Misogynistic and racist: what should a practitioner do when a client holds abhorrent views?

Mark Brown

How should a therapist, nurse or social worker respond when their client expresses misogynistic or racist views? Mark Brown speaks to professionals who have worked with individuals that have expressed offensive opinions.

It will not have escaped the attention of the reader that we live in increasingly polarised times where, depending on your political views, political correctness has gone too far or a backlash is occurring against hard won equality and the casting off of outmoded discrimination and prejudice.

From the election of Donald Trump in the US, to the resurgence of white nationalism, to the birth of regressive online movements; it feels to some of us that a time has arrived where people feel freer than ever to 'say the unsayable' even when maintaining they are being prevented from doing so. The division within the UK focused by the EU referendum has spilled into many unexpected parts of public and private life.

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Mental health care, and specifically therapy, have often been considered both as an agent of social control and of liberation depending on the tenor of the times. At its heart, mental health is about relationships. But what if those relationships are subject to the same kinds of battles of ideas as wider society? Is it possible for therapy and healing to happen when one party is appalled by what the other believes?

In this post mental health awareness era, we tend to focus upon the prejudice that is experienced by those who experience mental health difficulties while finding it awkward and difficult to discuss prejudices that might be held by people who experience mental health difficulties. People with mental health difficulties, like any other group in society, have political ideas and social attitudes. Racist, sexist, homophobic, transphobic views will be as likely to be held by people with mental health difficulties as any other group.

We widely accept that anyone carrying out their job should not be subjected to abusive behaviour as they carry out their work. Hate speech and discrimination based on characteristics such as ethnicity, religion, gender, age, disability and sexuality are proscribed in law. We would be appalled if a mental health professional held prejudiced or discriminatory views, but what if the person being treated or supported does?

I spoke to a range of people within mental health about the challenge of working with a patient or client who held views that were abhorrent or actively offensive. It was an issue that many were keen to discuss but most did not want to appear on the record for professional reasons. One professional spoke of a young person with such extreme Alt-Right views that safeguarding under Prevent duties was needed. Others spoke of their professional duty to the understanding and supporting of the individual, overriding any distaste for the views that person held.

Educate or enquire?

A professional I spoke to discussed their sadness and dismay when a peer worker they had recruited revealed some opinions about 'black people always playing the race card' when in the company of the professional and a friend, both of whom are black. In this case the person expressing the prejudiced views was a colleague rather than a patient, but the professional was shocked and found it challenging to find a comfortable line between condemning and understanding the views the other held. They told me their initial response had been one of justified anger shifting to an impulse to inform and then to a position that it was neither their obligation nor responsibility to educate and that, in this case, an expression of why the expressed views were inappropriate was enough.

Christine is an experienced mental health nurse working in addictions. One of her patients was very hostile to staff. When he first met with Christine he would not engage with treatment and maintained that 'everyone was a c**t'. He held profoundly Islamaphobic views and also considered himself one of the online movement of 'Men Going Their Own Way (MGTOW), viewing women negatively and believing they were manipulative towards men.

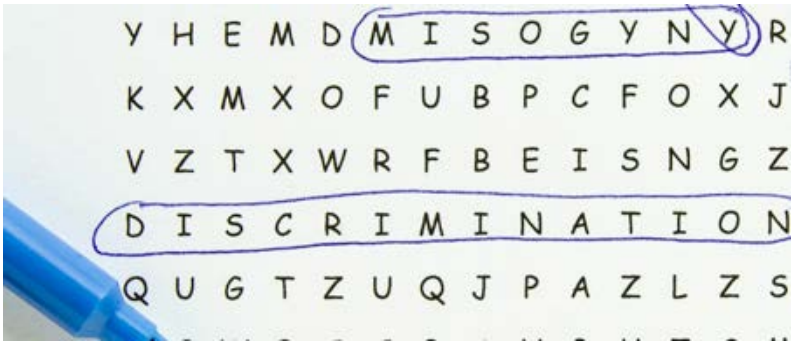
"I am a very experienced nurse and I have worked in psychiatric intensive care and forensics so I'm not unused to extreme behaviour but he definitely was challenging. These men would only have sex with women if they paid them as they viewed themselves as in control of the transaction or they would "go monk" and choose celibacy," Christine says. "I chose to allow him to openly express those beliefs. I told him I couldn't agree with them and that lots of people would find them offensive but I didn't express offense myself. Over time he began to engage with me in relation to his treatment as he seemed to feel listened to and would therefore engage. At no point did I agree with his views but I was very careful not to express offense as I did not feel it was helpful to the therapeutic relationship. I still heard lots of offensive things about Islam and I found them awful but he was able to access treatment due to this approach. It is not my job to make a moral judgement or to allow it to affect the care delivered."

