

Working with Diversity in Psychotherapy and Counselling

Joanna L. Ringrose

What follows is an account exploring the popular “isms” looking at the ways in which out groups and individuals are discriminated against with an exploration of some of the less publicised prejudices. Specifically, I intend to critically evaluate literature on discrimination, bias and prejudice in respect to four broad classes 1.) race, culture, ethnicity and religiosity; 2.) sex, gender and homosexuality; 3.) class; and 4.) individual difference factors such as age, obesity, physical handicaps and so forth.

There is substantial literature pertaining to areas of diversity, the majority of which focuses on the popular “isms”, racism, sexism etc. Also, some researchers such as Goffman (1963) have endeavoured to categorise various stigmatised groups. However, in exploring the literature on diversity, I have become somewhat surprised and perturbed to discover that I have been unable to find anyone who promulgates their ideas of a particular “ism” in relation to diversity generally. Hence I have read numerous articles which focus attention upon one “ism”. My unease about this discovery stems from the realisation that researchers, in this apparent lack of understanding of the importance of looking at diversity as a whole, or in the context of a whole, may inadvertently exacerbate the very condition they are trying to ameliorate through their publicity. Surely an article which focuses upon one issue, be it homosexuality, racism, or whatever “ism” one cares to choose, in that focus, draws attention away from all other aspects of difference. For example, if there are three thousand articles written about racism and one about weight-“ism” what does that say to the people who have been prejudiced against because they are obese? (note weight-ism is not as yet an accepted word, unlike racism, sexism etc which in itself seems highly significant). Also I am left wondering which particular “ism” I am supposed to focus my attention upon if someone is from several perceived “out” groups, being say black and disabled for example. Therefore, lastly, I use “isms” in this account purely for example purposes, I sincerely don’t want my reader to go away with the assumption that I am convinced that some “isms” are more important than others, in this respect I am very dubious.

However, some researchers, for example, Crocker (1993) argue the possibility that differences which cannot be concealed from public gaze such as skin colour, physical handicaps, physical deformities, age, sex, weight, height, may be more debilitating than differences which can be concealed from others, such as homosexuality, learning difficulties and religiosity. There is an argument that the person who has an obvious difference has no choice as

regards public responses to their difference and therefore is more likely to receive prejudice or discrimination as a result. However, Crocker (1993) also notes;

“some conditions such as being physically handicapped or being from a disadvantaged racial group, elicit positive responses from many people, such as sympathy concern or the desire to be egalitarian in addition to negative responses”(p.61).

However in writing about the possible positive effects which may arise from having an obvious difference, I am ascribing to the possibility of a hierarchy and in that creating an imbalance of emphasis, whereby some differences may be argued to be more important or damaging than others. Also, I can hear the shouts from those people with “unconcealed differences” whose experiences have been more negative than positive and also the response from still further people who do not wish to attract “sympathy concern or a desire to be egalitarian” from onlookers.

When reading about cross dressing, transvestism and gender identity (Bland 1994), I drew the conclusion that this group of people had decided that, generally speaking, concealment of their gender identity from the public gaze, was preferential. I based this on the realisation that few men, who look like men dressed as women, (rather than men who can pass in terms of physical appearance as women) openly dress as women. I say generally speaking because there are and have been several television celebrities who openly dress as women (e.g. Lilly Savage). Maybe then concealing ones difference is better than non concealment?

Also, in terms of cross dressing, it seems that some men have striven for a level of acceptability through making fun of their difference. So we have the dame at the pantomime who we all howl with laughter at? The likes of Dame Edna on the television who is also hilarious? In some bazaar way I felt duped when I first read of the plight of men who feel aggrieved at people laughing at their cross dressing. Isn't this what we have always been encouraged to do? However, what effect has this had upon other cross dressers who would like to publicly express their feminine gender but don't want to be laughed at?

