

Prejudiced Patients: Ethical Considerations for Addressing Patients' Prejudicial Comments in Psychotherapy

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Psychologists will often encounter patients who make prejudiced comments during psychotherapy. Some psychologists may argue that the obligations to social justice require them to address these comments. Others may argue that the obligation to promote the psychotherapeutic process requires them to ignore such comments. The authors present a decision-making strategy and an intervention based on principle-based ethics for thinking through such dilemmas.

Public Significance Statement

This article identifies ethical principles psychologists should consider when deciding whether to address their patients' prejudicial comments in psychotherapy. It also provides an intervention strategy for addressing patients' prejudicial comments.

Keywords: psychotherapy, principle-based ethics, prejudice

During psychotherapy a patient used the “N-word” as part of a comment unrelated to his presenting problem. The psychologist responded with an affronted facial expression and said, “don’t use that word.” The patient was momentarily embarrassed but simply said “okay,” and the psychologist continued with treatment. The issue was never discussed again. Years later when the psychologist described the situation to his graduate class, some students said that he acted unethically because he did not take the opportunity to educate the patient on the harm caused by such comments. From the standpoint of principle-based ethics, they might have argued that the overarching principle of general beneficence or responsibility to society required the psychologist to redirect psychother-

apy onto issues of social justice. According to them, an opportunity to educate the patient was lost.

Other students said that he acted unethically because he interrupted psychotherapy and took the attention away from the patient’s presenting problem. From the standpoint of principle-based ethics, they might have argued that the overarching ethical principles of beneficence (promoting the well-being of the patient) and nonmaleficence (avoiding harm to the patient) required the psychologist to focus on the treatment needs of the patient and not on other considerations. According to them, the psychologist risked the quality of the psychotherapist–patient relationship for an issue unrelated to the patient’s treatment. The example above dealt with

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a racial slur. However, other prejudiced comments could focus on gender expression, disability status, sexual orientation, age, socioeconomic status, religion, spirituality, immigration status, education, and employment, among other variables. This article will address various ethical dilemmas psychologists may encounter when patients make prejudicial comments as well as how and when psychologists should respond using principle-based ethics as a guide.

Patient-Generated Prejudice

Despite the increased emphasis on multiculturalism in the training of psychologists, there are no clear guidelines regarding whether multicultural competence necessitates tolerance of patient-generated prejudice. In daily practice, it is not appropriate for psychologists to promote or oppose the political, religious, or cultural views of their patients, but is patient prejudice distinguishable in a way that requires psychologists to confront it? At the very least, the APA (2017b) ethical principles, guidelines, and accepted moral standards of society give no clear direction when encountering prejudicial statements by patients in therapy.

Most psychology graduate programs offer only a single diversity course, and students receive little or no formal training on how to handle patient-generated prejudice in the context of psychotherapy (Abrams, 2018). While it is easy to agree that prejudice is morally wrong and is antagonistic to striving for social justice, it is unclear if, how, or when the psychologist should intervene in an individual therapy setting when patients make prejudicial comments. This failing exists despite the fact that trainees have expressed a desire to receive additional training about how to navigate situations in which patients make prejudicial comments during therapy. For example, in a book on multicultural issues faced by psychologists, one author recounted feeling “alone, unprepared, and yet responsible” when her patient made racist remarks during one of their sessions (Ali et al., 2005).

It is generally accepted that a psychologist can provide effective treatment to patients even when they do not share the same beliefs (Maroda, 2012), some of which may lie in stark contrast to their own. One might wonder why psychologists would have an ethical responsibility to address prejudicial beliefs when they are expected to remain silent on other personal views, such as their patient's political affiliations. However, cultural prejudices can be malignant in a way that other beliefs are not because they may have an overwhelmingly negative effect on society. Prejudice fuels behaviors ranging from contact avoidance to bullying and hate crimes (Agerström & Rooth, 2011; Bertrand & Mullainathan, 2004; Stephan & Stephan, 2000). In fact, there were 7,175 hate crime incidents recorded in the United States in 2017, a 30% increase from 2014 (FBI, 2017).