Rise above or reflect?

Separating the views of her client from his needs was important, but required space for Christine to explore her own feelings. "It was really important to me to have a safe space in clinical supervision to process my thoughts and feelings about the opinions he held. In practice supervision can often be a run through of patients, a kind of "what are you doing with them? Is your paperwork up to date?" But I was very clear that if I were to be expected to continue to work with such a cohort that I would need that reflective space and perspective."

The commitment of mental health professionals to rising above the prejudices expressed by clients or patients was a consistent thread of responses. A therapist I spoke to made the distinction between the needs of the therapist and the needs of the patient, suggesting that the relationship isn't about 'you' it's about 'them'. Even so, they acknowledged that therapists are also people, and exposure to others' challenging views had an effect.

Therapists might feel let down by patients revealing prejudices they had not expected or particular attitudes may be more difficult to hold at a professional distance. In group supervision the therapist found that it was more palatable to speak about personal biographical issues triggered during their practice than it was to speak about big prejudices expressed by clients such as racist views.



Perhaps, they wondered, personal issues were easier to deal with because colleagues did not feel they needed to worry about offending each other or being exposed to others' judgements.

Call out or create safety?

For many of us, it feels natural that we should challenge prejudiced views when we encounter them, whether we belong to the group being attacked or not. Lucy is a psychotherapist. She draws a distinction between the wider world and the environment of the therapy room. "Calling out is important and, I think, necessary. It is one of the few meaningful ways we can challenge bigotry," she told me. "But if you think about it, we call the racists, homophobes, transphobes out because we are upset. They have upset or offended us so we want to push back and show them they are wrong and we are right. This dynamic has no place in the therapy room. If I set out to show people they are wrong and I know better then I am stoking my own ego at their expense and shaming them. Therapy is a space where we need to be able to talk about the worst, most shameful aspect of ourselves and our lives. In order for therapy to work, we need to be able to tell our therapist about our worst selves."

"If we are dehumanising others then we aren't relating healthily," Lucy said, "and, on that basis, I will challenge expressions of hatred. Where I need to be careful is in not imposing my world and political view on my clients. We aren't here to censor people, even if their views are horribly offensive. I've heard clients say some awful things that landed pretty close to home for me. The most common one is expressions of misogyny which include sexual objectification, being devalued as a female therapist, and listening to usually male clients express some highly unpleasant views on women. I see this as a warped expression of fear, vulnerability and need."

Lucy spoke of countering hateful views with facts and figures but also tying this into the emotional reality of the lives of her clients. In one situation she "challenged their viewpoint and told them that I don't agree, and backed some of what I said up with stats. When I linked their hatred of [others] vulnerability to their self-loathing, they were more able to consider that I might have a point. In the following session they told me that they had thought about what I had said. If I had just left the challenge with my disagreement and the stats then I don't think I would have made any headway at all, I had to address the feelings at the heart of this as well."

"Sometimes," Lucy told me, "I will directly challenge offensive statements, and sometimes I will use them as sign posts to guide me to painful feelings that are being covered by expressions of hatred. Sometimes prejudice is a survival mechanism developed to make us feel powerful. We know that violence and hatred have their roots in pain and trauma: addressing the pain and trauma usually takes the edges off the most destructive aspects of hatred."

There is perhaps a difference between being the target of someone's prejudice rather than their audience. Ironically, in a discourse where 'safe spaces' are derided, the mental health professionals I spoke with were setting aside their own discomforts to try to create spaces that were safe for their clients or patients. "Being human means hatred and violence are within us all and aren't something that can or should be erased," Lucy told me. "But they can be helped, worked with and redirected. None of this is to say that therapy should enable dehumanisation, but to point out that we have a very different approach to it when in the therapy space."

Breaking down barriers to therapy

The professionals I spoke to all talked of treating patients or clients they did not agree with as being 'complex'; 'tricky' or challenging. They all stressed the need to look beyond the objectionable views of individuals in pursuit of their duty to make sure that the person in question could access the support or services they undeniably needed. As one person I spoke to said 'racism isn't a mental illness'. But that does not make it easier to swallow if it is directed at you.

Duty to the needs of the individual, no matter how abhorrent their views may be, was the professional justice that the people I spoke to served, setting aside their own beliefs or instincts, even if that meant accepting what would otherwise be unacceptable to them in any other circumstances. "It gets tricky when a client's views are pressing your own particular buttons over time," Lucy told me, "but it's not impossible to work with therapeutically. You just need to hold your own self-care in mind while doing it."

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