Sociopolitical Values: The Neglected Factor in Culturally-Competent Psychotherapy

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Abstract

The role of sociopolitical values remains a neglected factor in clinical practice. Many clinicians regularly commit "cultural malpractice" by failing to take into account their own sociopolitical values and those of their clients. However, sociopolitical values may be the most important factor to consider in any culturally-competent psychotherapy that is truly client-centered. Sociopolitical values are often central to a client's personality and identity. As such, understanding a client's sociopolitical values can be useful therapeutically, and a congruence between therapist and client sociopolitical values may enhance the therapeutic relationship. Although a lack of value congruence can be detrimental to the therapeutic relationship, this need not be the case if the therapist is culturally sensitive. Because mental health professionals overwhelmingly tilt to the left politically, they should be cognizant of the fact that their politically conservative, libertarian, and centrist clients will not share many of their values. Clinicians must be sensitive to the impact this may have on the therapeutic alliance and the ways in which this influences their diagnostic and therapeutic choices. Ensuring that clinicians are culturally sensitive with respect to sociopolitical values will require systemic changes in how mental health professions conceptualize culturally- and ethically-competent practice, develop and evaluate standards and guidelines for multicultural practice, and recruit and educate clinicians. While such advances are developing, however, clinicians can adopt practices to help ensure that they will be culturally competent when working with clients who have sociopolitical values different from their own.

Keywords

Political beliefs · Cultural competence · Bias · Psychotherapy · Therapeutic relationship

Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups.

Where scientific or professional knowledge… establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, or socioeconomic status is essential… psychologists

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have to obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services.

[P]sychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, or socioeconomic status … (**American Psychological Association**, 2018, Principle E, Standards 2.01 & 3.01).

A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation (**American Psychiatric Association**, 2013).

Counselors are aware of—and avoid imposing—their own *values, attitudes, beliefs*, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

Counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law (**American Counseling Association**, 2014, Principles A.4.b and C.5) (emphasis added).

Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity, or relationship status (**American Association of Marriage and Family Therapists Code of Ethics**, 2015, Standard 1.1).

Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, *political belief*, religion, immigration status, and mental or physical ability.

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, *political belief*, religion, immigration status, or mental or physical ability (**National Association of Social Workers**, 2017, Standards 1.05 & 4.02) (emphasis added).

As seen above, the ethical standards of the mental health professions prohibit discrimination or bias against clients on the basis of demographic characteristics such as race, ethnicity, gender, or sexual orientation as well as disability, language, socioeconomic status, or religion (For a discussion of the numerous scientific, clinical, and ethical problems with such an enumerated list in the ethics codes, see Cummings & O'Donohue, 2018; O'Donohue, 2016). Likewise, the multicultural practice guidelines of these professions require clinicians to be culturally competent, meaning that they are sensitive to client differences and needs as a function of the enumerated cultural factors (APA, 2003, 2017). Indeed, some suggest that multiculturalism is near the apex of the ethical imperatives: "[p]sychologists who privilege ethics over multiculturalism have a flawed understanding of the APA ethics code" (Fisher, 2014, p. 36). Cultural competence is thought to be a touchstone for efficacious treatment (see Whaley & Davis, 2007), and the accreditation standards of the American Psychological Association (APA) and the American Counseling Association (ACA) require that graduate programs incorporate multicultural training throughout the curriculum (APA, 2003, 2009; Council for Accreditation of Counseling and Related Educational Programs, 2016).

Except for those of the National Association of Social Workers (NASW) and to a lesser extent those of the American Counseling Association, the ethical and practice standards do not include *sociopolitical values* (SPVs) among the list of

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client characteristics that culturally-competent clinicians should consider, nor do they mandate that clinicians not discriminate on this basis. The APA's *Guidelines on Multicultural Education, Training, Research, and Organizational Change for Psychologists* (2003), which has become the standard for culturally-sensitive practice, say that "psychologists are urged to gain a better understanding and appreciation of the worldview and perspectives of those racially and ethnically different from themselves" (p. 385). The *Guidelines* repeatedly mention the "worldview" of clients and psychologists, but always within the context of racial and ethnic differences. The Association for Multicultural Counseling and Development's *Multicultural Counseling Competencies* (1996) are also framed in the context of demographic or religious differences. Likewise, leading treatises on multicultural practice (e.g., Comas-Diaz, 2012; Cornish, Schreier, Nadkarni, Metzger, & Rodolfa, 2010; Fouad & Arredondo, 2010; Leong, Comas-Diaz, Hall, McLoyd, & Trimble, 2014; Ponterotto, Cass, Suzuki, & Alexander, 2010; Sue, Sue, Neville, & Smith, 2019) generally fail to credit SPVs (independent of race, ethnicity, etc.) as an important cultural factor for clinicians to consider.

Yet, despite calls almost 20 years ago (Redding, 2001) to include sociopolitical values (SPVs) among the culturally relevant considerations, they remain a neglected factor in clinical practice. Many clinicians regularly commit "cultural malpractice" (see Hall, 1997) by failing to take SPVs into account. But SPVs may be the most important factor to consider in any culturally-competent psychotherapy that is truly client centered.

This chapter discusses why SPVs are often central to a client's personality and identity. As such, understanding a client's SPVs can be useful therapeutically, and a congruence between therapist and client SPVs may enhance the therapeutic relationship. Although a lack of value congruence can be detrimental to the therapeutic relationship, this need not be the case if the therapist is culturally sensitive. Because mental health professionals overwhelmingly tilt to the left politically, they should be cognizant of the fact that their politically conservative, libertarian, and centrist clients will not share many of their values. Clinicians must be sensitive to the impact this may have on the therapeutic alliance and the ways in which this may influence their diagnostic and therapeutic choices. Ensuring that clinicians are culturally sensitive with respect to SPVs will require systemic changes in how mental health professions conceptualize culturally and ethically competent practice, develop and evaluate standards and guidelines for multicultural practice, and recruit and educate clinicians. While such advances are developing, however, there are practices that clinicians can adopt to help ensure that they will be culturally competent when working with clients who have sociopolitical values different from their own.