Prejudice refers to unjustified and/or inaccurate attitudes, which are usually negative, toward people based solely on the basis of their group membership (McLeod, 2008). Although prejudicial beliefs may develop out of a person's life experiences, the generalization of these beliefs to an entire group is generally unjustified. Such beliefs not only harm society but can they can also harm patients as well. Specifically, cognitive biases in information processing, including dysfunctional attitudes and beliefs, are risk factors of depression and distorted thinking (Beck, 2011). Assumptions and beliefs are often automatic and unquestioned, and

psychologists regularly challenge automatic beliefs and generalizations that harm their patients.

Some might propose that certain prejudicial beliefs are rooted in cultural or religious orientations and therefore need to be respected according to APA's (2017a) *Ethical Principles of Psychologists and Code of Conduct*, specifically regarding respect for people's rights and dignity. However, the APA also states that psychologists “do not knowingly participate in or condone activities of others based on [the patient's] prejudices.” Additionally, the APA states psychologists are expected to practice integrity by promoting accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. If psychologists are aware that prejudicial beliefs harm their patients, and that those beliefs might lead to prejudicial actions against others in society, then it would seem ethically defensible for them to provide the patients with the tools they need to start questioning inaccurate prejudices and assumptions.

Principle-Based Ethics

The English philosopher, W. D. Ross developed principle-based ethics, which hold that moral agents, such as psychologists, should generally follow several overarching ethical principles including acting honestly and avoiding harm to others. Later, American bioethicists, Thomas Beauchamp and James Childress identified overarching ethical principles of beneficence (promoting the well-being of patients or other service recipients, such as students or supervisees), nonmaleficence (avoiding harming service recipients), respecting autonomy (respecting the right of patients to make important decisions about treatment), and justice (treating persons fairly), and fidelity (commitment to keep one's promises) as being especially applicable to health care (Beauchamp & Childress, 2001). Additionally, Knapp and VandeCreek (2004) have proposed the concept of generalized beneficence, defined as the responsibility of psychologists to further the best interests and wellbeing of society as a whole. Along the same lines, the Universal Declaration of Ethical Principles for Psychologists has identified the Principle of Professional and Scientific Responsibility to Society, which holds that psychologists have responsibilities to “groups, communities, and society” as well as to individuals (International Union of Psychological Science, 2008, p. 4).

Principle-based ethics has influenced the development of the APA Ethics Code. The general aspirational principles in the APA Ethics Code appear to be modeled roughly after principle-based ethics, although the categorization and wording of the principles differs from those presented by Beauchamp and Childress. For example, instead of being two separate principles, the APA Ethics Code includes beneficence and nonmaleficence as one principle. Ordinarily, moral agents, such as psychologists, can act upon these overarching ethical principles without conflict. For example, psychologists can generally promote the well-being of their patients without violating any other overarching ethical principle. However, that is not always the case. Sometimes respect for patient autonomy, beneficence, nonmaleficence, general beneficence, or other ethical principles may collide with each other. Fortunately, psychologists have a process to follow when two or more ethical principles collide.

W. D. Ross (1930/1998) proposed a methodology to follow when ethical principles collide. When that occurs, Ross stated,

“what I have to do is to study the situation as fully as I can until I form the considered opinion (it is never more) that in the circumstances one of them is more incumbent than any other” (p. 268). Which ethical principle gets more weight depends on the “considered opinion” of the psychologist. In other words, the psychologist must give priority to one principle over the other because “one of them is more incumbent than any other,” meaning that it seems like the right thing to do. [Beauchamp and Childress \(2001\)](#) propose that when one overarching ethical principle takes precedence or trumps another it is important to minimize any negative effects of the infringement (p. 34). Therefore, psychologists should attempt to both minimize harm and select interventions that have a reasonable likelihood of success. This framework is relevant when psychologists must decide how to respond to a patient’s prejudiced comments, especially when the patient’s comments are not related to their presenting problems.

Scenarios

Below we present a number of case vignettes designed to illustrate some of the ethical issues concerning patients’ prejudicial comments in the context of psychotherapy.

Scenario 1: Freedom of Speech

A Caucasian patient arrived at her second psychotherapy session for treatment of mild anxiety at an independent practice. When Dr. Davis, the patient’s psychologist, came to get her from the waiting room, she overheard the patient use the “N-word” while speaking to the African American secretary in the public waiting room. Dr. Davis addressed this behavior with the patient during session, and the patient said it was a free country and insisted that she was allowed to exert her right to free speech. The patient continued to use the derogatory slur when speaking with the secretary at her next two appointments.

