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## Client-Centered Practice when Professional and Social Power are Uncoupled: The Experiences of Therapists from Marginalized Groups

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# Client-Centered Practice when Professional and Social Power are Uncoupled: The Experiences of Therapists from Marginalized Groups

## Abstract

*Background:* Client-centeredness is foundational to occupational therapy, yet virtually no research has examined this aspect of practice as experienced by therapists from marginalized groups. The discourse of client-centeredness implicitly assumes a “dominant-group” therapist. Professional power is assumed to be accompanied by social power and privilege. Here, we explore what happens when professional and social power are uncoupled.

*Method:* In-depth interviews grounded in critical phenomenology were conducted with Canadian therapists (n = 20) who self-identified as disabled, minority sexual/gender identity (LGBTQ+), racialized, ethnic minority, and/or from working-class backgrounds. Iterative thematic analysis employed constant comparison using ATLAS.ti for team coding.

*Results:* Clients mobilized social power conveying direct and indirect hostility toward the therapists. Clients used social power to undermine the professional credentials and competence of the therapists. In turn, the therapists strove to balance professional and social power, when possible disclosing marginalized identities only when beneficial to therapy. Strongly endorsing client-centered principles, the therapists faced considerable tension regarding how to respond to client hostility.

*Conclusions:* The discourse of client-centeredness ignores the realities of marginalized therapists for whom professional power is not accompanied by social power. Better conceptualizing client-centeredness requires shifting the discourse to address practice dilemmas distinct to marginalized therapists working with clients who actively mobilize systemic oppression.

## Keywords

racism, heterosexism, ableism, classism, ethnocentrism, Canada

## Cover Page Footnote

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## Credentials Display

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Research examining the experiences of occupational therapists from socially marginalized groups is extremely limited, with virtually nothing on the experiences of therapists from lower socioeconomic status backgrounds; those who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ+) (see Beagan et al., 2012; Jackson, 2000); or racialized and ethnic minority therapists. One UK survey concluded that racialized occupational therapists experienced barriers to career progression (Bogg et al., 2006), and a recent study with racialized therapists in Canada identified racism at interpersonal, institutional, structural, and epistemological levels (Beagan et al., 2022). Research on disabled occupational therapists is scant but has been increasing in the past decade, documenting how they are perceived in the profession as less competent and as potential risks to client safety, are treated like clients rather than colleagues, and may face barriers to career progression (e.g., Bulk et al., 2017, 2020; Jarus et al., 2020).

In this rather sparse field, there is some suggestion that experiences of client-centeredness may be dramatically different for therapists who do not enjoy the power that accrues to members of socially-dominant groups. One small study (Beagan & Chacala, 2012), conducted a decade ago, examined the work experiences of disabled and ethnic minority therapists in Ireland. Participants experienced marginalization by colleagues and supervisors, institutional norms and systems, but most difficult to address was direct and indirect hostility by clients. No participants reported client incidents to supervisors, fearing it would undermine their competence, and almost none confronted clients, even about overt hostile encounters. In only one instance did a therapist confront a client, and the therapist was still troubled by this years later, saying, “Professionally, I should have walked away. In hindsight, now, I did do the wrong thing, and I accept it” (p. 149). Arguing that she should have put her client’s needs ahead of her own, she stated, “It’s the client’s wish that is paramount. What I was doing was putting [first] my wish to be accepted as a person, to be recognized as a person” (p. 149).

Beagan and Chacala (2012) raised concerns regarding client-centered practice, particularly for therapists from marginalized groups: “Guidelines [for client-centered practice] tend to assume that all the power lies with the therapist [having] virtually nothing to say about clients discriminating against therapists and how that changes the client-therapist relationship and power differences” (p. 149–50). They note that occupational therapy’s emphasis on power-sharing with clients assumes the therapist is a member of socially-dominant groups, failing to address situations in which professional power and status may be undermined by membership in socially-subordinated groups. This is precisely the tension we explore in the current paper.