The exploration of literature on gender identity also brought up a whole host of other inequalities, I noted that it is acceptable for women to dress in suits and how society may label them feminist but men in skirts (kilts excepted) have a clinical condition, gender dysphoria (Bland 1994). Also, I realise that writing of difference in terms of groups, in this instance gender identity, I am encouraging the reader to assume that members in that group will be all the

same, when in reality there is diversity within all groups. Hence, there are men who feel they have been born into the wrong body and want sex realignment and those who have a satisfaction with being purely male and wish to cross dress occasionally. Also, within these two groups will be more groups based on issues unrelated to their gender, until finally we see the individual. I feel strongly that society's assumption that masculinity and femininity fall neatly into two categories is wrong. I contest that gender is relative and therefore on a continuum, where people may be more or less masculine or feminine based on a whole host of factors including genes, physiology, nurturing etc.

What this does tell me about difference issues, is that they are socially constructed. Society informs us of what is acceptable and unacceptable. Archer (1985) writes that the specific conditions which illicit negative reactions from others may change over time as knowledge, tastes and public acceptance of deviant conditions and behaviours change. Thus stigma arises not in the condition itself but in other's reactions to that condition. This is evident in terms of waist lines which have gone in and out as fashions change in different eras. Also the stigma associated with homosexuality appears to be abating as society generally is encouraged to address its prejudice against homosexuality through greater media coverage.

Crocker (1993) also adds that the level of prejudice against an individual's particular difference, is likely related to society's perception of the individual's perceived control over their stigmatised difference. Hence she argues that people who are overweight, likely suffer greater prejudice because many in society see this as the obese person's fault. Weiner Perry, & Magnusson (1988) calls such differences controllable and in the case of such stigmas the person is likely to feel and take responsibility for the negativity they receive in response and blame themselves for that response more readily than a stigma which is classed uncontrollable, for example being black.

I have deliberately focussed on differences which have been less evidenced and researched in the literature first. This is my difference and with it I have, in some domains, sacrificed an ability to formulate adequate discussion around how these minority differences have been researched to show they influence therapeutic practice. Whilst I know they will do, the research is very sparse. However, I felt that if I tried to address the imbalance that I see as regards diversity by only looking at minority differences then I am as guilty of bias as those who have focussed just upon the popular "isms". I also questioned the political correctness of writing an account on diversity and not mentioning racism but note that I didn't have this concern around not including any other "ism". Also I toyed with considerations of what "ism"

should be included where and why. With all these issues in mind, I now turn my attention to the popular “isms” and how they have the potential to influence therapy.

One of the widely publicised of the “isms” is racism. However, Dovidio, Gaertner & Bachman (2001) write;

“most acts of modern racism are of the covert type.. it is identified as a modern form of prejudice that characterises the racial attitudes of many whites who endorse egalitarian values, who regard themselves as non prejudiced, but who discriminate in subtle rationalizable ways” (p.418).

Similarly, Bobo, Kleugel and Smith (1996) write,

“people may presume they are racist free but unconscious forces are at work and may drive more of their judgements and behaviours than they consciously know or wish to know”.

In terms of therapy, here seemingly lies the biggest dilemma for therapists. If therapists are unaware of their prejudice or bias they are unlikely to respond differently. Laszloffy and Hardy (2000) argues that before a therapist can take steps against racism they first need to develop their own racial awareness and sensitivity. Racial awareness is the ability to recognise racism exists. Part of this awareness is an understanding that whites have privileges that people from minority groups do not. For example whites are more likely to be attended to in an emergency (Dovidio, Gaertner, Kawakami & Hodson, 2002) and are more likely to be recommended for a job (Bobo, Kleugel and Smith, 1996). Whereas African American or Hispanic people for example, are more likely to be adversely affected by bias in assessments (Lopez, 1989). Mexican Americans are more likely to have their emotional problems underestimated due to language interpretation difficulties (Sabin, 1975), Puerto Ricans are more likely to be labelled schizophrenic due to their religious and spiritual beliefs (Roger and Hollingshead, 1985) and even researchers exploring racial bias still use the word Hispanic which subsumes several cultures, Mexican American, Cuban, Puerto Rican and Central or South American (Lopez, 1988).

Laszloffy and Hardy (2000) also write;

“because many whites seldom interact with large numbers of people of colour, or do not have intense, intimate relationships with them, they do not learn how most people of colour see the world, or what is important to them. As a result, when interacting cross racially, most do not demonstrate racial sensitivity because they do not know how to relate in ways that are racially

meaningful, compassionate and respectful from the perspective of most people of colour” (p.37).