Ethical considerations. In this vignette, a conflict exists between beneficence (promoting the well-being of the patient by keeping the patient in treatment) and general beneficence (an obligation of the psychologist to protect society from hate speech). In addition, the psychologist has an obligation to ensure a work environment free from discrimination for her employees according to Title VII of the Civil Rights Act of 1964. Furthermore, this behavior could harm other patients in the waiting room who might overhear this comment. When two or more ethical principles appear to collide, the psychologist may select an option that prioritizes one ethical principle over another if the proposed intervention has a reasonable likelihood of success and if the psychologist tries to mitigate harm to the offended ethical principle.

In this situation, we contend that most psychologists believe that the overarching ethical principle of general beneficence, combined with the legal obligation to promote a safe work environment, would require the psychologist to prevent such speech from reoccurring, even if it means potentially infringing upon beneficence. If so, the first step would be to discuss the situation with the patient to see if it would be possible to resolve the conflict. Dr. Davis could attempt to explore the patient’s motivation for making such comments, explain why they are inappropriate and consider ways to make amends to the secretary who was the victim of such speech. When the patients’ intentions are not clear it is sometimes

indicated to “test the waters,” or to explore the depth of the patient’s belief systems and their intentions to determine how much flexibility the patients have in their belief systems.

Unfortunately, in this scenario the patient expressed little intention to change and one would surmise that the hate-filled speech would likely occur again. Given this situation, Dr. Davis would need to terminate psychotherapy with the patient if the patient continued to use hate-filled speech in the waiting room. The psychologist could try to minimize harm to the offended moral principle by clearly explaining the rationale for the termination and referring the patient or establishing conditions under which she would agree to take the individual back as a patient again.

Scenario 2: The Ignorance of Youth

A 55-year-old patient arrived at her first psychotherapy session with Dr. Khan for treatment of mild anxiety. Upon noticing Dr. Khan’s youthful appearance, the patient expressed her unwillingness to work with someone so young and requested a “more qualified and experienced psychologist.” Dr. Khan assured the patient he was well-qualified, but the patient refused to engage in further discussion and announced she would be seeking psychological services elsewhere. The patient then thanked Dr. Khan for his time and abruptly left the session.

Ethical considerations. In this scenario, Dr. Khan was unable to explore underlying reasons for the patients’ skepticism of her abilities as a young psychologist because of the patients’ abrupt departure. For example, it is possible that the patient believed Dr. Khan would be unable to relate to her due to their age difference. Despite evidence that matching patient–psychologist dyads on age and/or gender does not impact the therapeutic alliance ([Behn, Davanzo, & Errázuriz, 2018](#)), it is fairly common for patients to desire psychologists who share characteristics similar to themselves. Of note, the patient in this scenario did not specifically mention feeling uncertain about the psychologist’s ability to relate to her as her primary motivation for requesting a different psychologist. Rather, she appeared to infer the psychologist was incompetent solely based on his age, which is a form of prejudice (i.e., ageism).

Although a psychologist might wish to discuss the ageist beliefs with the patient, it is unlikely that such an intervention would be successful, given the patient’s strong intention to terminate the treatment and find an older psychotherapist. Regarding patient autonomy, it is probably best for Dr. Khan to respect the patient’s preference and provide her with referrals to older psychologists.

Scenario 3 (Part 1): Not Like the Rest of Them

For the past month, a patient received weekly psychotherapy for mild depression from his Native American psychologist, Dr. Locklear. Upon arriving late to a session, he calmly apologized and attributed his tardiness to being stuck in traffic behind a Native American driver. He then proceeded to make an offhand comment about the general inferiority of Native Americans. Recognizing Dr. Locklear may have been offended by his comment, the patient emphasized the fact that he has close friends who are Native Americans. He also insisted he was talking about the “other type” of Native Americans, rather than those he viewed as being similar to Dr. Locklear stating, “You’re not like the rest of them.” Then the patient changed the subject to events from the past week.

