Feeling Offended by Clients: The Experiences of Doctoral Student Therapists

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CITATION

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Ten doctoral student therapists (8 White, 5 female) in 1 counseling psychology doctoral program located in the Mid-Atlantic United States were interviewed for approximately 1 hour each about their experiences of feeling offended by a client during an individual psychotherapy session. Interview data were analyzed with consensual qualitative research (CQR). Trainee therapists typically felt offended related to their sociocultural identities (e.g., being a woman, LGBTQ+, racial-ethnic minority), felt frozen after the events and uncertain about how to respond, wished they had handled the events differently, and struggled when clients expressed opinions or beliefs that ran counter to their own values. Trainees had difficulty maintaining an empathic, nonjudgmental therapeutic stance where they could both value the client and maintain their own sense of integrity and beliefs about social justice and multiculturalism. Implications for training, practice, and research are provided.

Public Significance Statement
Doctoral student therapists reported on instances in which they felt offended by clients related to cultural or value differences. Therapists typically felt frozen and unsure of how to handle such situations, especially given their own countertransferential reactions, but wished they had handled the situations differently. These findings highlight the importance of training to provide therapists with tools to become more self-aware of inadmissible feelings and of alternative ways of handling difficult situations.

Keywords: offenses, psychotherapy, psychodynamic/interpersonal psychotherapy, qualitative methods, sociocultural identities

Imagine that you are a sexual minority therapist and your heterosexual client says that gays are corrupting the next generation. Or, you are a female therapist and your male client claims that women are inferior to men. Or, you are a Christian therapist and your atheist client says derisively that religion is only for stupid people. What do you do with your feelings of hurt, confusion, and outrage? What do you say and how do you behave, especially if the client has other pressing concerns that need to be addressed in therapy? How do you make sense of the client’s behavior? What intervention would be in the best interest of the client? And what if you are a therapist-in-training and have never encountered such an offense before, but you must react in the moment without the benefit of your supervisor’s input and coaching? These questions were at the heart of the current study, in which we explored how therapist trainees respond to and manage feeling offended in psychotherapy.

Offenses can be understood as times when one feels displeased, insulted, morally outraged, or attacked; or as violations of a moral or social code (Merriam-Webster Online, n.d.). For this study, we were particularly interested in instances when the therapist felt offended due to differences or discrepancies between their own and their client’s cultural identities and values, given the historical importance of these topics to the field of counseling psychology (Fouad et al., 2004; Mintz et al., 2009; Patterson, 1958; Vera & Speight, 2003). Although we found no other studies about therapists feeling offended by clients in psychotherapy, we briefly present literature from related areas that guided us in conceptualizing and designing this study.

Feeling Offended as a Reaction to Microaggressions
Microaggressions are “brief and commonplace daily verbal or behavioral indignities, whether intentional or unintentional, that
communicate hostile, derogatory, or negative slights and insults that potentially have a harmful or unpleasant psychological impact on the target person or group” (Sue et al., 2007, p. 273). Indeed, researchers have demonstrated that microaggressions can have a significant negative impact on targeted individuals’ well-being and functioning (Sue, 2010). Feeling offended is a typical reaction to experiencing a microaggression (Constantine & Sue, 2007).

Although there is literature on microaggressions perpetrated by therapists (e.g., Owen, Tao, Imel, Wampold, & Rodolfa, 2014), we are not aware of any studies on microaggressions perpetrated by clients. This may be due to the therapist’s structural power compared to the client, as well as the fact that the majority of therapists hold privileged identities compared to their clients (Lin, Stamm, & Christidis, 2018). In addition, much of the psychotherapy literature mirrors societal privilege and oppression by operating from a white, heterosexist, masculine narrative of the therapist’s role (i.e., therapist is dominant within the therapeutic dyad; Hare-Mustin, 1994).

An exception to this general lack of research is a focus group study, in which therapists were asked about whether they would challenge a client’s prejudice (Spong, 2012). The author found that some therapists would challenge the prejudice so that they could feel congruent and because they felt it was a social responsibility, others would not challenge to avoid expressing disapproval and belief that it may be a distraction from the counseling process, and yet others would not be able to work with clients who expressed prejudice because they would want to maintain their self-respect and self-protection.

The Potential Influence of Cultural Factors in Feeling Offended

Clients and therapists have spent their lifetimes absorbing the beliefs, values, norms, and behaviors of their respective cultures through socialization processes, and the resulting beliefs are often implicit, unexamined, and assumed to be shared by all people (Maccoby, 2007). It is quite possible, therefore, that clients perpetrate culture-related microaggressions accidentally and without realizing they have done, resulting in feelings of offense when therapists who have been socialized into a different culture.

Relational analysts have recently called for examination of how sociocultural issues are mirrored in the therapeutic relationship, such that transference and countertransference can be examined in the context of social oppression and the client’s and therapist’s respective cultural identities (Tummala-Narra, 2015). Cultural countertransference represents the therapist’s reactions in relation to the client’s culture and identities (Gelso & Mohr, 2001). In addition, feeling offended may be the result of culture-based transferential processes. For example, a male client who was raised in a culture in which women are expected to be submissive to men might have a strong negative reaction to a female therapist who challenges him, which could understandably result in feelings of offense on the part of the therapist. Thus, cultural countertransference reactions may be implicated when the therapist feels offended by the client.

Within the multicultural counseling literature, Hook, Davis, Owen, Worthington, and Usrey (2013) suggested that therapists overcome the perspective that their own values and beliefs are superior to the client’s and instead embody openness with the client. Often, multicultural counseling theorists highlight the importance of acceptance, openness, and nonbias toward clients (Ridley, Ethington, & Heppner, 2008). However, Ridley et al. (2008) noted that although it is important to respect clients’ cultural values, it may also be important to examine and confront a client’s cultural impasses. Thus, culture-based microaggressions that are perpetrated by the client may prove to be fertile ground for future therapeutic work, particularly if they are managed with care.

The Potential Influence of Discrepancies in Values in Feeling Offended

We were also interested about therapists feeling offended related to their values. In the past several years, the therapeutic zeitgeist has shifted from an emphasis on neutrality to an understanding that it may not be possible for therapists to withhold their values in therapy (Jackson, Hansen, & Cook-Ly, 2013). Differences between clients’ and therapists’ values have been linked with greater client drop-out (Vervaeke, Vertommen, & Storms, 1997). On the other hand, differences in values can be used as a therapeutic tool, such as when therapists directly challenge client values that hinder their progress and mental health (Williams & Levitt, 2007).