### **Client-Centeredness in Occupational Therapy**

Client-centered practice is grounded in the 1940s work of psychologist Carl Rogers, which was widely used in multiple professions (Kirschenbaum & Jourdan, 2005). Rogers argued that client-centered practice requires therapists to experience and communicate empathy and unconditional positive regard for the client and their frame of reference (Rogers, 1959). This involves “warm acceptance of each aspect of a client’s experience as being part of that client” and being a “genuine, integrated person . . . freely and deeply [one]self” (p. 828).

These concepts have clearly been endorsed in occupational therapy, where client-centeredness is a core value (American Occupational Therapy Association, 2020; Canadian Association of Occupational Therapists [CAOT], 2002; Royal College of Occupational Therapists, 2021; World Federation of Occupational Therapists, 2010). The current backbone of occupational therapy theory and practice in Canada, *Enabling Occupation II* (Townsend & Polatajko, 2013), reiterates the importance of client-

centeredness from its origins in *The Guidelines for the Client-Centred Practice of Occupational Therapy* (CAOT & the Health Services Directorate, 1983). In *Enabling Occupation II*, client-centeredness is described as “an essential element of occupational enablement; practice must be client centred” (Townsend & Polatajko, 2013, p. 208) and approached with a “tireless optimism” (p. 103). In this and other texts, client-centeredness entails focusing on client goals, involving clients in decision-making, respecting client experience and knowledge, respecting client values and perspectives, and, importantly, sharing power with clients through collaboration (Hammell, 2013a; Restall & Egan, 2021). *Enabling Occupation II*, echoing Rogers (1959), urges therapists to express “positive regard for people just as they are” (Townsend & Polatajko, 2013, p. 106) and advises that “successful, collaborative power sharing involves genuine interest, acknowledgement, empathy, altruism, trust, and creative communication” (p. 108).

### **Critiquing Client-Centeredness**

There have been numerous critiques of client-centered practice in occupational therapy (e.g., Hammell, 2013a, 2013b; McCorquodale & Kinsella, 2015; Restall & Egan, 2021; Wilkins et al., 2001), and even an entire issue of the *Scandinavian Journal of Occupational Therapy* (Vol. 22, issue 4, 2015) devoted to “critical perspectives” on client-centeredness. These critiques focus almost exclusively on challenges to implementing client-centeredness at institutional and systems levels, client-therapist differences regarding client-centeredness, and how therapists can fully enact client-centeredness. For example, Wilkins et al. (2001) argue for the need for a better understanding of power and power-sharing. Hammell (2013b) challenges the notion that clients experience occupational therapists as client-centered, emphasizing respect, humility, and critical awareness of power, privilege, and positioning (p. 147). Some have called for sustained critical reflexivity among therapists to identify how their social positioning affects client-centered therapy (e.g., McCorquodale & Kinsella, 2015). The most recent critique (Restall & Egan, 2021) suggests client-centeredness remains individualistic, ignoring social relational power differences: “There has been little acknowledgment of occupational therapists’ practices or complacency that perpetuate racist and oppressive practices and structures” (p. 3). They call for practice grounded in relational collaboration to promote justice and equity: “A collaborative relationship-focused practice requires therapists to be continuously aware of their own social positionality and the privileges and disadvantages accorded by their social identities including, but not limited to, race, sexuality, gender, and ability” (p. 4).

While we completely agree with this emphasis on critical reflexivity (interrogation of how practice is shaped by social structures of power and how therapists perpetuate or resist and transform those), we also argue it leaves something, or rather someone, out. The discourse of client-centered practice in occupational therapy assumes, implicitly, that the therapist is a member of socially-privileged groups: white, settler, Western, able-bodied, heterosexual, cisgender, and middle class. It also assumes clients hold little power, with any social power erased by the client-therapist dynamic.