Ethical considerations. In this scenario, beneficence (focusing on the treatment of the patient) conflicts with general beneficence (the importance of protecting society from hate speech). In addition, it is possible that the speech directed toward Dr. Locklear could affect beneficence, insofar as it might impair her ability to work productively with the patient. It is also especially important for Dr. Locklear to consider the motive behind the patient's prejudicial comment. Unlike scenarios in which the patients' prejudicial comments are directed at cultural groups that are seemingly unrelated to both the patient and the psychologist, this patient expressed prejudice toward a group to which he knows Dr. Locklear belongs. Therefore, in addition to considering whether the prejudicial statement reflected the patient's social environment and/or defense mechanisms (Thompson & Neville, 1999), Dr. Locklear might also consider whether this comment is the patient's way to express discontent with her. If Dr. Locklear discovered the patient truly held these prejudicial beliefs, she might consider addressing the prejudicial comment during one of their sessions, which would potentially benefit both the patient and society at large. Additionally, addressing his prejudicial comments may allow for further development of Dr. Locklear's case conceptualization of the patient (e.g., identifying defense mechanisms and/or expression of discontent with the psychologist), which would be in the patient's best interest.

However, in this scenario, both addressing patients' prejudicial comments and refraining from doing so have the potential to threaten the therapeutic relationship. For example, addressing the patient's prejudicial comment could result in the patient becoming angry and prematurely terminating therapy. Conversely, Grodin (2011) stated "at the patient's expense, [we can] rationalize, intellectualize and justify over sensitivity and defense in order to avoid addressing prejudiced statements. Under the guise of neutrality, [we can] become paralyzed" (p. 30). If Dr. Locklear was offended, she may have refrained from addressing the prejudicial comment out of a perceived obligation to convey a stance of neutrality in her role as a psychologist. Yet, Dr. Locklear's "neutral response" may result in feelings such as resentment toward the patient and difficulty empathizing with him regarding legitimate clinical issues.

However, Dr. Locklear's emotional response to prejudicial comments should not be the sole determinant of whether she is responsible for addressing them. If this were the case, it would create an expectation in which the only psychologists addressing prejudice would be the ones most emotionally affronted by them, which would often be the psychologists who belong to the minority groups that the patient is prejudiced against. This would create an unfair burden on the psychologists who are themselves the victims of prejudice. Instead, we argue psychologists have a duty to consider addressing prejudicial comments regardless of their group membership and emotional incentive. Nevertheless, in this scenario, it may be appropriate to conclude that general beneficence would trump beneficence and that the psychologists should respond to the comment if it is likely that the intervention would be successful, and harm to the offended ethical principle could be minimized.

Scenario 3 (Part 2): Agreeing to Disagree

Over the next few months the patient continued to make derogatory comments about Native Americans. Each time Dr. Locklear

attempted to discuss these comments, the patient responded by suggesting they could "agree to disagree" about whether his comments were offensive. The patient said they should not waste his time talking about these comments because he was not racist. Until now Dr. Locklear had been able to manage her feelings regarding this patient successfully, but now she began to dread sessions with him and found herself increasingly unable to put her feelings aside and empathize with him.

Ethical considerations. Consistent with the principle of generalized beneficence, Dr. Locklear had repeatedly addressed the patient's prejudicial comments and attempted to engage him in discussions about their validity, significance, and potential impact on the well-being of others. Consistent with the goal of providing quality treatment, Dr. Locklear could reflect on her motives for addressing these prejudicial comments and increase her awareness of transference and countertransference in session with the patient (Lewis, Ratts, Paladino, & Toporek, 2011). Self-reflection aids psychologists in managing their biases to better serve their patients (Grodin, 2011). Dr. Locklear may consider seeking consultation to determine if she can still help the patient given her growing resentment. Or, in an effort to adhere to both beneficence and generalized beneficence, Dr. Locklear could focus on the patient's emotions tied to the prejudicial comment and/or experiences that may have contributed to the development of the prejudicial beliefs rather than their accuracy (Bartoli & Pyati, 2009). For example, Dr. Locklear could explore the anger the patient expresses when making prejudicial comments rather than focus on the factual accuracy of these statements. This conversation would provide an empathic nonjudgmental environment for the patient to express himself while reducing the risk of him perceiving Dr. Locklear as agreeing with his prejudicial beliefs. Finally, it is important to acknowledge that regularly terminating treatment with patients who express prejudicial beliefs may be problematic. For example, doing so could promote and condone psychologists' refusal to work with individuals from certain cultural groups or belief systems, which could be viewed as discrimination and would be in conflict with the APA (2017a) ethical principle of justice, which entitles all persons to equal access to treatment.