Drawing on moral foundations research (Graham, Haidt, & Nosek, 2009), it is likely that some situations when therapists feel offended result from differing value foundations between the therapist and client. Offenses are likely to be particularly intense when the therapist’s values are deeply held. For instance, a White therapist might feel offended by a White client who expresses disagreement with the Black Lives Matter movement. Underlying this offense is the therapist’s value of justice and the client’s value of authority. Recognizing the value discordance that triggers an offensive event may help the therapist manage it effectively.

Ruptures and Rupture Repair

Therapists feeling offended by clients could be conceptualized as a rupture or tension in the therapeutic relationship (Safran & Muran, 2006; Safran, Crocker, McMain, & Murray, 1990). Although ruptures are of particular concern given their link with poor client outcomes and premature termination (Muran et al., 2009; Samstag et al., 2008), when therapists and clients repair ruptures and negotiate differences, positive psychological changes and a stronger working alliance can emerge (Binder & Strupp, 1997; Eubanks, Muran, & Safran, 2018; Safran & Muran, 2006). Most studies of the rupture-repair process have focused on clients experiencing a rupture as a result of something the therapist did. However, it is also important to examine ruptures that result from therapists’ reactions to client behavior to learn how therapists process these events.

In a recent qualitative study, Kline et al. (2019) investigated trainee therapists’ inner experiences during a rupture-repair process to better understand how trainees managed these events. During ruptures, trainees noted that they felt angry, frustrated, anxious, hurt, and devalued by the client as well as less self-efficacious. After ruptures, therapists felt more anxious about their subsequent work with their clients, but the work also became more productive, demonstrating that ruptures can have both negative and positive outcomes. Although this study made an important contri-
bution to the rupture literature by focusing on therapists’ inner experiences, it did not focus specifically on ruptures arising from therapists feeling offended by something clients did related to culture or values.

Countertransference and Countertransference Management

We speculated that therapists’ reactions to feeling offended could be related to countertransference, which can be defined as conscious or unconscious reactions to clients that are rooted in the therapist’s unresolved conflicts (Gelso & Hayes, 2007; Hayes, Gelso, Goldberg, & Kivlighan, 2018). These countertransferential reactions may sometimes be rooted in therapists’ own trauma related to injustice and fragility that may make it difficult to manage their reactions to offensive events perpetuated by clients. For trainee therapists, being unprepared for challenges related to countertransference can elicit feelings of being overwhelmed, which make it difficult to remain present during sessions (Gait & Halewood, 2019). Difficulties with countertransference may also make it difficult for therapists to attend to their clients’ needs, potentially putting clients at risk. Indeed, in a recent meta-analysis, Hayes et al. (2018) found a moderate relationship \( r = 0.39 \) between countertransference management and therapeutic outcomes.

Perez-Rojas et al. (2017) conceptualized two types of countertransference management: (a) understanding self and client, or therapists’ understanding of themselves and their empathic attunement toward clients, and (b) self-integration and regulation, or therapists’ ability to manage their anxiety by being grounded and not acting on it. Thus, when therapists are able to manage their anxiety, maintain appropriate emotional boundaries, and conceptualize clients’ presenting concerns and the therapeutic relationship, they are better able to serve clients’ needs (Gelso et al., 2001). Therapists feeling offended by clients may be a particularly potent test of trainee therapists’ ability to manage their countertransferential reactions and remain attuned to their clients. Given that clients may be enacting these offensive acts outside the therapeutic relationship, therapists can use their own reactions as a tool to share what may be happening in the room. Furthermore, supervision may serve as a useful space to manage and process countertransferential reactions (Gait & Halewood, 2019; Kernberg, 2019). Without such reflection, countertransferential reactions can be harmful to both the client and therapist, as therapists may act out these reactions and respond nontherapeutically (Agass, 2002; Gait & Halewood, 2019).

Present Study

Our purpose was to investigate instances in which therapists felt offended by their clients in relation to culture or values. Specifically, we wanted to learn about (a) the antecedents and types of events that were associated with the feelings of being offended, (b) how therapists reacted internally when feeling offended (including countertransference), (c) how therapists behaved in response to feeling offended, (d) how therapists felt about their responses, (e) how therapists conceptualized the events, (f) what therapists wished they would have done differently, (g) what barriers were to therapists implementing preferred actions, and (h) whether and how therapist trainees talked about their reactions in supervision.

We chose to study doctoral student therapists because they are in a formative period of their training. Therapist trainees often struggle with navigating such difficult scenarios (e.g., countertransference, multicultural concerns) given their lack of experience (Davis, 2002; Hill, Sullivan, Knox, & Schlosser, 2007; Sehgal et al., 2011).

Given the limited research on this topic and exploratory nature of the study, we analyzed the data using consensual qualitative research (CQR; Hill, 2012; Hill, Thompson, & Williams, 1997) to provide a rich description of the trainees’ inner experience of feeling offended by clients. CQR is appropriate because it is inductive, considers contextual factors, emphasizes culture, and relies on multiple perspectives (Hill, 2012). The philosophical foundations of CQR are constructivist in the belief that there is no “truth” but rather that people create their own reality, and postpositivist in the search for rigor and consensus among multiple judges (Hill et al., 2005).

Method

Participants

Therapists. Ten trainee therapists (five female, three male, one transgender man, one nonbinary masculine; five heterosexual, two gay, two queer, one preferred not to answer; eight White, two Asian/Chinese; age: \( M = 30, SD = 3.69 \)) in one counseling psychology doctoral program located in the Mid-Atlantic United States participated in this study. All trainees had at least one year of experience providing therapy at the time of the interview. Using a 5-point scale, where 1 = low and 5 = high, on average trainees rated themselves as adhering 4.05 \( (SD = 0.85) \) to humanistic/client-centered/existential, 3.80 \( (SD = 0.60) \) to psychodynamic/psychoanalytic, 3.30 \( (SD = 1.00) \) to multicultural/feminist, and 2.20 \( (SD = 0.75) \) to behavioral/cognitive orientations.

Each trainee discussed one of their cases with an individual therapy client. They reported seeing these clients in community clinics \( (n = 6) \) and college counseling centers \( (n = 4) \). The 10 clients (eight male, two female; four Black/African, three Asian, three White; all heterosexual) ranged in age from 21 to 70 years \( (M = 34.1, SD = 15.06) \).

