PEER-REVIEWED ARTICLE

White therapists grappling with racist comments in therapy

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ABSTRACT

Therapists can be seen to have a moral obligation to use their power to work against social injustice. Engaging with the dialogue of privilege and oppression in relation to race is one example of this. Since responses from white people in being named as privileged can sometimes lead to defensiveness and frustration, a challenge is posed in how to respond to this in therapy. This article suggests that understanding the intersectionality of privilege and oppression in all individuals facilitates the opportunity for more nuanced discussion. It proposes that tools such as the Multicultural and Social Justice Counselling Competencies approach could be used to enable clients to explore their own white privilege. A fictional case example of a white, gay man who is HIV (human immunodeficiency virus)-positive is presented and discussed in order to exemplify this proposal.

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INTRODUCTION

Within an increasingly white-privilege-aware society, therapists can be seen to have a moral responsibility to engage with ways in which clients themselves may be part of an oppressive majority (Drustrup, 2020). Yet, many individual clients come to therapy in the context of their own oppressive experiences, including white clients. In this article, I use a fictional vignette to consider how a client may present with oppressive experiences:

> *Gary defines as gay and HIV (human immunodeficiency virus)-positive. He describes himself as 'pathetic', 'the bottom of the pile', and 'not worth anyone's time'. He attributes his use of foodbanks to his HIV status, which has contributed to long periods of depression, substance misuse, and repeated suicide attempts. At the beginning of therapy, he explains that he believes the long waiting lists and early discharge at mental health teams, and strict benefit sanctions are due to immigration and pressure on statutory services from people of colour. He attends therapy in order to seek support for his depression and low self-esteem.*

> *He is also white and male, part of the privileged dominant group.*

Considering the vignette above, the question of how privilege fits into the experiences of oppression arises. Given the stigma, isolation, and abuse associated with a diagnosis of HIV and also with defining as LGBTQ+ (lesbian, gay, bisexual, transgender, queer or questioning, and other sexual identities), a client such as Gary may simply not consider talking about their own power and privilege (Blosnich et al., 2016; Joe et al., 2018; Turner, 2018). This article considers how a therapist might respond to racist ideology from clients, such as Gary, without undermining the weight of their experience. This is a theoretical article which poses an idea, with the shortcoming of not having clinical evidence to support the recommendation.

The term white privilege, popularised by Peggy McIntosh (1989), requires white people to consider the significant benefits and power they receive simply due to the colour of their skin, and highlights the privilege of not needing to consider this (Pinterits et al., 2009). It has been clarified repeatedly that white privilege does not discount that white people may experience oppression too and may be part of other oppressive groups; white privilege simply means that they have not experienced oppression specifically because of the colour of their skin (Clausen, 2015). The purpose of the many books, articles, blogs, and TV series written about this is to encourage white people to understand their complicity in a racist system (e.g., Bell et al., 2015; Saad, 2020; Wise, 2009).

To change the dominance of a white society, it is important for all people who hold white privilege to consider their own behaviour, yet empirical research has found that white people often respond with fear, anger, guilt, and/or shame to the idea of complicity, leading to disengagement from conversations about the issue (Pinterits et al., 2009). The defensive reactions to the term have become understood as a form of white fragility, yet qualitative research has shown that a further potential barrier is if a white person does not associate privilege with their life narrative (Croteau et al., 2002; DiAngelo, 2011). If someone considers

their life to be disadvantaged, engaging in the hard work of grappling with how their privilege impacts others seems a foreign task (Croteau et al., 2002; Dottolo & Kaschak, 2015). White therapists perhaps have a responsibility, and a fortunate position, to be able to support white clients to grapple with this whilst being held in a nurturing therapeutic environment. The values set by the British Association for Counselling and Psychotherapy include 'respecting human rights and dignity', 'improving the quality of relationship between people', and 'appreciating the variety of human experience and culture', which could be interpreted as promoting a social justice responsibility for therapists (British Association for Counselling and Psychotherapy, 2018, p. 8).