Scenario 4: Those People

A Caucasian patient, recently admitted for brief inpatient psychiatric treatment following a suicide attempt, was in her second psychotherapy session with her Caucasian psychologist, Dr. Miller. During the session, Dr. Miller noticed the patient had been reassigned a new nurse since their last session. When the psychologist inquired about the whereabouts of her original nurse, the patient casually explained she requested a new nurse because her original nurse was Mexican American, and she wanted a nurse "who belonged to a race with fewer gang affiliations." The patient then changed the topic to her active suicidal ideation.

Ethical considerations. Consistent with the principle of beneficence, Dr. Miller may prioritize addressing the patient's presenting problem over addressing the patient's prejudices toward Mexican Americans. Promptly addressing the prejudicial comment may cause the patient to feel angry, ashamed, or judged, which could exacerbate her suicidal ideation. Yet, refraining from addressing prejudicial comments in psychotherapy may unintentionally convey implicit approval of the patient's prejudices (Knapp,

Small, & Cohen, 2014). If Dr. Miller chooses to prioritize generalized beneficence, she could attempt to address the prejudicial comment at a later time prior to the patient's discharge when the patient might be less vulnerable. A strong therapeutic alliance between the psychologist and the patient is crucial to satisfaction and self-growth in psychotherapy (Beck, 2011). Dr. Miller has only had one prior session with this patient, and the two have not yet formed a strong therapeutic relationship that fosters trust and conveys a nonjudgmental environment (Stiles & Goldsmith, 2010). As such, potentially sensitive topics of conversation, such as prejudice, are likely to be met with less defensiveness when introduced within the confines of a stronger therapeutic bond.

Practically speaking, the patient's brief time in inpatient care may prevent Dr. Miller from having the opportunity to develop a strong therapeutic relationship with her. In addition to the lack of a strong therapeutic relationship, the patient's high level of clinical risk (i.e., recent suicide attempt and active suicidal ideation) may indicate that Dr. Miller's priority should be reducing the patient's level of distress rather than promoting generalized beneficence. In this scenario, the principle of beneficence may supersede that of generalized beneficence.

Scenario 5: Unintentionally Offensive

For the past year, a patient received weekly psychotherapy for mild depression from his psychologist, Dr. Williams, who, unbeknownst to the patient, was gay. Upon arriving late to a session, the patient apologized and attributed his lateness to the fact that he went to buy a water bottle from a nearby store. The patient explained that he bought the water bottle after seeing a gay couple drink from the water fountain in the psychologist's office building because he was afraid the couple might have contaminated the water fountain with AIDS.

Ethical considerations. Refraining from addressing the patient's prejudicial comment may appear to condone the patient's behavior, which would violate the principle of general beneficence. However, consistent with the principle of beneficence and nonmaleficence, Dr. Williams might first consider the potential negative and positive consequences of addressing this comment for the well-being of the patient. No matter how sensitively it is done, addressing the prejudicial comment may cause a rupture in rapport, possibly leading the patient to prematurely terminate therapy. Yet, the patient's mild depression does not put him at significant clinical risk, and he has been receiving psychotherapy for a year from Dr. Williams' suggesting the two may have a moderate to strong therapeutic relationship. Therefore, the patient may be less defensive and more willing to explore this topic with Dr. Williams than the patient in Scenario 3. There might also be a greater chance that any potential rupture in the therapeutic relationship created by Dr. Williams' intervention could be repaired.