The implied socially-privileged therapist in occupational therapy discourse warrants critique. Amir Jaima (2019) suggests texts concerning racism almost always assume a white reader, writing to persuade and justify, to convince that racism exists. This “discursive orientation toward whiteness” tacitly establishes the white reader as normal, expected, and normative. Similarly, when the discourse of client-centeredness in occupational therapy emphasizes (unidirectional) power-sharing, enabling (incapable and/or powerless) others, coaching and educating others, the “discursive orientation” assumes the therapist embodies not only professional power but also social power through socially-privileged status (Hunter &

Pride, 2021). Power-sharing is described as the therapist “giving” clients power to participate in the enabling process; therapists are urged to “invite clients to exert their power” (Townsend & Polatajko, 2013, p. 107). Occupational therapists are exhorted to recognize how they “exercise power over patients” (Iwama, 2007, p. 23) and to “learn how to let go of some power and give it to the other” (p. 24). Even literature urging therapists to develop critical awareness of power, to recognize when they are imposing their (dominant) worldviews on clients (Hammell, 2013b; Restall et al., 2021), is still speaking to dominant-group therapists:

As educated professionals, occupational therapists are usually accorded higher status than clients, and this may be reinforced by the inequality of their specific social positions that may derive from their dominant class and racial status, gender identification, sexual orientation, physical ability, dominant language fluency, citizenship status, colonial history, ethnicity, age, religion, learning abilities, mental health, and material wealth: positions that intersect to determine significantly the distribution of social power, privilege, and life opportunities. (Hammell, 2015, p. 239)

This discursive orientation that binds professional power to social power ignores the realities of therapists from marginalized groups while conveying a message that they are unexpected in the role. The dominant discourses of the profession are not speaking to them. This is confirmed by the absolute absence of any guidance for therapists from oppressed groups on how to enact client-centered practice in the context of oppression. Social realities of racism, ableism, heterosexism, and so on do not vanish when a person earns therapist credentials. A truncated and unidirectional understanding of power is employed, with the therapist all-powerful, the client only vulnerable. Without denying professional power, we argue this framing erases myriad social power relations that complicate this absolute binary.

In Canada, we collect almost no demographics in the profession, but calculating from census data, “visible minority” therapists make up about 14% of occupational therapists (Statistics Canada, 2016). We can only guess what proportion identify as disabled, LGBTQ+, working-class origin, ethnic minority, and/or Indigenous. How, exactly, are those therapists (who may well collectively be a majority in occupational therapy) expected to take up client-centered practice with its emphasis on power-sharing and attending to therapist privilege? How, in the context of systemic racism, ableism, classism, ethnocentrism, gender binarism, and heterosexism, does client-centeredness play out? These are the questions we ask in this research.

### **Client-Centered Practice in the Context of Oppression**

While this question has not been interrogated in occupational therapy, it has been explored in social work, another profession immersed in Rogers’ client-centered practice. In Toronto, Harjeet Badwall (2014) found clients expressed overt racism toward racialized social workers, questioned their credentials and abilities, refused to work with them, and directed violence and threats toward them. Such moments were experienced as “violent, shocking, and painful” (p. 1), yet when participants spoke of racism to colleagues or managers, they were reminded “to stay client-focused, empathic, and critically reflexive about their professional power” (p. 2). Some were instructed “to continue working with clients who uttered death threats and exercised physical violence toward them,” not allowing their own feelings to “get in the way” (p. 12). Some were told client expressions of racism reveal effective client-centered practice, building such trust that clients feel free to articulate their racism. Colleagues denied or explained away racism, urging participants to focus on clients’ past trauma.

Badwall (2014) argues that the “governing scripts” of the social work profession, “empathy, client-centered practices, and critical reflexivity,” regulate workers “as they come to represent the right way of performing one’s role” (p. 8). They simultaneously entrench whiteness at the heart of the profession, “tacitly assum[ing] that the worker is a member of the dominant group” (p. 9). “Good” social workers acknowledge and counter their own power when working with clients (p. 9). Client-centered discourse, then, only allows workers to occupy subject positions of power, insisting clients reside in positions of powerlessness and need. Racialized social workers in this study inevitably embodied professional power but did not experience themselves as embodying social power relative to dominant-group clients when they were on the receiving end of racial violence. Yet naming racism in the therapeutic encounter violated client-centered scripts, thereby situating the racialized professional outside the norms of “good social worker.”