Empirical Study of the Role of Sociopolitical Values (SPVs) in Therapy

As Lambert & Baldwin (2009) pointed out, researchers have focused on the efficacy of various treatment approaches and have neglected to study the effects of therapist variables. However, our discussion of the role of clinician and client SPVs in therapy will be supplemented by the results of an exploratory study of the impact of clinician and client values on the therapeutic alliance and processes. The study (Redding, 2019) included 131 practicing clinicians (65% male, 35% female; 47% Caucasian, 24% African-American, 27% Asian-American, 1% Hispanic) who volunteered to complete a survey. Ninety were doctoral-level clinical or counseling psychologists, 13 were clinical social workers, and 8 were master's level psychologists or marriage and family therapists. Approximately half had been in clinical practice for four or more years, and most subscribed to a cognitive-behavioral, psychodynamic, or family systems therapeutic orientation. Regarding the socioeconomic status of most of their clients, 32% were middle class, 45% upper-middle or upper class, and 23% lower-middle or lower class. Most were diag-

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nosed with an adjustment disorder, somatoform disorder, mood disorder, and/or anxiety disorder. Fifty-eight surveys were completed by clinicians attending a continuing education seminar in Virginia;[1] 73 were completed by licensed mental health professionals in Massachusetts and Texas who completed the surveys, which were mailed to a random sampling of clinicians in their states.

The study also surveyed 152 Americans (51% male, 45% female, 4% did not specify their gender; 70% Caucasian, 9% Asian-American, 7% African-American, 5% Hispanic, 9% other race or did not specify; 51% had college degrees), who were paid $10 to complete an online Mechanical Turk (MTurk) survey. Research using participants drawn from MTurk, a 500,000-member online labor market run by Amazon.com, is now common in social science. Recent studies show that the "data quality on MTurk is good" (Paolacci, Chandler, & Ipeirotis, 2010), including when used with clinical populations (Shapiro, Chandler, & Mueller, 2013). A total of 44% were treated by a psychologist, 23% by a psychiatrist, 10% by a marriage and family counselor, and 6% by licensed counselor. They had completed at least 5 sessions of psychotherapy during the last 5 years for an average of 10 sessions, most reported having been diagnosed with a mood or anxiety disorder, and at least 40% were receiving some form of cognitive-behavioral therapy.

The clinician and client surveys asked a series of Likert-scale and free-response questions about their SPVs (e.g., political views generally and on social and economic issues); whether SPVs (defined as "political, sociopolitical, or moral beliefs") were discussed in therapy and, if so, how they arose (e.g., did the client volunteer, did the therapist ask, and what was the context); the therapist's reaction to the client's disclosure of their SPVs; whether discussing SPVs was beneficial or harmful to the therapeutic relationship (e.g., did it increase or decrease the bond between therapist and client, the client's confidence/trust in the therapist, how well the client and therapist liked each other, and the therapist's understanding of, and empathy for, the client); and whether it was beneficial or harmful to treatment (e.g., was it helpful in case conceptualization or in addressing the presenting problems). The clinicians were asked how these factors typically play out in their cases. They were also asked to recall a recent salient case in which SPVs arose and answered a series of questions about that particular case.

The quotes at the beginning of the sections below were selected from the qualitative responses provided by the clinicians and clients who participated in the study.

SPVs: The Most Important Factor in Culturally Competent Practice?

Clients: It was very helpful to discuss my values. My values are the core of me. It affects everything.

It was helpful to me [to discuss our political beliefs] because it kept me from wasting any more time and money with someone who was clearly too different from me to be able to see life through my lens.

Clinicians: Clients' [SPVs] are exceptionally important for them as it defines them.

Some clients liked the idea that I was interested in them as people and not just their problems, but their identity as well.

Discussing the dimensions of client identity that a culturally competent practitioner should consider, the APA's recent multicultural guidelines identify "racial identity, multiracial identity, biracial identity, ethnic identity, gender identities, religious identity, and sexual orientation" (APA, 2017, p. 16), *yet make no mention of SPVs, which are a central aspect of cultural identity*. Such an omission might be understandable in 2003 when the guidelines were first promulgated. But not in 2017, by which time there was a con-

[1] I would like to thank Mary Alice Fisher, Ph.D., Director of the Center for Ethical Practice in Charlottesville, VA, for distributing the surveys in her continuing education seminars. Dr. Fisher is the author of *Confidentiality Limits in Psychotherapy: Ethics Checklists for Mental Health Professionals* (2016), American Psychological Association.

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siderable body of research (in neuroscience, social and personality psychology, and behavior genetics) suggesting that SPVs are not only often central to identity but that bias and discrimination on the basis of political beliefs are as pervasive and powerful as racial bias.

People's SPVs are often foundational to their self-identity, reflecting neurologically-wired personality traits and cognitive styles (see Mendez, 2017) arising from early gene (see Caprara & Zimbardo, 2004; Tesser, 1993) and environment interactions (Verhulst, Hatemi, & Eaves, 2012). Moreover, people are frequently discriminated against because of their political beliefs, especially when they are in the sociopolitical outgroup. One of the most robust findings in social psychology is that we tend to have affinity for those who share our values. "Belief in a common vision of reality, or rather a shared, social construction of reality, may be a far more potent social glue than the color of one's skin, cultural heritage, or gender" (Shafranske & Maloney, 1996, p. 564). Conversely, we tend to dislike those whose values differ substantially from our own (Rosenbaum, 1986). Because opposing sociopolitical values challenge our foundational worldview and the sense of understanding, purpose, security, and belongingness it provides (see Pyszcynski, Solomon, & Greenberg, 2003), we often are repelled by those who do not share our SPVs. Sociopolitical bias in interpersonal relationships may be stronger than racial or ethnic bias (see Haidt, Rosenberg, & Hom, 2003; Insko, Nacoste, & Moe, 1983; Mezei, 1971), as suggested even by studies conducted in the 1960s when racism was more potent than it is today in American society (see Hyland, 1974; Rokeach & Mezei, 1966; Rokeach, Smith, & Evans, 1960).