Fundamentally, many people experience both privilege and marginalisation in their life. These realities intersect and become part of the contextual factors that contribute to an individual's unique experience of the world (Ratts, 2017). The Multicultural and Social Justice Counselling Competencies (MSJCC) tool devised by Ratts and colleagues (2016) builds on intersectionality theory, which was developed initially to give voice to the nuance of the experience of women of colour, whose experience was often not acknowledged as different to white women, and to men of colour (Crenshaw, 1991). The MSJCC tool was developed through the historic multicultural and social justice counselling competency movement (Singh et al., 2020). The MSJCC offers a framework for therapists and clients to consider the therapeutic relationship through the lens of their own oppressions and privileges. This tool has been formed to enable therapists and clients to identify power imbalances within therapy (Ratts et al., 2016). However, an additional use of this tool would be to help a client to understand their privilege outside of the therapy room and how they use that privilege. This could be particularly powerful to use when clients make racist comments. The potential efficacy of this is illustrated here through considering how therapists engage with racist comments from a white, male client who is HIV-positive and experiences discrimination for their sexuality.

It is worth noting here that this article proposes an individualised response to what is also a societal issue (Abdi, 2021). Responding to structural oppression is also essential for the overhaul of change needed (Talwar, 2010). However, for individuals to be able to consider their own relationship with privilege and responsibility within that, an individual approach is also needed. For white therapists, this may well involve their input outside the therapy room too.

Reflexivity

It seems appropriate at this point to acknowledge an apprehension I feel in writing this article. I speak as a white, HIV-negative woman. I have been exploring my own white privilege, white fragility, and white supremacy much more in the last year, through reading, conversation, and attending an 'exploring privileges of whiteness' group. I experience influence both from family

and friends who are white and a partner and friends who are people of colour. I acknowledge that I am comfortable with the word privilege, and attribute this to me having white, cis-gender, heterosexual, and able-bodied privilege. From that position of power, I am unsure how appropriate it is for me to write this article (Clausen, 2015). I find that my perspective of the 'right way' to approach this topic changes often, the more I learn. I also, however, acknowledge that silence and fear of saying anything in case it is wrong is an example of white fragility (McWhorter, 2020). So, I simply offer the thoughts here, and hope they provide some useful food for thought, rather than appearing to be an authority in any way, especially as I do not consider there to be a homogenous experience of race or disability (Winker & Degele, 2011). The intention here is not to provide another 'what about people who are HIV-positive' question, but to further the deconstruction of whiteness as part of reducing its power (Case, 2012; Kinouani, 2020). For all white people to truly understand the impact of white supremacy on people of colour and for meaningful change to occur, the nuance of language must be unpacked, and consideration must be given to how this work might look from different perspectives (Mosley Wetzel & Rogers, 2015).

WHITE, MALE PRIVILEGE

'Privilege is typically lived but not seen' by those who have it, despite it being visibly obvious for those who do not (Niehuis, 2005, p. 481). Privilege therefore remains unchecked, and its invisibility enables it to continue and to be denied (Dottolo & Stewart, 2013). As a term, white privilege is useful in highlighting the huge benefit that the invisibility of race has granted white people and challenging the uncritically accepted assumption that race is 'other' and white is the norm (Dyer, 2005). Whiteness operates continually in all aspects of life, granting privileges not afforded to people of colour, through white dominance in powerful jobs, TV shows, religious icons, and many other settings (DiAngelo, 2011; Dottolo & Stewart, 2013). Even in settings intended to be accessible to marginalised groups, often people of colour describe feeling silenced, reaffirming their sense that they are not of value in a white world (Kinouani, 2020).

At first glance, those who possess male privilege alongside white privilege hold dominant power roles nationally, in local society, in families, and within couples (Etchells et al., 2017). Male privilege exists due to the well-established patriarchal systems developed historically and maintained in the present (Coston & Kimmel, 2012). However, unlike whiteness, research deconstructing male privilege is limited and men have perhaps only been encouraged to consider their masculinity through the eyes of female oppression rather than through their own privilege (Etchells et al., 2017).

EXPERIENCES OF OPPRESSION THROUGH BEING HIV-POSITIVE AND LGTBQ+

For Gary, in the vignette, being HIV-positive and identifying as LGBTQ+ are experienced as forms of oppression. People living with HIV often experience both significant mental health distress and intense stigma and judgement linked to how the illness is contracted. Choosing to silence and distance themselves to avoid others isolating from them is often used as a self-protective mechanism, though can instead lead to loneliness (Joe et al., 2018). Another example of the oppressive impact is the increasing numbers of people who are HIV-positive who are identified as in poverty and receiving support from foodbanks (HIV Psychosocial Network, 2018).