Researchers. The researchers were five female counseling psychology doctoral students (one White, one Black, one Hispanic, one Asian, one South Asian; three heterosexual, one queer, one bisexual, aged 25 to 32) and one 70-year-old White, female, heterosexual counseling psychology professor. All research team members were from the same program as the therapist trainees. Using a 5-point scale, where 1 = low and 5 = high, researchers rated themselves as adhering 4.83 \( (SD = 0.37) \) to psychodynamic/psychoanalytic, 4.17 \( (SD = 0.69) \) to multicultural/feminist, 4.17 \( (SD = 0.37) \) to humanistic/client-centered/existential, and 2.50 \( (SD = 0.50) \) to behavioral/cognitive orientations. The six researchers developed the interview protocol together and served as both judges and auditors; the graduate student researchers conducted all the interviews.

Prior to data collection, the research team recorded their biases and expectations about the outcomes of the study to increase their awareness. For several, “isms” (e.g., racism, sexism, heterosexism) are bad, and some felt that clients who display “isms” in therapy should be educated to elevate their critical consciousness. On the
one hand, team members worried that they would be judgmental if trainees handled the event poorly, were not immediate with a client, experienced countertransference, or did not discuss feeling offended in supervision. On the other hand, team members thought that they would be sympathetic toward trainees given the difficulty of coping when feeling offended by clients. In terms of expectations, the researchers expected that trainees would feel most offended by “isms” (e.g., clients endorsing racism, sexism, or heterosexism) that racial and ethnic minority trainees would report more intense feelings of being offended but also have greater critical consciousness, and that trainees and interviewers would share similar values related to multiculturalism.

Interview Protocol

The interview protocol was developed by the research team on the basis of a literature review and the researchers’ reflections about their therapy and training experiences, particularly in terms of feeling offended by clients. The interviews were semi-structured to allow interviewers to gather consistent information across participants but also to probe individual participants in depth about personal experiences. Five pilot interviews were completed and changes were made to refine the protocol (see Appendix).

Procedure

IRB approval was obtained for the study after the interview protocol was finalized and before recruiting participants. 

Recruitment. Interviewers were randomly assigned to participants by a graduate student team member, but interviewers were not assigned to anyone with whom they had a potential conflict of interest. In an e-mail invitation, potential participants were told that the goal of the study was to learn more about events where trainees felt offended by something the client said or did related to culture or values. Participants had to be a doctoral student in the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program, 12 agreed to participate (most who declined could not assign themselves to the program). The therapist was thus in a minoritized position in relation to the client regarding the focal identity, even though the therapist was professionally in a position of authority. Importantly, the events were not personal attacks on the therapists’ competence or about the therapeutic relationship.
In several of these cases, a male client said something to which the female therapist took offense. In P5, the client said that he could understand why his uncle wanted to beat up his wife who said “horrible” things. In P6, the client said to his “whimpering, pathetic, and sulking” girlfriend to “behave properly.” In P3, the client made sexist, hostile comments toward women, calling his mother vulgar names and saying that “women who sleep around are slutty” and “deserve the bad things that happen to them.”

In other cases, a heterosexual male client said something that a gay or queer male therapist took to be offensive. In P9, while discussing the transgender bathroom legislation the client said, “I just really don’t think that men should be able to use women’s bathrooms,” called trans women “men,” and stated that trans people are mentally ill and need to be “fixed.” In P10, the client said that the country is moving in the wrong direction in terms of LGBTQ+ issues.

In yet other cases, gender identities (i.e., male client/female therapist) intersected with racial/ethnic differences. In P7, a Chinese male client revealed to his White female therapist that he lost his temper when his girlfriend was “sort of childish” and “needed to be taken care of.” In P8, an African American male client told

<table>
<thead>
<tr>
<th>Table 1</th>
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<tbody>
<tr>
<td><strong>Domains/Categories/Frequencies</strong></td>
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<tr>
<td><strong>Domains/categories/subcategories for offenses in therapy</strong></td>
</tr>
<tr>
<td>Therapeutic relationship before the event</td>
</tr>
<tr>
<td>Strengths in the therapeutic relationship</td>
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<tr>
<td>Challenges in the therapeutic relationship</td>
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<tr>
<td>The event associated with the therapist feeling offended</td>
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<tr>
<td>Affront to therapist’s identity</td>
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<tr>
<td>Affront to therapist’s beliefs about gender equality</td>
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<tr>
<td>Affront to therapist’s beliefs about equality based on sexual orientation</td>
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<tr>
<td>Affront to therapist’s beliefs based on the intersection between gender and race/ethnicity</td>
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<tr>
<td>Affront to therapist values</td>
</tr>
<tr>
<td>Therapist internal reactions to the offense</td>
</tr>
<tr>
<td>Shocked</td>
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<tr>
<td>Confused</td>
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<tr>
<td>Negative feelings toward client</td>
</tr>
<tr>
<td>Frozen</td>
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<tr>
<td>Negative feelings toward self</td>
</tr>
<tr>
<td>Countertransference based on identities (gender/LGBTQ/age/religion)</td>
</tr>
<tr>
<td>Therapist Interventions Immediately After Offense</td>
</tr>
<tr>
<td>Did not directly tell client feelings about offense</td>
</tr>
<tr>
<td>Helped client explore situation and gain a new perspective</td>
</tr>
<tr>
<td>Managed emotions through intellectualization/conceptualization</td>
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<tr>
<td>Tried to be present/empathize/understand</td>
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<tr>
<td>Therapist Feelings about How They Behaved During the Event</td>
</tr>
<tr>
<td>Bad feelings</td>
</tr>
<tr>
<td>Satisfied</td>
</tr>
<tr>
<td>Therapist Gained a New Conceptualization of Client Offense was related to identity/cultural norms</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Race/ethnicity</td>
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<tr>
<td>Sexual orientation</td>
</tr>
<tr>
<td>Religious differences</td>
</tr>
<tr>
<td>Offense was related to socialization about identities and cultural norms</td>
</tr>
<tr>
<td>Offense was related to client attachment insecurity</td>
</tr>
<tr>
<td>Offense was related to client toxic masculinity</td>
</tr>
<tr>
<td>Offense was related to client lack of empathy</td>
</tr>
<tr>
<td>Offense was related to client feeling out of control</td>
</tr>
<tr>
<td>Therapist wishes they had been able to process event with client</td>
</tr>
<tr>
<td>Barriers to preferred actions</td>
</tr>
<tr>
<td>Feared relationship was not strong enough to tolerate discussion of event</td>
</tr>
<tr>
<td>Therapist lacked skills</td>
</tr>
<tr>
<td>Therapists’ need to protect selves</td>
</tr>
<tr>
<td>Focus needed for other topics</td>
</tr>
<tr>
<td>Supervision</td>
</tr>
<tr>
<td>Sought supervision</td>
</tr>
<tr>
<td>Supervisor was supportive and helpful</td>
</tr>
<tr>
<td>Supervisor provided options or conceptualization</td>
</tr>
<tr>
<td>Didn’t bring up the offense</td>
</tr>
<tr>
<td>Therapist experience of the interview</td>
</tr>
<tr>
<td>Some distress in interview</td>
</tr>
<tr>
<td>Felt helpful</td>
</tr>
<tr>
<td>Shared identities facilitated interview</td>
</tr>
</tbody>
</table>