Frequently, SPVs are important to people because foundational moral values underlie them (Haidt, 2007, 2012) along with views about human nature (see Frisby, 2018a, 2018b). Liberals and conservatives tend to differ in the moral values supporting their political views, with liberals prioritizing concerns about harm vs. care, fairness vs. cheating, and liberty vs. oppression and with conservatives prioritizing concerns about loyalty vs. betrayal, authority vs. subversion, and sanctity/purity vs. defilement (Haidt, 2007, 2012). Consider the client who said of her therapist, "because we share basic opinions about topics such a fracking, I feel we connect on another level now" (Redding, 2019). To be sure, the environmental issue of oil fracking was not relevant to her presenting problems. But the fact that the therapist shared her view on this particular issue likely signaled to the client that they shared a broader, fundamental moral worldview.

SPVs Often Arise in Therapy

Clients: Talking about my political and social beliefs made it easier for me to discuss my problems. I didn't have to worry as much about what she would think of me.

I liked the chance to express how I stand on [political] subjects so that my therapist could better understand me.

We were talking about times when I felt really angry and I described a lady that was very against abortion. We then discussed the subject.

I was in a bad mood and felt like voicing my opinion on Obama and how he was going to destroy America. His socialist healthcare will ruin my access to mental health care.

Clinicians: Allowing them to talk about their [SPVs] is exceptionally effective. They WANT you to know.

The utility [of discussing SPVs] is evident in understanding their worldview.

"It is tricky to avoid political discussions in the course of therapy, because they may have psychological meanings under the surface, just as psychological discussions may be latently political" (Strupp, 1980). Forty-three percent of clients reported that SPVs were explicitly discussed during therapy, with 26% reporting that the therapist initiated the discussion about the client's SPVs (Redding, 2019). Indeed, many issues of concern to clients implicate SPVs, including child-rearing practices, unwanted pregnancy, abortion, substance use, lifestyle choices, death, sexual orientation issues, and marital relations, to name but a

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few. Moreover, as the partisan divide has become more pronounced in recent years, many clients are now anxious, angry, or depressed about political issues. Roughly half of those surveyed in the APA's 2018 Stress in American Survey reported feeling stress over news and political issues such as mass shootings, climate change, and immigration (Bethune, 2019). Clinicians reported that their clients discussed, among other things, the current president, their views on government and personal responsibility, healthcare policy, tax policy, gun control, family differences in political views, and their dislike of those with opposing political views (Redding, 2019).

Differences over politics are affecting clients' relationships with family members, friends, and work colleagues. As one clinician explains, "We're seeing families and friendships fractured along political lines…. [some clinicians] now inquire, at the outset of a session, whether clients are following what's going on in the political world right now, and if so, how it's affecting them. The result is that many clients open up about anxieties and relationship strains they hadn't previously shared… probably because they thought the therapy room was supposed to be a politics-free zone… I see both liberal and conservative members of our community feeling as if their values are no longer acceptable in the public arena… and to their friends and family" (Doherty, 2017, p. 34).

Thus, issues relating to SPVs frequently arise in therapy, and enabling a discussion of such values can enhance the therapeutic relationship. Just as "[a] therapist's willingness to discuss racial matters is of central importance in creating a therapeutic alliance with clients of color," it is important for therapists to discuss SPVs when clients directly or indirectly broach such issues. A clinician's failure to do so may hinder therapy because the clinician will be out of sync (see Leong, 2007) on a matter of foundational importance to the client: his or her sociopolitical self-identity. "[S]ince who we are depends on the circumstances we are placed in and the discourses available in the setting we find ourselves in" (Monk, Winslade, & Sinclair, 2008, p. 122), the therapy room certainly should provide clients a comfortable space to give voice to that identity. "[T]he discourse that dominates always gives some people more entitlement to speak, to do things, and to be recognized in their social world" (Monk et al., 2008, p. 123). Perhaps because a person's SPVs are reflective of their foundational moral values and their personality, temperament, and cognitive style, clients inevitably intuit the therapist's values (Strupp, 1980). The client's intuitions about the therapist's SPVs may affect whether the client feels comfortable discussing such issues in therapy (just as the therapist's intuitions about the client's SPVs may have positive or negative biasing effects in how he or she handles the therapeutic relationship). If, for example, the clinician adopts an implicitly liberal discourse in therapy with a conservative client (see next section), that client will likely feel less empowered to speak their truth in therapy. Indeed, clients may "unconsciously submit their therapists to 'transference tests'" to see whether the therapist will behave toward them in a manner that "confirm[a] a pathogenic belief" (Muran, 2007, p. 265) – that the therapist will reject the client's SPVs, for instance. "If the therapist passes the test by not confirming the belief, therapeutic progress takes place" (Muran, 2007, p. 265). Likewise, the therapist may become aware of his or her biases "only in dialogue with [the client], where there is a possibility for a 'fusion of horizons' – a moment when a prejudice can be differentiated from its alternative" (Muran, 2007, p. 262).

