values, which is a philosophical stance towards 'otherness' that transcends beyond the mere 'knowing' of the different cultural contexts of minorities and the acquisition of specific skills in order to work therapeutically with diverse clients.

Furthermore, the above authors have been able to demonstrate empirically that cultural humility is likely to be a more critical factor for positive therapeutic outcomes than the broad range of *cultural competencies* advocated by Sue and Sue (2003). Although Sue and Sue do stress that there is not one single therapy for all diverse clients and that some clients may need interventions beyond the conventional western psychotherapy, an attitude of broad cultural humility could help therapists acknowledge their own cultural limitations and what they can genuinely offer to diverse clients and what they cannot.

Given that, the question that rises is what kind of knowledge (if any) would facilitate such an approach of cultural humility? Thompson (2012) suggests that practitioners should be familiar with the social circumstances under which different minorities live, the diverse cultural values that communities are engaged to (and thus these values should not be judged in the light of the pre-dominant social values), the difficulties and disadvantages that minorities are faced with and so on. The author is offering examples from the social work field, taking into account the challenges introduced by the fact that social work is typically a middle-class profession.

However, such challenges could be present in the counselling room as well. For example, a middle-class therapist, grown up in a liberal family which values more the autonomy of the person than their integration into their community, may fail to empathise with the strong feelings of rejection of a client who is a single mother and comes from a cultural/religious background where this is totally unacceptable.

Ridley (1995) also argues that mere consciousness raising is not sufficient and he proposes additional guidelines, which could act as a facilitating bridge between the awareness of theoretical concepts and the interpersonal encounter with clients, which is what actually matters (as Bozarth, 1998, demonstrates). Referring to racism, Ridley (1995) suggests, among other guidelines, that therapists should attempt to explain behaviour by considering first non-racial factors, they should facilitate adaptive strategies for clients in order to function efficiently in both their race and their non-race community, encourage 'reality testing' (distinguishing real racist behaviours versus distorted perceptions), avoiding pathologising language, which reflects internalised ideologies, setting goals that are culturally relevant and implementing a proper termination, as this may trigger rejection issues for clients from minorities. Furthermore, Needham and Carr (2009) stress that the active input of clients in the 'co-production' of any intervention is also critical for a real anti-discriminatory practice.

Epilogue

While there is nowadays an increasing awareness for the need for anti-discriminatory and anti-oppressive practice in psychotherapy, practitioners are still likely to be faced with tensions and dilemmas that may not be so straightforward to resolve. Two central themes discussed here have been the occurrence of implicit (or even non intentional) discrimination and 'silent discrimination' and their implications for psychotherapy. Such tensions may unfold in various forms when the therapist aims at synthesising equally significant but competing values. For example, demonstrating unconditional positive regard while being congruent and transparent with their own anti-discriminatory values, demonstrating empathy vs. acknowledging the uniqueness of each client's felt experience, holding minority specificities together with universal human needs, or judging when the therapist's use of self shall be beneficial in therapy and when it will not. At the end of the day though, all the knowledge, professional guidelines, self-awareness and attitudes shall become meaningful, when we manage as therapists to truly meet our clients at their unique place of pain and hope.

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