A further large area of research examining discrimination looks at homosexuality gender and sex. Bland (1998) writes that as soon as a baby is labelled boy or girl, behaviours will be encouraged and discouraged dependent upon that label. Thus children learn what is masculine and feminine. Boys grow up remembering when they first wore long trousers, discarded their teddy bear, didn't cry when they fell over and many other instances perceived by family and peer group as unmanly. Similarly, girls may recall when they were told they mustn't climb trees, must sit quietly, look clean, and learnt they will be good in the house and become “natural” mothers. From these societal rules (conditioning) both males and females (or should I say females and males to counter any possible subconscious patriarchal influences) may learn to suppress what doesn't fit their ascribed sex so as to conform to gender expectations. Alternatively they may react against societal rules and be labelled accordingly as effeminate or feminist for example. Do these learned responses to stereotypical norms of sex and gender roles suddenly disappear as we take on the role of therapist and what consequences might these stereotypes have in the therapy room?

There has been a substantial amount of literature looking at sex and gender issues in psychotherapy generally with inconclusive findings. For example Fuller (1963) found that clients preferred male therapists, whereas Howard, Orlinsky, & Hill (1970) found clients preferred female therapists. McKinnon (1990) postulated the idea that it was not sex but gender issues which influenced clients biases. He found that clients rated androgynous and masculine-oriented therapists significantly more favourably than they did feminine-oriented therapists. They also found that masculine men were accorded the highest ratings and feminine men the lowest. They interpreted their results as illustration of stereotypical prejudices.

What clients wish to bring into the therapy room also influences their preference for a male or female therapist. McKinnon (1990) also found that feminine therapists were preferred when discussion was of a personal nature but masculine therapists were preferred when issues related to assertiveness and academic concerns. Also both the androgynous and masculine orientations were generally rated higher than the feminine orientation. For women, he writes;

“compounding this bind is the double bind illustrated by research that on the one hand demonstrates that women are disadvantaged by their display of what might be regarded as masculine behaviours (Shaffer & Wegley, 1974)

but that on the other hand demonstrates that if they wish to move into powerful organisational positions, women need to look as masculine and as unattractive as possible (Cash & Janda, 1984). Findings that more positive qualities are attributed to attractive than moderately or unattractive stimulus persons (Moore, Graziano, & Millar, 1987) do nothing to mitigate the dilemma”.

There is also a vast amount of literature exploring the role of class in terms of psychotherapy. Proctor (2002) writes clients are more likely to be poorer than their therapists and from a working class rather than middle class background. Tidwell (1992) argues that crisis counselling is the preferred format of therapy for the underclass with an emphasis in therapy upon issues which she sees are significant, for example issues around low income, health problems and stressful life events. She argues it is the preferred format because it is inexpensive, brief and symptom oriented.

In terms of working with the elderly, Samuel (1986) states that the therapist must truly believe that growth is possible at any age. Therapists also must encourage a review of the person's life and an opportunity to expiate past offences. Regarding disability, Wilson (2003) emphasises the importance of challenging attitudes and reactions to controversial issues in therapy such as sex, death and the mystery behind altering body image, and brings to the surface the desires, hopes and frustrations of disabled people living in an environment ridden with fears and prejudices. What all this literature demonstrates however is the diversity of “isms” and the belief by many theorists that psychotherapists and counsellors should target specific issues when practising with specific client groups. How can this be possible? Can we all realistically be experts in every field?

At the time of my undergraduate degree in psychology, the buzz word was biopsychosocial. Psychologists use of this word appeared to be their way of trying to explore people in an all encompassing way. However I came to realise that like researchers use of “isms” this new word was far from encompassing and focused attention onto behaviours which neatly fit one of these categories i.e. biology, psychology or sociology. I questioned where spiritualism entered into explorations of people, or religiosity for example? I began to feel discontented with the limits placed on this new word despite its attempt to be all encompassing it wasn't and isn't. I was therefore very attracted to the idea of a psychotherapy that looked at the individual person. The Client-Centred approach doesn't have pigeon holes in which to place people in terms of either their emotional well-being or how they are in society. People are seen just as individuals with no two truly alike and all

equally valued. I therefore was very drawn to this approach for this reason. In a similar vein Goldfried (1999) writes;

“our therapeutic schemas serve as a hindrance to our effective functioning, particularly when they lead us to distort information provided, inaccurately fill in the gaps, or selectively recall that which fits with our theoretical construction”.