It is beneficial to the "special kind of friendship" that is the therapeutic relationship (Hallam, 2018) when the clinician likes and empathizes with the client (see Hall, Horgan, Stein, & Roter, 2002; Pederson, Crethar, & Carlson, 2008; Spiro, Peschel, McCrea Curnen, & St. James, 1996). When recalling a recent case in which SPVs were salient, 59% of the clinicians said that the client disclosure had the potential to improve the therapeutic relationship (Redding, 2019). Fifty-seven percent reported that their empathy for the client increased after the client disclosed his or her SPVs; only 7% said it decreased their empathy. Twenty-eight percent said that the client disclosure made them like the client more; only 14%

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said it made them like the client less. Not surprisingly, these factors are correlated. Increased empathy was correlated with increased liking ($r = 0.33$, $p < 0.01$) and a potentially improved therapeutic relationship ($r = 0.27$, $p < 0.05$). Moreover, increased empathy was correlated with increased clinician confidence ($r = 0.50$, $p < 0.001$), improved problem conceptualization ($r = 0.47$, $p < 0.001$), and an improved treatment approach ($r = 0.26$, $p < 0.05$).

Clinician and Client SPVs Will Sometimes Differ

Clients: My therapist likes to talk about his disgust with the government and the president. It came up when talking about honesty.

During the elections my therapist asked me if I was going to vote and if I paid attention to politics. She shared with me a story about her right-wing conservative relatives and how she has to deal with them during the holidays.

Clinicians: I am very liberal; most of my clients are politically or religiously conservative.

The client's hesitation [about sharing her SPVs] revealed other issues that she feared might not be "approved" given her (correct) assumption of my liberal bias.

A female client was excited about purchasing her first gun and was hesitant to share it with me because she assumed I would not "approve."

Not infrequently, there is a mismatch between the clinician's and client's SPVs, with the most common mismatch involving a liberal therapist and conservative client. Surveys find that the overwhelming majority of psychologists are politically liberal, many quite so, particularly on social issues (Duarte et al., 2015; Redding, 2012). A 2002 random survey of members of the clinically oriented APA divisions found that 67% were Democrats and only 6% Republicans; 77% were liberal and only 9% were conservative (Bilgrave & Deluty, 2002). A recent survey of mental health professionals in Florida found that 54% were identified as liberal, progressive, or socialist, whereas only 24% identified as conservative or libertarian (Norton & Tan, 2018). In the Redding (2019) study, only 27% of clinicians described themselves as politically conservative, whereas 67% were liberal. With respect to social issues, which are the kinds of SPVs most likely to arise in therapy and those most likely to drive bias and discrimination, the liberal tilt was more pronounced. Only 15% of clinicians described themselves as social conservatives, whereas 69% were socially liberal. In contrast, the clinicians reported that many of their clients were politically conservative or centrist, and there was only a modest correlation ($r = 0.32$, $p < 0.01$) between the political views of clinicians and those of their clients.

Indeed, the strong liberal tilt of the mental health professions may be one reason why conservatives are reluctant to seek mental health treatment (see Brody, 1994), just as the underrepresentation of minority clinicians may partly explain the relatively low utilization of mental health services by minorities (see Holden et al., 2014; Meyer & Takeuchi, 2014). The liberal-humanistic values inherent in much of psychotherapeutic practice are likely to be seen by liberals as more consistent with their SPVs than they will be for conservatives. Indeed, 61% of clients in the Redding (2019) study self-identified as politically liberal.

SPV Similarity Is Often Beneficial to the Therapeutic Relationship

Clients: Discussing political, sociopolitical and moral beliefs helped me to connect better with the therapist, who had similar beliefs, and allowed me to become more open with him.

The therapist felt as comfortable with me as I felt as comfortable with him, knowing that we each had similar political, sociopolitical, and moral beliefs.

When we had this conversation [about politics] it just reinforced that we were a good match for our therapist.

Instead of a patient, I became a person [when we talked about politics], and I think that the dynamic of the therapy changed for the better.

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Clinicians: A client specifically asked me on the initial consultation what my general political leanings are because he is so liberal that he would not be able to work with a conservative therapist.

If we are similar, I have more to work with.

Attitudinal similarity between clinician and client is, in most cases, likely to be beneficial for establishing a strong therapeutic relationship and for mutual understanding between client and clinician. The personal rapport between client and clinician is thought to be the touchstone for therapeutic outcomes (Lacewing, 2014; Luborsky et al., 2002; Vasquez, 2007; Zilcha-Mano, 2017), with research consistently showing it to be a key determinant of treatment success irrespective of presenting problem, diagnosis, setting, or treatment approach (Horvath, Fluckiger, Re, & Symonds, 2011; Martin, Garske, & Davis, 2000). A strong therapeutic relationship is conducive to clients' self-disclosure, confidence in the therapist, positive expectations of improvement, active participation in therapy, development of insight, and internalization of behavioral and relationship modeling from the therapist. Clients are also more likely to terminate therapy early when the therapeutic relationship is poor (Tryon & Kane, 1993). When clinicians feel that they have strong relationships with clients, they tend to be more invested in the therapeutic relationship, have greater confidence in their ability to help the client, and show greater warmth, empathy, and positive regard for the client (see Lacewing, 2014). The therapeutic relationship is especially important in psychodynamic therapies, where the client transfers feelings onto the therapist and develops new, more adaptive mental models of functioning and relationships out of the object relationship formed with the therapist (see Shedler, 2010).

Because "the therapeutic relationship is 'an intermingling of two value systems'" (Gass, 1984, p. 230, quoting Glad, 1959), a positive relationship is more likely when both parties share a common worldview. As Kottler (2010, p. 148–149) notes, "[o]f course, we are supposed to treat all clients with an equal degree of respect, seriousness, and caring… It even says so in our ethical codes! But we know that is not nearly the case. We genuinely like some clients better than others – we are drawn to them (or even overly drawn to them) because they share our most cherished values." Clients likewise prefer clinicians who share their values, whom they perceive as being more trustworthy than clinicians who do not (Lewis & Walsh, 1980).