**Note.** G = general; T = typical; V = variant.
Table 2
Demographic Characteristics of Therapists and Clients

<table>
<thead>
<tr>
<th>Client</th>
<th>Client demographics</th>
<th>Therapist demographics</th>
<th>Offensive event</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>36, Female, White, Heterosexual</td>
<td>26, Transgender male, White/Western European, Queer</td>
<td>Client accepted two job offers. She planned to work at one job for 6 mo., and then quit and start second job</td>
</tr>
<tr>
<td>P2</td>
<td>50, Female, Black, Heterosexual</td>
<td>34, Male, White/German/Polish, Heterosexual</td>
<td>Client commented that, according to her religious beliefs, same sex relationships were sinful</td>
</tr>
<tr>
<td>P3</td>
<td>23, Male, White, Heterosexual</td>
<td>28, Female, White, Heterosexual</td>
<td>Client made inappropriate comments towards women</td>
</tr>
<tr>
<td>P4</td>
<td>22, Male, Asian American/Chinese, Heterosexual</td>
<td>33, Male, Asian American/Chinese, Gay</td>
<td>Client made a comment about someone being gay and being okay with it as long as person didn’t “hit” on the client</td>
</tr>
<tr>
<td>P5</td>
<td>21, Male, Asian/Indian, Heterosexual</td>
<td>31, Female, White/German/English, Heterosexual</td>
<td>Client shared that he can see why men are emotionally abusive towards women</td>
</tr>
<tr>
<td>P6</td>
<td>26, Male, African, Heterosexual</td>
<td>38, Female, White, Heterosexual</td>
<td>Client made a comment about needing to take care of his girlfriend “whimpering”</td>
</tr>
<tr>
<td>P7</td>
<td>24, Male, Asian/Chinese, Heterosexual</td>
<td>29, Female, White/Prefer not to answer</td>
<td>Client pushed his ex-partner to the ground in front of their daughter</td>
</tr>
<tr>
<td>P8</td>
<td>42, Male, African American, Heterosexual</td>
<td>28, Female, White/Non-Hispanic, Heterosexual</td>
<td>Client made comments about legislation around bathroom bills and against trans people</td>
</tr>
<tr>
<td>P9</td>
<td>27, Male, White, Heterosexual</td>
<td>25, Non-binary masculine, White, Queer</td>
<td>Client made a comment about how he believed that LGBT people shouldn’t get married</td>
</tr>
<tr>
<td>P10</td>
<td>70, Male, African, Heterosexual</td>
<td>32, Male, Asian/Hong Kong Chinese, Gay</td>
<td></td>
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</table>

and his White female therapist that he pushed his ex-partner to the ground in front of their young child.

**Affront to therapist’s values.** In the final two cases, the offense was related to differences in values, where the therapists perceived themselves to be more ethical or progressive than their clients. In P1, the female client told the male therapist about her job search. After having signed a contract for one position, she interviewed for and also took a second position, planning to work at the first job for a short time and then quit to go to the other one. The therapist felt that it was dishonest to manipulate the employers so blatantly. In P2, there was an intersection between race/ethnicity, religion, and gender differences. The African American female client made comments to the White male therapist suggesting that she was prejudiced against LGBT people because of her religious identity, “I sort of view same-sex relationships as different, sinful, not okay because of my religious beliefs.”

**Therapists’ internal reactions to the event.** Therapists were generally distressed by the events. They reported feeling shocked and having strong visceral reactions to the clients’ statements. They felt surprised, taken off guard, disbelieving, tense, threatened, and afraid. P4 said, “It’s kind of like a bit of a slap in the face where you’re like ‘wait what just happened?’” P1 felt “a little bit of a heart stop of like ‘oom’.” They also generally felt overwhelmed, stuck, and unsure about what to do next. P7 was uncertain about how to confront the client in a therapeutic way, especially because she was unclear about her role in the situation and how to address the cultural elements of the offense in only eight sessions of therapy. P8 was unsure “where to go or what to do with [the client],” she questioned “how to remain empathic” without seeming as though she supported the client’s violent behavior toward his ex-partner. P9 was confused and wondered if the client “perceives me as a queer person.” P4 was not sure how to react, so his initial instinct was to not react but he worried about whether that was appropriate (“I knew it felt like a bit of a slap in the face to me personally but I was questioning what was appropriate in terms of a therapist’s reaction to him”).

Furthermore, therapists typically felt angry and hostile toward the clients, as well as hurt and betrayed by them. P5 felt “disgusted, anger, visceral... was like ‘Yuck.’” P3 was scared of the client during the event and thought, “I need to deescalate this” given that “the level and intensity of his anger was very threatening.” P9 felt betrayed and hurt by client, “after all of the work that we did,” and felt disgusted with the client (“I’m sure that when he said it I made a face at him, a face of judgment, of disgust maybe”). Another typical reaction was feeling frozen or paralyzed, holding back feelings out of fear, shock, and confusion. P10 felt “frozen... and anxious, like what should I say” when the client talked about not being accepting of LGBTQ rights or people. When hearing the client’s angry and disparaging comments about women, P3 felt unsafe and “shut down” and dissociated. She remembered that she “almost looked... like a zombie... just leaning back in my chair, my hands were here almost like I was bracing.” P4 felt his “protective mechanisms kicked in” so he “dissociated from it and intellectually understood it and moved away from it.”

Variantly, therapists had negative feelings about themselves. P2 felt discomfort and “guilt” due to growing up religious and noted that these feelings contributed to his “avoidance of the topic” and judgment. P7 felt like she was complicit in sexist statements, stating, “It didn’t feel good. It felt like I’m somehow... you know when you’re colluding kind of.”
Countertransference Reactions to Event Based on Identities

Perhaps not surprisingly given that they felt shocked, frozen, and confused, therapists indicated that their feelings were triggered by countertransference generally related to their identities. For P2, the event triggered reactions tied to his experiences growing up in a Christian church, where he had learned the same messages as the client had about same-sex relationships.

It touched a lot of perspectives I’ve held in my life and so a lot of my discomfort I think could be about the notion “Oh this was me” like I learned these in a certain way growing up and a part of that religious community I could see why individuals develop those beliefs even though my religious community was probably different than my clients. But I also think that I have a little bit of guilt or sense about those beliefs that contributed to my avoidance of the topic.

