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Reflections on an anti-discriminatory stance in psychotherapy

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Reflections on an anti-discriminatory stance in psychotherapy

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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.

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Anti-discriminatory practice in psychological therapy

What is discrimination and oppression?

While the content of the terms discrimination and oppression might seem obvious, I think it is worth revisiting what we actually mean by these terms. The Oxford Dictionary attributes two different, but related meanings to discrimination, the first one being "the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, or sex" and the second one being the "recognition and understanding of the difference between one thing and another" (The Oxford Dictionary, 2014). Hence, while discrimination is the unequal and unfair treatment of people that belong to a certain minority group, based on a prejudice against this group, it is also a fundamental cognitive function. In fact, it is a developmental 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 an unconscious level (Kaye, 2010). Social psychology extended this idea in the research of inter-group relations and 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).

Similarly with discrimination, oppression is defined by Oxford Dictionary as the "prolonged cruel or unjust treatment, or exercise of authority" (The Oxford Dictionary, 2014). In fact, Thompson (1998) argues that oppression is one of the basic outcomes of discrimination. However, I would argue that mere cognitive discrimination, as a process of categorising people in groups and also probably attributing certain social characteristics to them, does not lead automatically to oppression. As the Oxford definition implies, it is the prejudice that leads to an overt negative behaviour and treatment of members of minority groups that also produces oppression, in terms of human rights, resources and equal opportunities.

Challenges and tensions for Psychologists and Psychotherapists

Especially Counselling Psychologists are explicitly committed to 'recognise social contexts and discrimination and to work always in ways that empower rather than control and also demonstrate the high standards of anti-discriminatory practice appropriate to the pluralistic nature of society today" (British Psychological Society (BPS), 2001). However, Psychologists and psychotherapists in general, as well as their clients, as all humans, shall utilise cognitive discrimination and shall make some kind of judgments about others and this will probably unfold both outside and inside the counselling room. Perhaps, expecting from human beings to be totally devoid of any kind of cognitive, or other discrimination, would equal with the expectation 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 ultimately their need to utilise legitimate psychological 'defences' (Freud, 1937) to reaffirm their confidence and self-esteem.

The ethical issue rises when this discrimination is entangled with prejudice and disadvantageous treatment of others. Psychologists and humanistic therapists in general are faced with additional and complex challenges and dilemmas: while they endeavour to build a therapeutic relationship/alliance by demonstrating their unconditional positive regard for the whole experiencing of their client (Bozarth, 2013) and therefore embrace all the latter's views and judgments for themselves and others (which will inevitably be present, as discussed above), at the same time their 'congruent selves' (Grafanaki and McLeod, 2002) shall object to any prejudiced discrimination.

How could a practitioner then reconcile these two 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 congruent manner, could have a healing power and it could also be perceived by the client as genuine care.

However, the situation will be rather more challenging when clients judge and discriminate inappropriately against others and when they possibly also feel strongly about these beliefs. I believe that instead of challenging directly these beliefs, it would be preferable to invite the client to explore their internal needs to which such beliefs (judgments) respond. I mentioned above two prominent interpretations of "in-group" and "out-group biases and prejudice, but given that as humanistic psychotherapists we search for the uniqueness of each individual, the understanding of the prejudice and discrimination of a client would need to stem from a unique and collaborative case formulation. Thus, the focus would be on the self-understanding of the client, instead of judging them or demanding from them to change.

I am aware although that 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 the therapy, since such clients' beliefs could involve issues that the former also feels strongly about them and thus their unconditional positive regard for the client could be compromised. 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 her/his own beliefs and feelings and being able to engage in the therapeutic relationship - despite of these - can certainly be a major challenge. If the therapist chooses to work with such a client (making the choice of not working with a particular client can also be a legitimate option in extreme cases), this shall require a high level of self-awareness and subsequent congruence from their part. Hence, before a therapist engages in the exploration of the clients' discriminations and prejudice, they need to become aware of their own (and try to fight or control them in their practice) and of how they experience the discriminations of others in everyday life.

In the essay in hand, I shall draw on two personal examples, regarding racial discrimination and sexual orientation. In fact, despite the prominent nowadays discourse of 'evidence-based practice', the value of the therapist's use of self (and personal experiences) is increasingly acknowledged for any therapeutic relationship (Rowan and Jacobs, 2002) and moreover the latter's ability for critical reflection on this aspect of the therapeutic process is now recognised as a vital competency for Counselling Psychologists (HCPC, 2012). In other words, what matters for the therapist as a person, matters as well for them as a therapist and such self-awareness can indeed facilitate and enrich their ability to connect with clients and especially with these experiencing discrimination and oppression. As Jung succinctly put it, "it is [the therapist's] own hurt that gives the measure of his power to heal" (Jung as cited in Stevens, 2001).