Thus, a significant mismatch between clinician and client SPVs may adversely impact the therapeutic relationship (Bergin, Payne, & Richards, 1996; Sue, 1998). Atkinson and Schein (1986) examined 16 studies comparing the effects of attitudinal similarity between clinician and client to other studies comparing the effects of similarity in race, sexual orientation, socioeconomic status, or personality and cognitive variables. They concluded that there was little effect of demographic or personality variables on the therapeutic relationship (e.g., rapport, trust, empathy), but often significant effects of attitudinal similarity, primarily during the initial rapport-building phase of therapy. A case vignette study of 363 clinical psychologists found that the ideological match between the therapist and client significantly affected the therapist's empathy for the client, with politically liberal therapists having less empathy for conservative clients (Gartner et al., 1990). These research findings on clinician-client congruence in psychotherapy mirror those on racial or ethnic concordance between physician and patient, which leads to better physician-patient communication, patient participation in the treatment process, treatment adherence, patient satisfaction, quality of care, and outcomes (Powe & Cooper, 2004; Cooper et al., 2003).

SPV Dissimilarity May Bias Clinical Judgment

Clients: I think that the therapist's different beliefs temporarily made her not care much about helping me because she seemed to cut that session short and acted distant.

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There was a "look" [from the therapist]….
By some of what she said, her body posture, and the way she said what she did, it became very clear to me that my beliefs (and thus me) were the epitome of everything she was raised to think of as "wrong." Her demeanor took on a coldness after this exchange.
I liked the therapist less – due to the judgment I felt.
Clinicians: [Our different SPVs] made me feel tense or irritated, which I considered to be my own counter transference.
Finding out that my client was raised hard core Christian and understanding the impact of her strict religious culture has had on her made it difficult for me to find a way to work with her because her beliefs were so rigid – this contributed to me liking her less.
In my opinion, it was a good thing that I might impose my values on the client, because this kid's views foster prejudice, hate, and materialism which I do not believe will serve him well in the wrong run… The client's assumption that those less fortunate than he do nothing but collect money from the government… I came to see him as an entitled, privileged, materialistic brat.

Psychotherapy is inherently value laden, and the therapeutic process is heavily infused with politics (Halleck, 1971). Therapists' SPVs can influence their diagnoses, therapeutic interventions, and relationships with clients (Cushman, 1995; Woolfolk, 1998), and a relative match between clinicians' and clients' treatment goals and means for achieving them is positively related to treatment outcomes and client satisfaction with therapy (Sue, 1998). In fact, studies suggest that SPV differences between client and therapist may bias clinical judgment and practice far more than differences in race, gender, or socioeconomic status (Abramowitz & Dokecki, 1977; Mazer, 1979). Since often in therapy the client's values gravitate toward those of the therapist (Bergin et al., 1996), there also is the concern that therapists may unwittingly impose their values on clients. Thirty-four percent of clinicians in the Redding (2019) study said that knowing the client's SPVs had the potential to bias their diagnosis, 31% said it had the potential to negatively affect the treatment approach, 40% said it posed the risk of the clinician imposing his or her values on the client, and 50% said it had the potential to negatively impact the therapeutic relationship.

Forty-nine percent of clinicians say that their political beliefs moderately or strongly influence how they practice psychotherapy (Bilgrave & Deluty, 2002). When asked to choose among a list of 11 demographic and cultural factors (age, race, gender, religion, political preference, language, sexual orientation, country of origin, socioeconomic level, immigration status, other cultural factors), 23% of clinicians identified *a client's political preference as being among the top three factors that affect them most* when working with clients who are different from them (Redding, 2019).

Consider the following case composite, provided by a practicing clinician. The client likes to talk about his support for Trump and cancelled a therapy session to attend a Trump rally. Schwartz (2016) illustrates the dilemmas that such a case, which may not be uncommon today, poses for the client's politically-liberal therapist and liberal clinical supervisor:

> [We] saw Trump as an authoritarian populist, a demagogue neo-Fascist… We asked ourselves, is [the client's] support of Trump is essentially a grievance compensation for impotence, inadequacy, and envy? Are his politics essentially vicarious identification, an unconscious wish to merge with a strong-man leader?… Still, regardless of his compensations, identity politics, or wishes to merge, we need to ask, is his unconscious justification unreasonable for someone in his situation? Doesn't a person's politics often attempt to address grievance?… When is inquiry into the roots and significance of Bob's politics appropriate and to what end? And when is the absence of inquiry collusion?… I worried how silent is assent to an aggrieved and violent movement.

We see how the politically-liberal clinician interprets certain conservative SPVs as being pathological or maladaptive and the clinician's temptation to frame therapeutic goals so as to shift the client's SPVs, perhaps implicitly imposing his values on the client. Moreover, therapy

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sessions here may be shortchanged by "missed empathic opportunities … moments when a client reports emotional issues and the clinician changes the topic without addressing or reflecting the client's feelings" (Vasquez, 2007, p. 882). "Dr. James has to choose between being a therapist for Bob or sticking to his own political/religious guns … the latter is unprofessional and unethical. Dr. James has no play here unless he genuinely gets Bob's world and recognizes the core therapeutic issue: Bob lives in a world that has not authentic place for him … He needs a world that does" (see Schwartz, 2016).

It is useful to consider the concept of "racial microaggressions," which "are brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., 2007, p. 273). Microaggressions take one of three forms: microassaults (intentionally discriminatory or insulting behaviors), microinsults (subtle slights, insults, or gestures communicating lack of regard or insensitivity), and microinvalidations (behaviors that exclude or dismiss the other's psychological or experiential reality). Microaggressions can also be environmental or contextual, such as an exhibit that features notable white Americans but none of color (Sue et al., 2007).

Sue et al. (2007, p. 280) argue that "therapists must make a concerted effort to identify and monitor microaggressions within the therapeutic context … reminiscent of the importance of becoming aware of potential transference and countertransference issues between therapist and client and how they may unintentionally interfere with effective therapy." The validity and usefulness of microaggression theory is debatable (see critiques by Campbell & Manning, 2014 and Lilienfeld, 2017, and rejoinder by Sue et al., 2019). However, consider how clinicians can unwittingly communicate to clients that their SPVs are not well received in the therapy room. Consider a therapist reacting to a client's sharing about his or her SPVs by making a derisive comment about those political views (microassault) and body language that evinces derision for the client's expressed SPVs (microinsult), or reacting to a client's disclosure of SPVs by changing the subject or discounting their relevance (microinvalidations). Environmental microaggressions might include a therapist having in their office political stickers or literature that evince hostility toward certain political groups or photos of prominent liberals but none of conservatives.