P3, a female therapist, felt that the male client wanted her to stay in a submissive position because he felt threatened “anytime a woman really expressed herself” and would get “rageful and so intense,” which made her “coil up into a turtle shell.” She later connected this to her “own history of being in an unhealthy, abusive, romantic relationship. But . . . didn’t connect it to [the client], then . . . until months after the incident.” P4’s client’s comment about not wanting gay people to “hit on” him reminded P4 about his painful high school experience, during which he felt misunderstood because peers would say things like “gay is something you can catch if someone hits on you.”

Therapist Interventions Immediately After Feeling Offended

Typically, therapists did not address the offense directly in the moment with the client. Some therapists changed the topic, others ignored it, and others addressed the topic but not their feelings (see next sections). They did not feel good about the decision to not reveal their feelings but rather felt frozen and unsure about what to do (see earlier section on internal reactions). P1 “intentionally moved on from the topic,” which was “the most genuine” he could just listening the best as I can, and trying to be present with, empathize with, and understand the client. P2 diverted the attention away from the offensive comment and did not return to it, because he “wasn’t feeling particularly equipped to do that at the moment.” He just wanted to “move away and not come back to this.” P10 did not challenge the client in the moment but had a lot of reactions (“I think outwardly what I was presenting myself which is basically just listening the best as I can, and trying to be as present as possible, but I could definitely remember feeling more disconnected”).

In contrast, a typical and seemingly adaptive intervention was, despite feeling shocked and unsure, to try to help the client think about the topic (as opposed to the offense) and understand it in a new way. Notably, instead of addressing their personal feelings about the offense, these therapists focused on helping the client reflect on the topic that they were discussing so that the client could explore and possibly come to understand underlying dynamics. P8 asked follow-up, clarifying, and exploratory questions to “get a sense of how it was impacting him now in the present.” P1 tried to withhold judgment as he helped the client explore her potential reasons for committing the offense (i.e., taking two jobs at once). He felt like he “was being nice a little bit. I mean, it’s one of those things that I wanted to believe that there was a rational reason, so I kind of withheld judgment internally being like ‘okay, let’s explore that.’” P6 asked leading questions to suggest “a different way of seeing” the situation with the client’s girlfriend. P8 tried to help the client “reconstruct this story and reconstruct this memory . . . [using] a few restatements, a lot of questions, just questioning about how he felt, what he was thinking, the sequence of events, just getting the story straight, for me and for him, and trying to think about and process the impact on his life currently.”

Another typical intervention was for trainees to manage their own emotions through intellectualization and conceptualization. In other words, they defended against and tried to avoid their negative feelings by being cerebral. P1 wondered about the meaning of the event and was curious as to what his “supervisor will think. What does this mean?” He wondered, “Should I have been offended by that? Or am I just crazy?” For P4, realizing that the client was socially inappropriate helped the therapist process the event differently and not take it personally:

He said what was on his mind. His thoughts could be overly simplistic . . . He was developmentally delayed in some ways . . . People, by this level . . . discrimination definitely exists, prejudice definitely exists, all these “-isms” exist, but people have learned to be more sophisticated about them. They’ve learned how to hide them. This guy has never learned that. So it is very much related to his issues. He’s socially inappropriate in a lot of settings.

An additional variant therapist intervention was trying to be present with, empathize with, and understand the client. P5 focused on feelings of anger and abandonment by the client’s father and the pain that was caused to the client by his uncle. The therapist “was really focused on showing empathy” and encouraging her client to “emote around those experiences.” P10 felt empathetic, listened, tried to be present, and “was trying to just offer support.”

Therapists’ Feelings About How They Behaved During the Event

Therapists generally felt badly about how they had reacted during the event. They were critical of themselves and had regrets. P5 felt inauthentic, stating “I was concealing part of myself, so I would say I was less authentic than normally because I think that something I really do a lot of and prioritize is sharing my reactions in the moment with clients.” P3 felt “partly powerless and partly just disappointed” with herself and wished she “would’ve been more assertive in the moment.”

Despite having reservations about their interventions, therapists variably felt some satisfaction with some aspects of their responses in the moment. P6 felt positively about asking the client to explore different perspectives because she was not sure that processing the event would have been helpful given the client’s cultural and gender identities and relationships with women (“Maybe there are different expectations for him about what it means to be, you know he’s thinking a lot about being in a family and being the man of the family and having a wife and the role that she’ll play”). P8 thought she did the best she could “at that moment” given her lack of experience and thus felt “a little bit of self-compassion” and pride that she was able to “maintain a therapeutic stance and continue asking questions and reflecting.”
Therapists Gained a New Conceptualization of Their Clients

Therapists all tried to make sense of why clients would say or do such an offensive thing, and thus gained a new understanding of their clients. By conceptualizing the problem and understanding the client’s dynamics, therapists were able to accept and work with the clients. In other words, the event provided new information that forced the therapists to rethink their conceptualizations of the clients and the therapy relationship. Within this general category, there were several subcategories.

Therapists generally conceptualized that they reacted as they did to clients’ behaviors because of cultural differences between them. More specifically, therapists typically cited gender differences (e.g., client’s anger and aggression was related to client’s male identity, P5), typically cited race/ethnicity differences (e.g., client’s attitudes toward women were related to his Chinese upbringing, P7), variantly cited sexual orientation differences (e.g., supervisor suggested that homophobic client may have been triggered by feeling close to a masculine presenting queer person, P9), and variantly cited religious differences (e.g., religious client who gave advice to therapist, P2).

Therapists also typically conceptualized that clients behaved as they did because of their socialization, because they had been brought up to act in an inappropriate, and perhaps bigoted or biased, way. P6 considered that the client had grown up in a culture that did not value women, such that he was “brought up to think about male-female [dynamics] and their relationships” and “the cultural norms around the ways that men and women interact” in his country of origin. Similarly, P2 believed that the client’s negative views about LGBT people were related to her race and religion, stating that her opinions might have been shaped by “her religious community or . . . the black community; there’s a different stigma towards the LGBT individuals.”

Another typical conceptualization was that the client acted out because of insecurities or difficulties stemming from attachment problems in childhood with parental figures, which led to difficulties in current interpersonal relationships. P6 believed that the client felt a “very strong feeling of being completely let down and abandoned by his family,” which led to his offensive comment about women because it “connected to . . . his own empathy that he’s . . . cut off because he’s been so hurt.” Because P1 conceptualized his client as not having “a lot of emotional support from her childhood” and tending “to push people away pretty easily,” he could understand “how [the client] could get into that mindset of ‘I got to watch out for myself,’” leading to her decision to manipulate or leverage her employment situation without concern for how it might impact others.