In this scenario, the patient's prejudice concerns a group with less immediately visible characteristics than those described in the previous scenarios, and the patient was likely unaware of Dr. Williams' sexual orientation. Thus, it is unlikely these comments are a product of the patient's transference. Yet, similar to Scenario 3, silence may pose an issue regarding the psychologist's ability to maintain an empathic and nonjudgmental stance. Of note, Dr. Williams' personal and cultural values and biases may affect whether or not he perceives his patient's comments as prejudiced,

but the responsibility to acknowledge this prejudicial comment should not solely depend on the Dr. Williams' emotional response to the comment. Dr. Williams' perception of the patient's intent in making prejudicial comments should be considered when deciding how to address them. For example, one could argue ill-intent is different from ignorance (e.g., using outdated terminology such as *oriental* or *retarded*). In this scenario, it might be more appropriate for Dr. Williams to first directly address the content of the prejudicial comment rather than explore the underlying motivation for the patient's comment (e.g., educating the patient about how AIDS is transmitted and informing them about the prevalence of HIV/AIDS in different populations). This scenario allows for the simultaneous promotion of beneficence and generalized beneficence. For instance, Dr. Williams could address this comment at a later date, if delaying the conversation was in the best interest of the patient (e.g., if the patient became very distressed while discussing events that occurred over the past week). Psychologists strive to facilitate the process of self-understanding within patients, and prior research suggests prejudices have the potential to harm the personal growth of those who hold them (Thompson & Neville, 1999). Therefore, addressing patients' prejudices may actually enhance Dr. Williams' understanding of the patients presenting problem and promote self-understanding in the patient (MacLeod, 2013).

Self-disclosures are interactions in which psychologists reveal personal information about themselves and/or reveal their internal reactions to patients as they arise in session (Knox et al., 1997). Self-disclosure is viewed as a useful therapeutic tool in some psychotherapeutic orientation (e.g., feminist) and as something to be avoided in other orientations (Bottrill et al., 2010). In this scenario, it may not be necessary for the patient to be made aware that Dr. Williams is gay for him to engage in dialogue with Dr. Williams about the prejudicial comment.

On the other hand, psychologists' self-disclosures may be inappropriate and harmful to the patient if it is motivated by defensiveness and/or a desire for retaliation (Goldstein, 1994). Dr. Williams' self-disclosure may lead the patient to feel ashamed, rejected, or judged. Furthermore, consultations with respected colleagues might be critical in preventing the psychologist from imposing his personal views onto his patient. It is also important to note that the patient is not obligated to keep Dr. Williams' personal disclosures to him confidential, which may be problematic if Dr. Williams has does not want this information to become public.

Recommendations

Multicultural training encourages psychologists to tolerate the beliefs and values of their patients, but there may be limits to what a psychologist is expected to tolerate. We offer the following general guidelines for psychologists to consider when deciding whether, and if so, how to address patient's prejudices in psychotherapy.

Education

It is wise for psychologists to be proactive in their ethical decision making and approaches to navigating ethical dilemmas (Crowley & Gottlieb, 2012). Similarly, they should also remain abreast of relevant research in their field as well as updated

practice guidelines. By doing so, psychologists may feel more comfortable defending their decisions in therapy.

Application of Knowledge

Assuming a dilemma regarding patient-generated prejudice arises, psychologists must thoroughly weigh the advantages and disadvantages of addressing their patient's beliefs. Could addressing these beliefs bring about any positive changes in the patient's life or for society? Could doing so cause patients to better understand themselves or their relationships? While psychologists cannot predict the future, they are well advised to consider all of the potential consequences of a therapeutic intervention regarding such matters. In agreement with principle-based ethics, if psychologists decide to address prejudicial comments, they should try to minimize the violation of the offended principles.

Self-Reflection

Prudent psychologists engage in self-reflection to understand their own motives for addressing or not addressing prejudicial comments whenever possible. As mentioned in Scenario 5, psychologists should be mindful of countertransference and the risk of shaming their patients with the unconscious goal of retaliation. A defensive or retaliatory intervention on the part of the psychologist could result in the patient feeling rejected, terminating treatment, or refusing to engage with psychological services in the future. Therefore, psychologists should instead assess the goals of an intervention and be sure that they are both realistic and directly related to the benefit of the patient and society and not merely for the psychologist's own benefit. The process of self-reflection might be difficult for some psychologists, especially if they feel emotionally compromised by the patient's prejudicial comments. In these cases, especially, psychologists are encouraged to promptly seek consultation.