Clinicians may be prone to commit microaggressions against sociopolitically diverse clients because it is human nature to harbor implicit or explicit biases against those having different sociopolitical views. However, in the particular case of a liberal therapist working with a conservative client, there is an added reason. Research had apparently established the cognitive rigidity and authoritarianism of conservatives as well as the self-serving or immoral motives underlying their political views (see Adorno, Frenkel-Brunswick, Levinson, Sanford, & Gordon, 2019; Altemeyer, 1988; Jost, Glaser, Kruglanski, & Sulloway, 2003; Lakoff, 2016; Sears & Henry, 2003). This research, which received widespread attention in the psychological community and popular press, has no doubt seeped into the consciousness of many practitioners. Recent research strongly challenges this pathologizing of conservatives and conservatism while also showing that partisan bias and motivated reasoning exist as much on the left as on the right (see Ditto et al., 2018; Greenberg & Jonas, 2003; Haidt, 2012; Haidt & Graham, 2007; Haidt, Graham, & Joseph, 2009; Redding, 2001). But the earlier research likely had a lasting ambient effect on the ethos of many psychologists, however, particularly since it only validated their preconceptions and biases about the sociopolitical (conservative) other. There is the danger that, when working with conservative clients, politically liberal psychologists may invalidate their values and see them as inferior.

In addition, since "clients often pursue psychological care due to deeply held religious and moral beliefs and may experience significant emotional distress in addressing these issues" (Rosik, 2016), we must consider how differences in religious values, which are often closely

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related to SPVs, can bias the therapeutic process. Historically, psychology has viewed religion with suspicion or hostility (Cummings, O'Donohue, & Cummings, 2009; see Willis and Lancaster, this volume) and certainly as an unscientific competitor to psychotherapy. "When we look at the content of what both psychology and religion offer the individual, the similarity is rather striking: Both move away from the social and material world, to deal with the invisible world of feelings and fantasies. Both offer salvation at the individual and internal level … Both psychology and religion tell us that the road to happiness is through individual change" (Beit-Hallahmi, 1974, p. 126). Psychology has become more receptive to religion in recent years, now recognizing (at least in principle if not always in practice) the relevance and potential value of religious belief in therapy (see Aten & Leach, 2008; Fisher, 2014; Miller & Delaney, 2005; Milstein, Manierre, & Yali, 2010). Yet Christian therapists report having experienced relatively high levels of prejudice by colleagues and fear that it will be increasingly difficult to be a Christian in professional psychology and apply religious values in their work (Rosik, Teraoka, & Moretto, 2016). The mental health professions have far fewer people of faith than the general population or most other professions (Bilgrave & Deluty, 2002; Delaney, Miller, & Bisono, 2013; Miller & Delaney, 2005; Whitley, 2010). Thus, there is the danger that clinicians may not appreciate the relevance of a client's religious values in therapy. Mental health professionals may even equate religious beliefs with authoritarianism, anti-egalitarianism, or pathology (see Cremmins, 2002; Ellis, 1983).

Client SPVs Can Inform Treatment

Clients: We discussed how my sexuality plays a significant role in my anxiety and how this has been affected by the larger sociopolitical landscape and the greater acceptance of homosexuality and gay marriage across society.

My therapist challenges the way I think about the world and for me that is a good thing.

Clinicians: Knowledge [of the client's SPVs] impacted the choice of therapeutic intervention. An approach was adopted that meshed with the client's value system.

Knowing the client's views can shape an intervention to be understood in terms familiar to the client.

Usually the issue is not the client's beliefs, but how those beliefs impact their thoughts and interactions with others.

Because of the client's cognitive/emotional rigidity [which I discovered by exploring his SVPs], my treatment approach was adjusted to take that into account.

"[T]herapeutic approaches are no longer applied in universal ways but are adapted according to the values and needs [of the client]" (Kottler, 2010, p. 7–8), and effective client pacing will be tailored to the client's personality and values (see Hirsh, Kang, & Bodenhausen, 2012). A therapist in sync with the conservative SVPs of their client may opt for an approach that emphasizes personal responsibility or religious models of coping, which provide a particularly good example of how the client's SPVs can be important for fashioning the most effective therapy (see Miller, 1999; Shafranske, 1996). Noting the possible clash in values between traditional CBT, which values self-efficacy, and religious clients who value dependence on God, Propst, Ostrom, Watkins, Dean, et al. (1992) found that religious clients who received religiously based cognitive-behavioral therapy (CBT) for depression improved more than matched clients who received traditional CBT. "Religious therapists may also better understand certain problems of religious clients, such as struggles around sexual orientation, sexuality, abortion, marital problems, or depression arising out of religious conflicts" (Neumann, Harvill, & Callahan, 1995), and a better therapeutic alliance may be established when religious clients are matched with a religious therapist (Shumway & Waldo, 2012). Clients of faith may benefit when religious values

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and practices are incorporated into therapy (Fisher, 2014). For instance, "Biblical passages can be employed by a therapist within a framework of other methods and strategies to foster emotional support, challenge maladaptive beliefs, or confront maladaptive behavior" (Gass, 1984, p. 235). There are available evidence-based spiritual and religious-based therapies (Hook, Worthington, Davis, Jennings, & Gartner, 2010).