However, I have realised that the lack of labelling and categorisation in Client-Centred psychotherapy which is very evident in the majority of other fields (biopsychosocial in psychology, DSMiv and ICD-10 in Psychiatry, categorisation of disorders in Cognitive-Behaviour therapy and more loosely the ego states in Psychodynamic and Transactional Analysis) leaves the onus of exploration of issues around diversity very much up to the individual psychotherapist and their client. This at one level seems satisfactory but on another not. Whilst categorisation, structural labels and “isms” have their limitations, they do nonetheless provide a framework which may be used to guide readings and explorations of difference issues. Without these structural labels Client-Centred psychotherapists may wrongly assume that they have addressed diversity by virtue of the fact they are Client-Centred. On the advantages of frameworks Goldfried (1999) writes;

“if we think of our theories of therapy as therapeutic schemas, it becomes clear that they help us to fill in the gaps by hypothesising that which may not yet have been observed. At times, they have the potential for enhancing our clinical effectiveness”.

As stated above much bias discrimination and prejudice arises due to a lack of awareness (Laszloffy & Hardy, 2000). If a Client-Centred therapist is unaware of a difference, the fact that they have read theory on differences may make it less likely that important issues will be missed. However, there seems to be an assumption that if there is no categorisation, then bias cannot exist. If we don't have the pigeon holes then we cannot place the pigeons. This is untrue because the bias lies with the individual who is categorising and not the category itself. Hence Client-Centred therapists can prejudice against a client without there being any need for a category. Indeed Client-Centred psychotherapy carries its own biases within its theory, as feelings take precedence over cognitions and non directivity over directivity irrespective of client differences.

In conclusion, I have attempted to demonstrate diversity is neither one, nor a collection of “isms”. I have argued that research which has focussed on one “ism” and failed to put that “ism” into context, misses the main issues of

diversity. I base this argument on two premises. Firstly, by focussing on one aspect of the individual, their "ism", other parts of that individual's difference will be ignored. Secondly, by focussing attention on one "ism" a hierarchy is developed whereby some "isms" are deemed more significant than others, this I would argue increases rather than decreases prejudice.

I have also explored some factors which influence the likelihood of someone experiencing prejudice on the basis of their difference. The factors explored include; the influence of societal attitudes, conditioning, whether or not the difference is concealed and the perceived level of control members of society see that individual having over their perceived difference.

I have also explored these issues in relation to psychotherapy. Highlighting the difficulty when the therapist's prejudice is covert. I have explored theorist's solutions, namely therapist awareness, sensitivity and causes of prejudice, as well as the arguments for and against "tailored" therapy. Lastly, I have argued the advantages and disadvantages of the use of categorisation of information in relation to Client-Centred theory and its practice and some of the pitfalls of Client-Centred theoretical assumptions in relation to client difference.

References

Archer, D. (1985). Social deviance. In G. Lindzey & E. Aronson (Eds.), *Handbook of Social Psychology*. Vol. 2, 3rd ed. , p.743-804. New York: Random House.

Bland, J. (1994) & Bland (1998) Transvestism and Gender Identity. <http://www.gender.org.uk/derby/mon1.htm>

Bobo, L., Kleugel, J. R. & Smith, R. A. (1996, June). *Laissez-faire racism: The crystallization of a "kinder, gentler" anti-Black ideology* New York: Russell Sage Foundation. Retrieved December 26, 1999, from [http:// www.epn.org/sage/rsbobo1.html](http://www.epn.org/sage/rsbobo1.html) <<http://www.epn.org/sage/rsbobo1.html>>

Cain, D.J. (1989) The paradox of non directive-ness in the Person-Centred Approach. *Person Centred Review*, 4, p.123-130.

Cash, T. F. & Janda, L. H. (1984). The eye of the beholder. *Psychology Today*, pp. 46-52.

Crocker, J. (1993) The stigma of overweight: Affective consequences of attributional ambiguity. *Journal of Personality and Social Psychology*. Vol.64. 1. Jan. p.60-70.