Furthermore, anger was typically cited as a reason for the client’s behavior. Thus, therapists conceptualized that their male clients had a lot of anger and hostility and perhaps had been taught that it was acceptable for men to be aggressive. Four of the therapists in this category were women and the other two were gay men and all seemed to be particularly sensitive to expressions of anger. P5 stated that “my client [was] carrying around a lot of anger and resentment and feelings of aggression towards others,” which may have been related to the “ways in which he’s internalized this toxic masculinity stuff.” P3 said her client “was just so angry” and would “act out in this super mean way” toward women who “had some power, who were kind of assertive or kind of dominant or who he felt took away some of his masculinity.”

In a variant category, therapists conceptualized that the client’s behavior resulted from a lack of empathy on the client’s part. That is, the therapist believed that the client was not socially aware enough to know how their actions would affect the therapist. For example, P1 stated of the client, “There’s no sense of regret or even social awareness” and “She doesn’t recognize the feelings of others very well.” P4 thought that the client might have an Autism Spectrum Disorder because he had “trouble connecting with people . . . he was very blunt, he said what was on his mind . . . even if [most people] have some homophobic tendencies . . . they have learned to at least not state them so bluntly . . . this [client] has never learned that.”

In this final variant category, therapists conceptualized that clients were acting out because they were overcompensating for feeling a lack of control. P8 thought that the client harmed the ex-partner because “he didn’t have control . . . that’s not the kind of person that he is . . . he doesn’t want to be violent.” P10 thought the event was related to the client trying to “get a sense of control” in reaction to a traumatic loss.

Therapists Wished They Had Been Able to Process Event

Therapists generally wished they had been more direct with clients about feeling offended and then processed the event with the client so that it could have been used therapeutically. P10 wished he had been able to turn the event into an educational experience and let the client know that such comments about LGBT people can be harmful. The therapist thought it could have been an important conversation to have from a multicultural perspective, to educate his client that what he said “might actually be somewhat maybe harmful to other stigmatized populations.” Furthermore, this therapist stated that “even if it’s not related to his presenting concerns . . . from a multicultural and diversity perspective, given also the differences and similarities I share or don’t share with my clients, that might be an important conversation to have.” P4 wished that he had “consulted with someone who . . . knows how to have conversations about homophobia and addressing that” in a way that would bring it “into the session appropriately.” P8 asked a lot of clarifying questions in the moment but wished she would have been more “present and more aware” so that she could have felt her reactions “in that moment.” Additionally, this therapist wished that she had asked more about the client’s feelings, had been able to identify more with the client in the moment, and most importantly, that she “could’ve responded more empathically” because “that piece was missing, because I just felt so distant from the client.”

Barriers to Preferred Action

Therapists typically did not do what they wished they had done because they feared negatively impacting the therapeutic relationship. The therapists either thought that the relationship was not strong enough or that the discussion would damage the relationship. These barriers illustrate what therapists might have been intuiting when they felt shocked, confused, frozen, stuck, and overwhelmed. P1 felt scared about offending the client, harmning
the relationship, or “provoking a transferential reaction.” P3 felt fearful that responding to the offense in the moment would cause the therapist to get more “rageful and so intense” and have thoughts of terminating if they could not get through it. P6 thought the relationship was not strong enough for a challenge and was unsure of the “value of being more direct and inserting what could have felt like a judgment.”

A second typical barrier was therapists thought they lacked the skills or confidence to be able to therapeutically address the offense. RS2 noted her inexperience as a therapist and that her “uncertainty of how to respond . . . and inability to recognize the countetransference and manage it in that moment” prevented her from knowing what to do. Similarly, P9 was not more immediate due to being a trainee and not being sure how to respond. For P10, this was the first time he had worked with older adults and was still working on his own “developmental process as a clinician to assert [his] voice in the therapy room.”

Another typical barrier to addressing the offense was the need for therapists to protect themselves. For example, P8 was worried about handling the client’s rage, feeling “a little bit concerned or a little bit worried” for herself because she was “in this room with this man who committed violence in the past . . . against a woman.” P2 felt like she had to avoid the topic due to her “emotional reactions and judgments” to the client’s Christian beliefs and identity.

An additional typical barrier was that therapists thought that other topics were more important to discuss. P5 wanted to stay with the client’s sharing about a trauma because the client had not explored this before, and bringing up her reaction to the offense would have shifted the focus to the therapist instead of the client. She stated, “If I need to go emotionally process being offended, I’ll go and do that in my own therapy.” P7 let the event go because “there was just a lot going on” in the work and they were working within a time limit of 8 sessions; the therapist “didn’t feel like the client had enough time in the space to do anything different,” and that focusing on the client’s emotions was more important. P4 thought that addressing the topic “wasn’t worth the effort” on a personal or therapeutic level given that there were other things that needed focus, and the therapist did not want to open up “raw emotions in having to process all this” that seemed more personal than related to the client.

Supervision

All therapists were in supervision at the time of the offense. Typically, they sought and got helpful support and guidance from their supervisors about the offense. A few, however, did not seek help from their supervisors, either because they did not think the supervisors could help them or because they thought the offense was not serious enough to merit time in supervision.

Therapists typically talked to their supervisors about the offense in their attempt to make sense of and figure out what to do about it. When trainees talked in supervision about feeling offended, supervisors typically were understanding and nonjudgmentally allowed therapists to talk about the event and vent their feelings. P7 felt validated in supervision because of the shared connection of both being women dealing with a male client who “evoked emotions within her and me and both of us being women, we kind of connected over that.” P9 processed the event during several supervision sessions, including an emergency session, and the supervisor responded empathically and supportively. He recalled “bawling in [the supervisor’s] office” about the experiences of and violence against trans people, and that the supervisor “let me process that.” P10’s supervisor empathized and validated the trainee’s reactions to the offense, which helped the trainee feel “validated but at the same time we were able to talk about how to conceptualize all this.” Supervisors also typically helped trainees figure out what was going on with the client and what to do differently in sessions. P7’s supervisor helped her [trainee] consider how the client’s familial and cultural expectations to take care of women in his life “are so engrained in how he views himself.” P9’s supervisor provided a possible conceptualization that helped P9 find empathy for the client, and then role-played with P9 about how to talk about the event in later sessions.

Therapists variantly did not bring up their feeling offended in supervision, often because there were other cases that needed more attention (e.g., P5 said “I thought about if I wanted to spend time on that in supervision, and then I decided that I did not because I had 20 people in my case load” and that she “wasn’t really stressed about it” and wanted to spend the time in supervision focusing on other clients). For another therapist, the offense was not important enough to warrant time in supervision (e.g., P4 said, “Some other client’s needs took up most of supervision that week”).