With respect to their salient cases involving SPVs, 67% of clinicians said that they tried to ascertain the client's SPVs (Redding, 2019). Clinicians were asked whether knowing about the client's SVPs was (1) relevant in therapist selection and/or treatment choice (yes = 52%), (2) had the potential to improve their conceptualization of the client's problems (yes = 52%), (3) had the potential to improve the treatment approach (yes = 59%), (4) had the potential to point the way to alternative treatment approaches for the client (yes = 56%), and (5) affected their overall confidence in their ability to help the client (increased = 28%, decreased = 25%, no effect = 47%). Not surprisingly, these factors are correlated. Ascertaining the client's SPVs was correlated with improved problem conceptualization ($r = 0.26$, $p < 0.05$) and treatment approach ($r = 0.30$, $p < 0.01$). Clinicians' increased confidence was correlated with improved problem conceptualization ($r = 0.44$, $p < 0.001$) and treatment approach ($r = 0.48$, $p < 0.001$).

Knowing the client's SPVs may also be relevant for tailoring treatments to address the types of behavioral and attitudinal changes that would be therapeutically beneficial (with appropriate caution that the therapist not impose values). Sixty-nine percent of clinicians said that the client's SPVs had the potential to be detrimental to the client's adaptive functioning (Redding, 2019). Some examples they provided included:

The strength and inflexibility of the client's beliefs rather than the beliefs themselves

The client's extreme anger toward those who held different views

The client's values that included cultural components that devalued women

The client's racial beliefs that generalized that everyone discriminated against him

The client's assumption that those less fortunate than he, particularly other races, do nothing but collect money from the government for sitting around… this negative view contributes to his bitterness and discontent, and his cognitive rigidity about things like this impair his adaptive coping

Forty-eight percent of clinicians thought it is appropriate to challenge the client's SPVs in therapy, though they apparently recognized the ethical risks in doing so.[2]

Although there were modest positive correlations between thinking it appropriate to challenge the client's SPVs and the view that knowing the client's SPVs improved problem conceptualization ($r = 0.25$, $p < 0.05$) and treatment approach ($r = 0.22$, $p < 0.05$), it was also correlated with the potential to negatively affect the therapeutic relationship ($r = 0.22$, $p < 0.05$) and to bias diagnosis ($r = 0.29$, $p < 0.01$).

Toward Sociopolitically-Competent Clinical Practice

Clinicians should engage in ongoing introspection into their own SPVs and how those may play out in their practice, and "may want to actively increase their tolerance and trust" (APA, 2003, p. 384) of *sociopolitical* "Others." Will they understand and appreciate their values, so that they are effective mutual collaborators with them in the therapeutic process, appropriately modify-

[2]An interesting example of the relevance of knowing a client's SPVs and religious beliefs and how such values may affect treatment goals, is research showing that authoritarian parenting, which has been well established in the literature as being potential harmful to children's development, may not necessarily be harmful to children in conservative religious families because "children immersed in a supportive community in which a systematic rationale for strict governing is explicitly promoted experience this governing differently from children lacking such support and rationale" (Gunnoe, Hetherington, & Reiss, 2006, p. 590).

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ing treatment modalities to be consistent with their values and goals? Clinicians ought to adopt a “multicultural virtue ethic” for working with clients of diverse SPVs, “including respectfulness, reverence, openness to the other, and willingness to engage in a collective effort to identify and achieve the good” (Fisher, 2014, p. 37). Clinicians should also consider how their chosen therapeutic approach may be influenced by their SPVs and be cognizant of SPVs implicit in different approaches. For example, clinicians who adhere to certain therapeutic orientations (humanistic, psychodynamic) are more likely to be atheistic or agnostic than those who adopt a cognitive-behavioral orientation (Bilgrave & Deluty, 2002), which conservative clinicians tend to prefer, whereas liberal clinicians tend to prefer psychodynamic or humanistic orientations (Norton & Tan, 2018).

While practice guidelines for sociopolitical competence await future development, clinicians can assess their sociopolitical competence with the client. How do the client’s SPVs, clinicians’ SPVs, and the interaction between client and clinician SPVs implicitly influence case conceptualization, diagnoses, and therapeutic goals and choices? Clinicians should consider how their SVPs affect clients’ “treatment expectations, perception of clinician credibility, trust, engagement, and the development of a therapeutic alliance” (Comas-Diaz, 2014, p. 423). Does the clinician understand the client’s value system and how it shapes his or her behavior, relationships, and life choices, in both adaptive and maladaptive ways? Does he or she empathize with the client’s values or hold implicit or explicit sociopolitical biases against the client? If so, what steps can they take to overcome such biases and minimize their impact on the therapeutic relationship? Does the clinician experience countertransference with the sociopolitically different client?

Clinicians should determine the salience and centrality (see Phinney, 1996) of SPVs to the client generally and with respect to his or her presenting problems, assessing how discrepancies between the client’s SPVs and those inherent across the client’s environments and relationships affect his or her social, occupational, and psychological functioning. They should also assess the similarities and differences between client and clinician SPVs (asking the client how he or she feels about their differences and similarities; see Comas-Diaz, 2014) and their relevance to the therapeutic relationship and process. But for purposes of first establishing the therapeutic rapport, the clinician should discuss similarities in their SPVs first before discussing differences. Client SPVs should be seen as assets beneficial to therapy (LaRoche & Maxie, 2003), and clinicians should be alert to how “the meanings and saliency of cultural differences are influenced by ongoing issues within the therapeutic relationship” (p. 183). It may be useful for clinicians to tell clients something along the lines of: “Please let me know if there are things that I say in our work together that do not fit with your values, beliefs, or life experiences. I would like for you to challenge me on these differences, because I think it will be useful in our working together” (LaRoche & Maxie, 2003, p. 184). In addition, providing clients with relevant information early on in therapy about the therapists’ values may serve as a prophylaxis against subtle values imposition by the therapist (Neumann et al., 1995).

With respect to religious values, Aten and Leach (2008) provide a comprehensive resource for how therapists can become aware of the role of their religious values in the therapeutic process; how a client’s religious values ought to be considered in clinical intake, assessment, case conceptualization, and treatment design; and how a client’s religious values can impact client commitment and the therapeutic alliance.