HIV has become recognised as a disability relatively recently (Inckle, 2015). A definition of disability as 'impaired' offers connotations of weakness and inability; the antithesis of privilege. Having a disability is experienced by many as a marginalisation within an able-bodied 'norm', because of the societal construct that a perfect body exists and that anything other is deficient in some way (Inckle, 2015; Winker & Degele, 2011). Indeed, it has been argued that being temporarily able-bodied carries a similar privilege to whiteness in not needing to think about how society and systems are constructed for the able-bodied (Inckle, 2015).

Mental distress is also often experienced by those who identify as LGBTQ+ (Blosnich et al., 2016). A cross-sectional, observational analysis of a survey conducted in the USA indicated that gay men reported seven times more suicide attempts than heterosexual men (Blosnich et al., 2016), rates which also increase for younger gay men (Bybee et al., 2009). For many men who are HIV-positive, the stigma and distress are exacerbated by the intersection with identifying as LGBTQ+ (Garrett-Walker & Galindo, 2017; Hatzenbuehler et al., 2013). Longitudinal analysis has indicated that emotion dysregulation develops due to the stress induced from stigma for both HIV-positive status and identifying as LGBTQ+ (Rendina et al., 2017). Health research is also largely hetero-focused, itself contributing further to the stigma (Hatzenbuehler et al., 2013).

It is, however, important to note that being LGBTQ+ is, for many, a huge source of joy, instead of or alongside also being an experience of oppression (Feinstein et al., 2020). However, the experience of guilt and shame, often exacerbated by the stigma, can have significant ongoing impacts on how individuals engage with themselves and others (Bybee et al., 2009). This can have implications for how individuals engage with their own sense of white privilege.

INTERSECTIONALITY

Using Crenshaw's intersectional approach, the intersectionality of privilege and oppression could be explored (Ratts, 2017). The implicit message of Crenshaw's discussion of women of

colour is that identities lead individuals to either be privileged or marginalised (Ratts, 2017). Yet both privilege and oppression impact most people's lives (McIntosh, 2012). Intersectionality is not seeking to consider which lived experience causes more oppression, nor attempting to balance out privilege and marginalisation (Ratts, 2017). Instead, it gives insight into the specifics of that individual life experience to understand how they perceive their status in society (McIntosh, 2012). Intersectionality can be applied in multiple ways; for example, as a theory or as a form of analysis in research (Winker & Degele, 2011).

There is also a risk that people find it easier to talk about the oppression they face than to acknowledge the privilege they have (Ahmed, 2006). For example, a recent incident in America portrayed a hostile response to a statement that a deaf-blind disability activist was a privileged white person (Lee, 2020). This type of dialogue is paralleled by debate about whether white poverty indicates an absence of white privilege (e.g., Bridges, 2019; Winders, 2003). Many of these articles argue against each other, attempting to persuade the listener to understand their privilege better. Despite these ongoing conversations, it seems that little progress is made (Asthana, 2020). It has been argued that discussions about singular issues in isolation inevitably become problematic and negate the complexities of individual experience (McIntosh, 2012). Intersectional pedagogy appropriately positions the different social groups each person is part of as equal and interplaying, rather than engaging with a singular conversation of privilege (Case, 2017).

It could be critiqued that using intersectionality in this light is trying to promote white comfort. Some suggest that it is only through discomfort that people reassess their own privilege (Applebaum, 2017). However, Zembylas (2015) has suggested that discomfort as a means of education could be understood as ethical violence. Instead, by acknowledging the narrative of both oppression and privilege within someone's experience, intersectionality can promote an individual's investment in identifying with the marginalisation they create for others, without feeling their own experience is ignored (Coxshall, 2020).

Intersectionality allows for the validity of all experience, removing generalisations of 'the experience of [people] of colour' and hearing both that individuals differ within groups and have fluid identities within themselves (Applebaum, 2008, p. 405; Bhavnani & Bywater, 2009). As such, intersectionality is a perfect tool for supporting a client to consider their context and to enable them to understand their interplay of oppression and privilege.

APPLYING INTERSECTIONALITY TO GARY

Clausen (2015) argues that all white people carry the 'robust social power of whiteness' (p. 1), irrelevant of their other experience. Furthermore, 'white consciousness' and 'white solidarity' are terms used by DiAngelo (2011). These statements overlook lack of cohesion within white experience (Bejan, 2020). Recognising the significant privilege differences within

whiteness may enable a more deep-rooted change from that social power than currently seems to be occurring (Bejan, 2020; Showing Up for Racial Justice, n.d.). Intersectionality is well placed to be able to offer this. In working with Gary, the core factors considered here in an intersectional light are white, male, HIV-positive status and identifying as LGBTQ+.