Therapist Experience of the Interview

Therapists generally said that they felt some sense of distress or discomfort in the interview. P2 said it was difficult to talk about the event because “it’s a very confusing experience,” and felt that he “could’ve done something differently, part of me feels regret.” In the back of his mind, P4 assumed the interviewer “was open and empathic person” but stated that “being gay, there’s always a bit in your mind, you’re like ‘Huh, I wonder just how openly—I wonder just how open and accepting someone is.’” At the same time, therapists typically said that it felt helpful to talk about the experience. P6 said it was helpful to “reflect on and talk about the client . . . indicative of the tension that I feel with this client.” P10 appreciated the questions and said that it felt “good to kind of reflect back on the incident.”

Finally, therapists also typically noted that it was easy to talk to the interviewer because of shared identities. P5 said that it was easy because of “shared female identities . . . possibly the same values” coming from the same doctoral program. P3 similarly noted that she would have been “a little uncomfortable” with a male interviewer who might superficially have understood but “kind of minimized it like ‘it’s not that big of a deal’” about being a woman responding to male aggression. P2 said that “entering racial conversations with another White person” made it easier for the therapist to discuss the racial/cultural differences with the interviewer.

Discussion

We interviewed 10 doctoral students about their experiences of feeling offended by a client in relation to culture or values. Importantly, the interviewers and participants were all doctoral students in the same counseling psychology program. This familiarity helped interviewees feel safe and understood because of their
shared professional identity, but interviewees also reported feeling some distress and vulnerability in the interviews because of the delicate nature of the topic.

The most exciting story that emerges from these data is how these therapists-in-training, who cared passionately about multicultural issues and social justice, negotiated a working relationship with clients who held different identities and values. In therapy, we hope that our clients will express themselves openly and honestly, and yet when they do, they sometimes say things that offend us. These therapists wanted to be warm, accepting, and nonjudgmental, and yet sometimes felt shocked, violated, and judgmental. The intensity of this internal struggle is a powerful reminder of the difficulties of negotiating boundaries and managing countertransference feelings, particularly among trainees.

Antecedents, Event, and Subsequent Process of the Offensive Events

Our results demonstrated that societal power, privilege, oppression may be reenacted in the therapeutic relationship. Although two therapists reported feeling offended due to discrepancies in values, the majority of therapists felt offended due to a client’s comment related to their minoritized social identities. These comments left therapists feeling shocked, confused, and frozen, perhaps because they felt that the event was an invalidation or rejection of themselves. Further, the event may have served as a painful reminder of the therapist’s lived experience with social inequality. Some therapists felt negative feelings toward the client, and a few felt negative feelings toward themselves such as feeling disregarded, dehumanized, or guilty. These reactions mirror systemic issues of power and oppression, as people feel dehumanized when others undermine their identity (Bastian & Haslam, 2011). Even if therapist trainees reported a strong therapeutic relationship before the event, the offensive event often changed the status quo.

Understandably, these events triggered therapists’ countertransference rooted in social oppression (Tummala-Narra, 2015). For instance, client behavior that was seen as a manifestation of toxic masculinity triggered feelings of inferiority, thoughts about the “Me Too” movement, and the perception of objectification for some female therapists. In the moment, therapists typically did not directly tell clients that they felt offended and did not process their immediate interpersonal discomfort. Rather, some therapists helped their clients explore the situation and gain new perspectives, while others focused on managing their own emotions. Although these responses are an understandable reaction to in-the-moment fear, they may have perpetuated dominant societal narratives of staying silent.

It is important to note that the demographic characteristics of the therapists in our sample (most were White, and half were women) likely influenced their experience of feeling offended by their clients. First, participants were likely more attuned to potential offenses related to their minoritized identities (in this case, gender) and less attuned to offenses related to their majority identities (in this case, race). Thus, a more diverse sample of therapists might have recalled being offended in relation to a different or more varied set of cultural identities and values than the current sample. Indeed, it is notable that offenses related to race did not emerge as an independent category in our study, given the charged political climate as related to race in the United States. In addition, the demographic characteristics of the sample may have influenced how the therapists reacted internally and externally to the offensive event. Research suggests that White women are socialized to be passive, agreeable, and “nice” (Bramen, 2017) and that they are particularly likely to avoid conflict related to race, in part to protect their own racial privilege (Hurtado, 1989).

After the Offensive Event

When reflecting about the event, most of the therapists were distressed. They felt regret, were critical of themselves, and felt that they had been inauthentic. It is possible that the therapists had competing motivations in the moments after the offensive event. On the one hand, they may have wanted to be authentic and immediate, to share their genuine reactions, and to challenge oppressive acts. On the other hand, they may have been anxious about their own safety and concerned about speaking up given that many of these clients held privileged identities. A few therapists felt relatively satisfied with some aspects of how they handled the situation. These therapists may have felt more self-compassion toward themselves or may have perceived themselves to be more efficacious in responding.

As a result of the event, therapists gained a new understanding and conceptualization of the client. They generally conceptualized the event as being related to cultural differences (e.g., gender, race/ethnicity, sexual orientation, religious differences). In some cases, therapists believed that power dynamics may have played a role given that the clients were male and the therapists were female. Relatively, research has shown that client-therapist match on identity variables (e.g., language, ethnicity, race, gender) is linked with lower dropout, increased number of sessions, higher working alliance, and higher client functioning (Chao, Steffen, & Heiby, 2012; Flaskerud & Liu, 1991; Ibaraki & Hall, 2014; Russell, Fujino, Sue, Cheung, & Snowden, 1996).

Therapists also typically conceptualized the event as being due to the client’s identity-related socialization and to toxic masculinity. This conceptualization is consistent with identity theory, which suggests that people internalize various social roles (Stryker & Burke, 2000). For example, some clients may have been socialized in heteronormative ways. Similarly, some men may have learned from an early age that masculinity means having power over women, being emotionally unavailable, valuing independence, and being physically tough (Amin, Kågesten, Adebayo & Chandra-Mouli, 2018).

Therapists also typically cited attachment insecurities as a reason for the client offense. For example, one client felt abandoned by his birth father, and thus developed a false independence and looked down on others, including his girlfriend, and may have also enacted this dynamic in the therapeutic relationship with his female therapist.

Lastly, some therapists believed that the offense was related to the client’s lack of empathy or the client feeling out of control. For example, a therapist believed that the client had difficulties in connecting with others, was too direct and judgmental, and did not realize that they had the ability to hurt others. Similarly, Fiske (1993) argued that stereotypes are a form of controlling others while maintaining power.