Toward Sociopolitically Competent Mental Health Professions

To improve the quality and appropriateness of psychotherapy with sociopolitically diverse clients as well as to encourage such clients to utilize needed mental health services, the mental health professions must: (1) incorporate in the professional codes a provision prohibiting discrimination based on sociopolitical values, (2) include SPVs in the enumerated lists found in multicultural guides of relevant factors to consider in culturally sensitive practice, (3) develop

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evidence-based best practices for working with sociopolitically diverse clients and critically evaluate the values and assumptions underlying current practice guidelines, (4) incorporate issues involving SPVs along with cultural awareness about diverse sociopolitical groups into multicultural education in graduate and clinical training programs and provide continuing clinical education programs involving culturally sensitive practice, and (5) take steps to encourage those having diverse sociopolitical backgrounds and values to enter the profession, particularly political and religious conservatives, who are vastly underrepresented in the mental health professions. Each is briefly discussed below.

Given that people are often discriminated against because of their SPVs, the potentially strong biasing effects that client SPVs can have on clinical judgment, the importance of SPVs to clients' identity, and the frequent relevance of SPVs to clients' presenting problems and their psychological as well as interpersonal functioning, sociopolitical values must be included in the lists of enumerated cultural factors found in our ethics codes and multicultural practice guidelines (see Duarte et al., 2015; Redding, 2001). Multicultural training, which has "been found to promote students' self-awareness and to increase their therapeutic competence" (APA, 2003, p. 386; for a review of the effectiveness of training programs, see Rogers & O'Bryon, 2014), is now an important component of every APA and ACA accredited training program. Graduate programs should include training on SPVs, perhaps including "safe zone" training geared toward developing understanding and sensitivity toward sociopolitically diverse clients, much like the training programs developed to sensitize students to LGBTQ issues (see Finkel, Storaasli, Bandele, & Schaefer, 2003).

Importantly, we must develop evidence-based best practices for working with sociopolitically diverse clients, just as we have for other kinds of culturally diverse populations, and multicultural practice guidelines, treatises, and training programs must incorporate such content. In addition, multicultural competency assessment tools (for reviews, see Cartwright, Daniels, & Zhang, 2008; Frisby, 2018a, 2018b) should be expanded to assess SPV awareness. "Cultural competence" and related constructs (e.g., microaggressions, multicultural assessment, cultural oppression) still lack sufficient definition and empirical validation (Frisby, O'Donohue, Benuto, & Casas, 2018; O'Donohue & Benuto, 2010; Satel & Redding, 2004) and, importantly, research on their application in the context of sociopolitical values. We must develop training curricula (see Rogers & O'Bryon, 2014) for SPVs as well as best practices for clinical supervision (see Inman & Ladany, 2014) so that supervisors have the awareness, knowledge, and skills necessary for training and mentoring supervisees.

In developing evidence-based practices for serving sociopolitically diverse clients, we must also consider how the liberal SPVs of the mental health professions can impact clinical practice broadly. For example, some therapy approaches adopt a leftist-oriented victimology approach designed to help clients gain insight into how their problems may be due to societal oppression (e.g., racism, sexism) and privilege (e.g., white privilege) (see Comas-Diaz, 2012; Munoz & Mendelson, 2005; Smith, Reynolds, & Rovnak, 2009). Indeed, some suggest that the multicultural practice movement is driven by a politically liberal identity politics that views certain demographic groups as victims and others as oppressors (see Frisby & O'Donohue, 2018; Lukianoff & Haidt, 2018; O'Donohue & Benuto, 2010; Satel & Redding, 2004). For example, "multicultural ethics" is seen as including a commitment to social justice and a focus on the role of oppression (Fisher, 2014).

On the other hand, some therapies perhaps associated with conservative SPVs are deemed unethical. Consider therapies aimed at changing a client's unwanted same-sex attraction (see Santero, Whitehead, & Ballesteros, 2018). The APA condemned these therapies as being ineffective, potentially harmful, and homophobic (see APA, 2009). Commenting on the APA's *Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (APA, 2009), an APA official said, "We cannot take into account what are fundamen-

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tally negative religious perceptions of homosexuality-they don't fit into our worldview" (Yarhouse, 2009). The APA's position is framed by the view that homosexuality is normative and that a client's desire to change his sexual orientation reflects societal stigma and discrimination (APA, 2009). Perhaps, however, clients should have the freedom to choose their own therapeutic goals. There are many reasons (e.g., to avoid discrimination or rejection by family or friends, to have a biological child in a traditional family structure, to conform to their religious beliefs, to explore a heterosexual lifestyle) that a client may wish to try to change their normative sexual behavior, if not their normative sexual orientation. Should our professional guilds reject clients' values and life choices by blocking access to such therapies, particularly when the evidence for their ineffectiveness or harm is at least arguable? (For counterarguments to the extant scientific and clinical evidence against these therapies, see Rosik et al., 2016).

Finally, we need more sociopolitical diversity in the mental health professions. In particular, we need more politically and religiously conservative clinicians if we are to competently and fully serve these populations. Increasing the number of conservatives in the profession will likely require affirmative reaching out and recruiting efforts not only in graduate admissions but also in faculty hiring (Redding, 2001, 2012). In addition, we certainly should not be doing what Eastern Michigan University's counseling program did when it dismissed a conservative graduate student because she introspected on her values and religious beliefs, concluded that she could not work with a gay client who was sociopolitically different from herself, and took the ethically appropriate action of referring the client to another counselor (Ward v. Polite, 2012).

These five professional reforms are necessary to move toward being sociopolitically competent mental health professions. If we fail to do so, sociopolitically diverse clients may be reluctant to seek needed mental health services, our training programs will not adequately prepare clinicians to work with sociopolitically diverse clients, and our therapeutic success with these clients will be compromised.

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