Disability and race intersect in perceptions of the body, both relevant in discussions of what an ideal body should be (Winker & Degele, 2011). Men who are HIV-positive may not experience the dominant privilege of masculinity and whiteness, as stigma often reduces their access to those privileges (Fleming et al., 2016). Clausen (2015) suggests that white people experience unconditional acceptance, yet a lack of acceptance is something widely felt by people who are HIV-positive (Joe et al., 2018). The diagnosis also often involves frequently attending hospital appointments and applying for disability benefits due to the impact on mental health and interrupted careers (HIV Psychosocial Network, 2018; Owen & Catalan, 2011). Within a climate of ongoing contention in UK society of whether hospital waiting times and disability benefit cuts are linked to immigration or not (Giuntella et al., 2018; Shahvisi, 2019), there is potential for someone in Gary's position to form a view that they have been unfairly impacted by immigration. Whilst I as a therapist might strongly disagree with this viewpoint, the fact that clients may hold this perspective is a consideration that cannot be entirely ignored in discussing racial injustice. Where HIV status and race intersect for individuals is, of course, nuanced, and therefore acknowledging individual experience, even with intersection, is paramount (Gordon, 1997). The task in individual therapy is how to grapple with that with the client.

This discussion suggests that white privilege may be too simplistic a term to unquestioningly accept for a white person who has experienced their life as lacking privilege (Bridges, 2019). However, the privilege of one aspect of someone's identity should not be disregarded because of their marginalisation of another group (Ratts, 2017). As such, those who are HIV-positive are still accountable for the impact of white privilege. However, responding to their white privilege must be engaged with by acknowledging its distinction from the white privilege experienced by those who are HIV-negative (Bejan, 2020).

ADDRESSING RACIST COMMENTS IN THERAPY, USING THE MSJCC

Therapy can be social action if it focuses on and attunes to both the client's sense of marginalisation and those who they marginalise (Case, 2017). Therapy can also enable growth and change for the client (Rogers, 1951). It can be transformative and deeply moving for therapists of colour to successfully confront racism in white clients (e.g., Leary, 1997). Yet, the responsibility for this should not be left only to therapists of colour (Drustrup, 2020). Using the above context gives all therapists, and in particular white therapists, the opportunity to consider how to respond to Gary. An intersectional approach, which acknowledges

experiences of oppression and privilege, offers much more than a discussion about white privilege in this context.

Intersectionality appeals to a natural therapeutic approach of considering the multiple self-schemas and identities which a client presents with (Ratts, 2017). Ratts, who defines as a person of colour, suggests that there has been a lack of suitable frameworks for considering intersectionality in clinical practice, leading to a lack of confidence for professionals. Ratts and colleagues (2016) use an intersectional framework to propose the MSJCC to consider how the therapist's privilege and marginalisation meets the client's privilege and marginalisation. They have built a therapeutic tool, designed to be used at the beginning of therapeutic sessions, in which both client and therapist complete a form which gives space to reflect on each social group they are a part of and whether that is a privileged or marginalised identity. For example, the therapist and client each complete a section on their self-awareness of their experiences of marginalisation and their worldview in relation to that. They also both complete a section on their self-awareness of their privilege and their worldview in relation to that. They are then invited to consider the interplay between the therapist's identities and the client's identities and the power and oppression dynamics this creates in the therapeutic relationship. By using the form at each session, the therapist can use this to develop conversations about privilege and oppression over many weeks (Ratts, 2017).

Moving this further, the MSJCC model also has potential to be used in enabling a conversation with the client about their own privilege outside of the therapeutic space and how their wider worldview impacts their interactions with others. Through visually considering the ways in which the client experiences marginalisation, immediately alongside the ways in which the client experiences privilege, a constructive conversation could be formed. The therapist would have the opportunity to validate the feelings of marginalisation, which may enable the comfort of the client before attempting to discuss the more challenging identity of privilege (Coxshall, 2020).

Introducing the MSJCC at the start of therapy, with all clients, could enable early discussions about the client's experience of privilege and oppression. Often the initial session(s) of therapy include the space for client and therapist to get to know each other and many therapists use a number of different tools at this time as part of this (Finn et al., 2012). Adding the MSJCC to this could offer a natural way to open the conversation about the client's intersectionality and consider how this might impact therapy. Rather than the MSJCC being a tool which is brought in later, potentially suggesting it is only following the therapist's agenda, it becomes more of a piece for discussion and reflection as part of the opening assessment, much like a genogram or psychometric test (Finn et al., 2012; McGoldrick et al., 1999). Clear rationale for its inclusion should be given and informed consent granted before the tool is used.