Looking back, therapists wished that they had been able to process the event and use it more therapeutically. They wished
they had been direct about the offense, turned the event into an educational experience, been more genuine, or used the event to explore the client’s core concerns. Similarly, other researchers have found that therapist immediacy (i.e., talking directly about feelings related to the therapeutic relationship in the moment) can be helpful in the development of insight and a stronger therapeutic relationship (Hill et al., 2008; Hill et al., 2014; Hill, Knox, & Pinto-Coelho, 2018).

In the moment, therapists’ fear may have prevented them from enacting a more preferred response to the offense (e.g., being direct). Therapists typically feared that the relationship was not strong enough to tolerate discussing the event, worried that they lacked skills, wanted to protect themselves, or wanted to focus on other topics with their clients. Directly addressing ruptures may be uncomfortable and threatening and can activate competency issues (Safran et al., 1990). Given that our sample only included trainees, they may not have been emotionally or intellectually ready to be immediate with their clients. In addition, there can be consequences when those with minoritized identities take a stand against privilege and power.

Typically, the therapists sought supervision, and the supervisors were supportive and provided options or conceptualization to help the therapist understand the event. When working with clients who express discriminatory views, constructive clinical supervision is one way to help trainees engage in critical reflection and understanding of the client’s perspectives and their own personal reactions (Guifrida, Tansey, & Miller, 2019). Effective supervisors teach trainees to be responsive to clients when ruptures occur; supervisors may directly teach the client this skill or model alliance repair (Friedlander, 2015). Positive supervision also requires that trainees feel safe, supported, and protected within the supervisory relationship and consequently, feel able to disclose more regularly (Knox, Edwards, Hess, & Hill, 2011; Singh-Pillay & Cartwright, 2019).

Some therapists, however, did not bring up the event to their supervisor. In these cases, therapists felt like other cases or topics were more important, did not feel supported by the supervisor, or did not feel the need to process the event in that moment. Similarly, others have found that trainees withhold information due to fear of judgment, evaluation, power dynamics or the dismissal of their concerns by supervisors (Boyle & Kenny, 2020; Singh-Pillay & Cartwright, 2019). It is possible that a parallel process is at work: therapists struggle with being direct with both their clients and their supervisors.

Limitations

Although this study provides a novel understanding of a unique experience that may be difficult for therapist-in-training, there are some limitations that should be noted. First, our sample size was relatively small, although finding mostly general and typical results indicates that there was convergence in themes across participants. These consistent results were probably the result of a fairly homogenous sample (e.g., mostly White doctoral students holding a psychodynamic/interpersonal theoretical orientation), and thus may have influenced the results with their shared training experiences. For example, racial-ethnic minority therapists or CBT therapists may have different responses to feeling offended.

In addition, our sample only included doctoral student trainees, who may have had stronger emotional reactions than experienced therapists would have (Brody & Farber, 1996). Future researchers should examine whether results differ with therapists of different professional and personal identities. Lastly, given that our participants were all in the same doctoral program, it would make sense to examine the experiences of trainees in other programs to explore which results are consistent and different across programs.

Additionally, we note that the therapists and researchers were all from the same doctoral program. Although credibility may have been established with the use of peer researchers and interviewees shared deep and personal experiences, they may have felt held back from full disclosure given the potential limits to confidentiality (Morrow, 2005) and multiple relationships (Haverkamp, 2005).

Implications for Training, Practice, Supervision, and Research

Given our finding that therapists often felt offended by identity-related events, there is a continued need to focus on multicultur-alism in psychology training programs. We suggest that practicum instructors develop modules for working with offensive situations and working with clients from different cultural and values backgrounds. Instructors could help trainees practice and become more confident in their ability to discuss difficult topics with clients, while also inviting discussion of their own experiences related to societal oppression.

Notably, several trainees found supervision to be a helpful space to process their reactions toward clients. They reported that supervisors were generally understanding, supportive and validating, and helped them gain a deeper understanding of the clients. We were troubled, however, that not all participants felt comfortable talking to their supervisors about the offenses. We suggest that supervisors should be tuned in to trainee therapists’ potentially strong reactions to clients from different cultural/values backgrounds. Supervisors should initiate conversations about how trainees are reacting to their clients, especially if clients hold privileged identities. Similarly, supervisors from different cultural backgrounds than their supervisees can model talking openly about such concerns.

In terms of future research, these findings need to be replicated with doctoral student trainees from other programs and with more diverse samples in terms of gender, race/ethnicity, and theoretical orientation. Researchers could also examine differences between therapists who often have felt offended by a particular client compared with only a single instance of feeling offended, whether there are difference between trainee and experienced therapists in how they handle feeling offended, and use other data sources such as focus groups (Morrow, 2005).

References


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(Appendix follows)
Appendix

Interview Protocol

Instructions: In this study we are specifically examining events when therapists have felt offended by a client and had a strong immediate reaction. The offending event may be related to culture (e.g., a therapist may recall an incident when a client made an antisemitic or a heterosexist comment) or values (e.g., when a client describes committing a violent act or describes having cheated on a romantic partner). Pick an event that you remember well, preferably within the last year, when you felt offended and had a strong reaction.

Background

Tell me briefly about the client and your relationship. (probe for presenting problem, client dynamics, and salient history)

Event

Tell me about the event with this client when you felt offended. (only go into one example in detail)

What was your reaction (e.g., feelings/emotions, thoughts, physical reactions etc.)?

What did you do or say when this occurred? (probe for immediate vs. later in the session)

How did you feel about your response in that moment? (Probe for genuineness and authenticity)

How did you feel about the event after the session and before supervision?

Supervision

How did you address this event in supervision?

If you didn’t, why not?

○ If you did, how open were you about exactly what happened and your thoughts and feelings about what happened?

□ How did your supervisor respond to this event?

□ How did you feel discussing this with your supervisor?

Consequences

□ How did this event impact your view of the client?

□ How did this event impact your relationship with this client in subsequent sessions? (probe for changes in process, probe for ambivalent feelings)

□ How did you make sense of this event in the context of the client’s core issues?

□ What countertransference reactions (i.e., reactions due to past events that were stirred up) did you have that were triggered by this event?

□ What role did culture play in the event? (probe for both therapist and client culture)

□ After you have reflected on this event, what do you wish you had done or said in that moment? (probe for either immediately or in a later session)

□ What do you think stopped you from doing or saying what you think you would have liked to have done or said?

□ How does it feel to share this with me now?

□ Is there anything about my cultural identities that make it easier or harder to share this with me?

□ What do you think about this event now? (probe for any lingering thoughts or reactions)