Crompton Lee Field notes from Leeds Metropolitan University conference.

Davis and Proctor (1989) Lee Field notes from Leeds Metropolitan University conference.

Dovidio, J.F., Gaertner, S.L. & Bachman, B.A. (2001) Racial bias in organisations: The role of group processes in its causes and cures. In M.E. Turner (ed) *Groups at work: theory and research* (p.415-444) Mahwah, NJ: Erlbaum.

Dovidio, J.F., Gaertner, S.L., Kawakami, K. & Hodson, G. (2002) Why can't we just get along? Interpersonal biases and interracial distrust. *Cultural Diversity and Ethnic Minority Psychology*, 8. P.88-102.

Fuller, F. F. (1963). Influence of sex of counsellor and of client on client expression of feeling. *Journal of Counselling Psychology*, 10, 34-40.

Garrett and Davis (1995) taken from notes from Lee Field Leeds Metropolitan University conference. In BPS Race and Culture Resource Pack.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Goldfried, M. R. (1999) Role of theoretical bias in therapeutic interventions: To see or not to see? *Journal of Clinical Child Psychology, Dec, Vol. 28. 4, p.544.*

Grant, B. (1990) Principled and instrumental non-directiveness in Person-Centred and Client-Centred therapy. *Person Centred Review, 5, p.77-88.*

Howard, K., Orlinsky, D. & Hill, J. (1970). Patients' satisfactions in psychotherapy as a function of patient-therapist pairing. *Psychotherapy: Theory, Research and Practice, 7, 130-134.*

Jacobson, N.S. & Truax, P.A. (1991) Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59. P.12-19.*

Laszloffy, T. & Hardy, K. (2000) Uncommon strategies for a common problem: Addressing racism in family therapy. *Family Process, Spring, Vol.39. 1. P.35.*

Lopez, S.R. (1988) The empirical basis of ethno-cultural and linguistic bias in mental health evaluations of Hispanics. *In Davison Neale Abnormal Psychology. John Wiley and sons inc. Revised sixth edition. P.102-104.*

Lopez, S.R. (1989) Patient variable biases in clinical judgement: Conceptual overview and methodological considerations. *In Davison Neale Abnormal Psychology. John Wiley and sons inc. Revised sixth edition. P.102-104.*

McAdoo, H.P. (1982) Stress absorbing systems in Black families. *Family Relations, 31, pp. 479-488.*

McKinnon, D.G. (1990) Client-preferred therapist sex role orientations. *Journal of Counselling Psychology. Vol. 37, 1.*

Moore, J. S., Graziano, W. G. & Millar, M. G. (1987). Physical attractiveness, sex role orientation, and the evaluation of adults and children. *Personality and Social Psychology Bulletin, 13, 95-102.*

Owen (1989) In Laszloffy, T. & Hardy, K. (2000) Uncommon strategies for a common problem: Addressing racism in family therapy. *Family Process, Spring, Vol.39. 1. P.35.*

Proctor, G. (2002) *The dynamics of power in counselling and psychotherapy.* Ross on Wye: PCCS Books.

Roger, L.H. & Hollingshead, A.B. (1985) Trapped Families and Schizophrenia. Maplewood, NJ: Waterfront Press. In Davison Neale *Abnormal Psychology*. John Wiley and sons inc. Revised sixth edition. P.102-104.

Sabin, J.E. (1975) Translating despair. In Davison Neale *Abnormal Psychology*. John Wiley and sons inc. Revised sixth edition. P.102-104.

Shaffer, D. R. & Wegley, C. (1974). Success orientation and sex-role congruence as determinants of the attractiveness of competent women. *Journal of Personality*, 42, 586-600.

Tidwell, R. (1992) Crisis counselling: a right and a necessity for members of the underclass. *Counselling Psychology Quarterly*, Vol.5.3.p.245-250.

Weiner, B., Perry, R. P. & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology*, 55, 738-748.

Wilson, S. (2003) : *Disability, counselling and psychotherapy: Challenges and opportunities*. Basic texts in counselling and psychotherapy. Basingstoke, England: Palgrave. xiv, 144 pp. ISBN: 0-333-96496-9 (paperback)