USING THE MSJCC WITH GARY

Using the MSJCC with Gary could enable him to first consider his feelings of minoritisation from his HIV-positive status, his sexual identity, and any additional disadvantages resulting from those (such as his experience of stigma, socioeconomic anxiety, and low mental health). It may be that one or two of these identities has the most impact for Gary. He could then also be invited to reflect on his position as a white man and to consider his privilege in this. This can develop a conversation about how these different elements interact with each other for Gary; perhaps the experiences of oppression impacting on racist ideation. It could also enable a conversation about whether anger or otherised views are correctly directed towards people of colour or not. This discussion may bring up emotions of shame and guilt, but these can be of value if they act as a starting point for change (Moore, 2019). Therapists are well placed to support someone to work through the challenging emotions that may arise from this work (Clark, 2012). A development of this could be to support the client to develop the stamina needed to counterbalance white fragility (DiAngelo, 2011).

The purpose of this is both a societal benefit and for Gary himself. Whilst predominantly facilitating a wider awareness of white privilege, enabling Gary to see areas of power in his life can also be empowering for him and help to change an identity of being only oppressed (Cooper, 2009). By focusing on Gary's strengths and resources, he can be offered the opportunity to see the benefits and challenges of power, and from that, to understand his own accountability. Furthermore, this enables him to access his own experience of vulnerability as a tool to understand the vulnerability someone else might experience as a result of his behaviour (Croteau et al., 2002). This speaks to the idea of increased solidarity that, despite huge differences between groups, finding a common ground can increase understanding and empathy (Gaztambide-Fernández, 2012). Secondly, it enables the client to see ways in which their frustration at their own oppression may interplay with how they use their own privilege (Croteau et al., 2002). Oppressing others through scapegoating can be a tool used if someone is repressing challenging emotions, such as anger at their own stigma or shame resulting from this. Psychotherapy can be an important resource in disentangling scapegoating (Scheidlinger, 1982).

This model could seem directive in contrast to a humanistic approach and may lend itself more comfortably to therapeutic models in which the therapist often introduces activities. However, this will also be determined by therapist preference. Offering unconditional positive regard and empathy for how the client has experienced oppression and power will likely be of core importance in how this is approached (Lago, 2011). Gary may not be interested in exploring his own racist ideation and therapists should not seek a specific agenda with clients (Feltham, 2018). Nevertheless, the MSJCC offers the opportunity for both therapist and client to explore their own oppression and privilege together, and how this impacts on their behaviour outside of the therapy room. This modelling can offer a safe space for Gary to explore within if he chooses to (Cooper, 2009).

There are limitations to this suggestion. Firstly, to date, this has not been used in direct work with a client. The suggestion here would need to be explored further in empirical research studying its use in practice to explore any potential difficulties. In addition, there are difficulties of therapist power in introducing this tool, which could be at odds with the client's agenda and presenting issue. Therapists are likely to have different approaches to how they grapple with social justice issues with clients. Some may feel that it is inappropriate to draw from the therapist's social justice perspective when responding to client distress. However, it is worth remembering that the MSJCC does also validate client experience of oppression. From that starting point, using the MJSCC model has the potential to enable the client to understand white, and other, privilege and why it is important for them to consider their power and to explore ways to respond differently to people of colour. The MSJCC is one suggestion of a tool which could be used in this way, and it would be of interest to consider how other tools could be similarly adapted too.

CONCLUSION

White people acknowledging white privilege is essential in rebalancing racial injustice (Clausen, 2015). The progress on this has been too slow and as such, creative approaches are required (Moore, 2019). This work should not only be done by therapists of colour—white therapists have a moral responsibility to use the power they have to tackle racial injustice (Tribe & Bell, 2018).

Through using an intersectional approach to consider white, male privilege alongside identifying as LGBTQ+ and having a HIV-positive diagnosis, this article has made a new contribution by suggesting that tools such as the MSJCC framework could be used to specifically address white privilege with clients who are HIV-positive and LGBTQ+. Working with the understanding that all clients have both privilege and disadvantage nurtures empathy and reduces tendencies to otherise (McIntosh, 2012). By mindfully considering the presence of privilege and oppression in a client's life and the interplay between these, the client's feelings of oppression are validated alongside being sensitively challenged on their privilege and racist views.

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