Consultation

When faced with these dilemmas, psychologist often do well to consult with other professionals and document the interaction. By doing so, they demonstrate their diligence and efforts to act consistently with overarching ethical principles. In a situation concerning prejudice, it would be wise for psychologists to seek advice from knowledgeable professionals with whom they do not already share a strong bond as the preexisting relationship might cloud the judgment of the consultant. Additionally, professionals who are more likely to have different points of view might help psychologists gain a broader perspective of the situation, rather than just speaking with someone who mirrors their own thoughts.

Intervention

If psychologists decide to address a patient's prejudicial comments, the aim should not necessarily be to immediately change the patient's beliefs, but rather to provide an open environment to explore these beliefs if the patient is willing. Conversations of this nature should be collaborative rather than confrontational to avoid instilling guilt and shame in the patient. The following scenario is provided to illustrate how an intervention encompassing core therapeutic techniques might be implemented.

Intervention scenario. A middle-aged man has been attending individual therapy for several months with Dr. Yang to address his anxiety. The patient complains about his wife's decision to continue holding a career after marriage on several occasions during the course of therapy. He feels that his wife's place is at home with his children. He explains that her decision is especially frustrating to him because his religion teaches that women must be subservient to their husbands. The patient further discloses that he and his wife have increasingly been fighting over her choice to go back to work.

Dr. Yang is aware that multiculturalism and the APA (2017a) ethical principle Respect for People's Rights and Dignity encourage psychologists to respect the beliefs that their patients may hold. However, she also has evidence that the patient's beliefs about women may harm society and apparently his relationship with his wife, which is further exacerbating the patient's distress. Although Dr. Yang will likely recommend marital or couples counseling, she may determine that discussions about the role of women would be productive in this session with the husband to determine his flexibility on this issue and whether a future intervention addressing his sexist beliefs would likely be effective. She can minimize any harm to the treatment and relationship with his wife by proceeding with the following step

Empathize. The first step is for the psychologist to display empathy and understanding through the use of a reflective statement. Whether or not the psychologist agrees with the patient's views, the psychologist can validate the emotions behind the patient's belief, display empathy, and provide some validation to help encourage the continued participation of the patient in the following steps.

In this scenario, Dr. Yang might begin her intervention using an empathic statement such as "It must be very hard on you to have such different beliefs from your wife. I can tell how frustrated you feel." Empathic statements help align the psychologist with the patient. The patient might feel negative transference toward the psychologist for challenging his beliefs. Therefore, this step is critical to help the patient feel that his emotions have been understood, even if he feels that his beliefs were not.

Create dissonance and highlight benefit. In this step the psychologist explores the patient's awareness of how his prejudicial beliefs might be harming his life and how addressing them could be beneficial. This step is designed to increase the patient's motivation and willingness to explore his beliefs by fostering some cognitive dissonance and then providing an avenue for the patient to relieve it. The psychologist does not want the patient to interpret the intervention as punitive or retaliatory which could lead the patient to his premature withdrawal. This step displays to the patient that the psychologist is taking the patient's welfare into consideration.

In this scenario, Dr. Yang might ask "How do you think your views about women may be impacting your marriage? It seems like your belief that your wife must always obey you is causing some internal distress. I think there might be a way for us to improve your relationship with your wife by exploring some of your beliefs about women." Therefore, Dr. Yang is able to address these statements by highlighting the way in which these comments may be negatively impacting his marriage.

Invitation to explore. In this final step the psychologist invites the patient to explore the topic. Possible avenues of exploration could include but are not limited to: the origins of the beliefs, the emotions connected to them, or their accuracy. In individual ther-

apy, the patient's goal might be completely unrelated to his or her prejudiced ideology. Therefore, the request should be to consider the implications of the beliefs on the patient and his or her relationships with others. In this step, one should remember that the patient has a right to his or her beliefs, and the psychologist should not expect to change prejudices instantly, but rather to begin an ongoing dialogue about the way these beliefs affect the patient and his or her interactions with others. In this scenario, Dr. Yang has shown empathy for her patient, created some dissonance for him, and highlighted the benefits of discussing his beliefs. In this final step she is now ready invite the patient: "Would you be interested in further discussing this topic with me?"

Conclusion

The issues addressed in this paper have been understudied, and they deserve far greater attention than they have received. Yet, conversations around these matters may be controversial or even painful; as a result, they may often be avoided. We hope this paper will spark further conversation and research that will advance the field. If so, we will be simultaneously providing better care for our patients and benefitting society.

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