A personal reflection on racial discrimination and cultural context

I chose to draw on the two specific personal experiences, not because they were the most vociferous ones, but because these very instances invited me to contemplate beyond what I think I already know.

The first example is one that emanates from the comparison of my relational status with the black community at two different periods of my life: the first one was when I was living for three years in the U.S. (Boston) and the second one is the current period of my life, where I am living in Scotland (Glasgow) for two and a half years now. During the first one, I never had a friendly or even social relationship with a black person (even though I was very sociable otherwise), while now I have at least two black friends so far. At all times, I felt quite clear about my anti-discriminatory stance towards people that differed to me in any fashion.

However, the above comparison made me think that discriminations are not only interpersonal matters, but they also reflect the - more or less implicit - concurrent ideological and cultural context. Another observation that strikes me is the fact that in Boston racial differences were almost a taboo discussion topic, which is 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.

To a more personal level, this experience made me revisit the idea that social attitudes are usually not 'black or white' and this probably also applies to my own attitudes: there is a most prominent non-racist configuration of myself, but there could also be another 'more quiet discriminating part', which is elicited under specific external circumstances. In the above example,

being a white, middle-class European going to the U.S.A. and attempting to enter the world of African-American music, (which originated from the black working class), probably had an impact on the interactive dynamics between me and members of the black community. Similar dynamics might become present in my practice and I might meet some clients at a place where it is difficult to totally accept each other in all aspects of our identities. However, an endeavour from my part to meet the 'whole person' of the client shall facilitate the mutual discovery of aspects of ourselves that we both can relate to (a holistic approach, Mearns and Cooper, 2005).

Exploring sexual orientation in therapy

My other personal experience 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 'subjective knowing' (Rogers, 1964, as cited in O'Donohue & Halsey, 1997) about her sexual orientation, according to the nowadays fundamental values of agency and non-directivity in therapy (Levitt, 2005).

Although I now consider that this therapist/psychiatrist took up the 'power role' he assumed for himself and trusted his 'clinical judgment' that his client needed reassurance about her (presumed) fear. 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. In this example, such areas could be 'how do I experience my sexuality', 'do I need to feel that my fantasies can be accepted/contained by others', or 'how important is it for me to explore my sexual identity or not'. On the contrary, 'shutting down' this window of discussion actually deprived the client from such areas of explorations, or even conveyed the implicit message that they are not acceptable.

Considering this and other similar examples, one might think that such oppressive approaches 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 argue that discrimination is not 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 is possible reluctance to view the world from the client's frame of reference. From that perspective, an anti-discriminatory stance is pan-theoretical and indeed Freud himself considered as legitimate different forms of sexuality (Freud as cited in Cohn, 1997) and he certainly did not regard homosexuality as an illness or disorder (Freud as cited in Shadbolt, 2004), while more recent developments of the psychoanalytic/psychodynamic tradition have elaborated on models of gay/lesbian affirmative psychotherapies (Hicks and Milton, 2010, Shadbolt, 2004).

Hence, 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 therapist's and client's sexuality is always preferable would presuppose that people with similar sexualities tend to be similar in most other aspects of themselves, 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 them the chance to explore and understand better the heterosexual world (Milton, Coyle and Legg, 2002). Shadbolt (2004) argues that empathy is more important than having the same sexual orientation with the client, although there will be cases where the latter will be of special importance. However, in such cases, the counselling contract will have to address how much lesbian/gay therapists are willing to disclose/share about themselves and to what extent 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, this example shows that such practices may be present even when they are expressed indirectly through the dismissal 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 can 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 than biologically pre-defined.

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 language 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-Social (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 to use language/terms that might feel devaluing or hurtful for certain clients, not assuming that belonging to a 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.

The role of knowledge and practice guidelines against discrimination and oppression

Therefore, what is needed is knowledge that expands beyond the relevant legislation (where significant advances have taken place, e.g. Equality Act 2010, Civil Partnership Act 2004, etc.) and the literature guidelines to an understanding and containment of the cultural dynamics between the client and their environment and between the client and the practitioner as well. Indeed, this latter dimension is especially vital for psychological practice, since the lack of such an understanding could impede the experiencing of an accepting and empowering therapeutic relationship, which has been shown to be the most critical factor in therapy (Asay and Lambert, 1999).

What is then the kind of knowledge that can facilitate such an approach? 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 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 I think can 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 an anti-discriminatory and anti-oppressive practice is arguably extremely vital, practitioners are likely to be faced with tensions and dilemmas on how to achieve a fair compromise between equally significant values, such as empathy vs. respect for diversity, acknowledging minority specificities vs. the universality of human needs, or how much of the

therapist's use of self shall be beneficial in therapy. At the end of the day though, all the knowledge, practice guidelines, reflection and self-awareness shall be meaningful when the practitioner really meets clients at their unique place of pain and hope.

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