The governing scripts about good practice were in direct tension with workers’ experience of racist attacks... Racism pulls the worker outside of their good practice, which is constructed as remaining focused on the client’s needs . . . . Is it possible to sit with a client’s racism, alongside their position as a person who is vulnerable, marginalized, and in need of help? The overarching and fixed understandings of the worker–client relationship as powerful/powerless leave very little room, if any, to discuss such transgressions within the context of social work. (Badwall, 2014, p. 10)

Client-centeredness assumes power is unidirectional, with professional status amplified by therapist membership in socially-dominant groups, thus rendering invisible (or invalid) therapists from marginalized groups.

In this paper we take up Hammell’s (2015) challenge to bring critical perspectives to dominant assumptions in the profession, to question taken-for-granted ideas, in this case, the tenets of client-centered practice that assume the all-powerful therapist and the always-powerless client. Our aim is to explore the experiences therapists from marginalized groups have with clients and how they reconcile those with client-centered practice. By including the experiences of therapists from multiple marginalized groups, we question the notion of unidirectional power relations in which professional power is *de facto* bound up with social power, asking what happens when professional power is not accompanied by social power.

### **Method**

This qualitative study was approved by three university research ethics boards. Twenty participants were recruited across Canada through professional organizations and networks. Team members sent study information to professional contacts and provincial organizations. Participants had to self-identify as disabled, working-class origin, racialized, ethnic minority, and/or minority sexual/gender identity and have at least 5 years Canadian practice experience. (Indigenous therapists will be included in Phase 2.) Those who were interested contacted the research assistants by email. Eligibility was confirmed, and they were sent informed consent documents. Those who agreed were scheduled for an in-person or telephone interview with one of three interviewers. Two were occupational therapists, one a sociologist, and all were members of the social groups recruited for the study. Informed consent was discussed before commencing the interviews.

Semi-structured, in-depth interviews were conducted by phone or in person. The interviews explored belonging and marginality, privilege and oppression, coping, and resistance and followed an interview guide serving as a memory aid. They were recorded and transcribed verbatim by a professional transcriber. Transcripts were coded using ATLAS.ti software. Codes were gradually identified through a

collective process, some arising from the data, others from engagement with theory. Some of the codes were eventually broken down for finer detail, and others were merged as a broader category became apparent. Quotations were eventually “cleaned” by removing false starts and filler words like “um,” “like,” and “you know.”

Iterative analysis moved between compiling coded data and re-reading full transcripts, comparing and contrasting, and organizing and reorganizing themes and sub-themes. The thematic analysis continued through the writing process. For example, we coded overt hostility and microaggressions, then later combined these and separated client hostility from colleague hostility. When we started analyzing those data through the lens of client-centeredness, we shifted to seeing this as an analysis of how and when social power is mobilized, and by whom. Critical interpretive research in the qualitative paradigm (Ahmed, 2006; Alvesson & Skoldberg, 2000) demands interpretive analysis in line with the researchers’ theoretical and methodological positioning. In this tradition, it is insufficient simply to report on or describe participant narratives, rather, the data must be interrogated in relation to theory and concepts, striving for theoretical density. Thus, our analysis process was iterative in the sense of circling more and more deeply into the data but also cycling back and forth between data and theory.

While we report demographics, we deliberately keep details vague to maximize confidentiality. The 20 occupational therapists all identified as members of at least one of the socially marginalized groups. Their ages spanned from the 30s, 40s, and 50s, with the participants fairly evenly distributed across years of practice, from 5 to 25 years. Most were women, and most worked in community or private practice, with some in academia, hospitals, and other institutions.

### **Limitations and Rigour**

The study is limited by having a relatively small sample that is also heterogenous, which may mean glossing over important differences in experiences. Nonetheless, saturation was deemed to have been reached on most themes. For example, we might lack detail regarding the experience of being a South Asian therapist in a small town, but our broad inquiry about processes of belonging and marginality, oppression, and coping, were well-addressed in the data. Qualitative data are not ideal for comparisons, rather, they enable depth of understanding. We began to see similarities in the processes of social exclusion across the transcripts, regardless of identity categories. This sense of growing familiarity is a classic lay definition of saturation. The heterogeneous sample adds strength by allowing exploration of experiences across multiple groups.

The study was further limited by having conducted only one interview per person. Though the single interview intended to reduce participant burden, this is minimal to examine such a complex topic. At the same time, getting even an hour with busy professionals was challenging.

We did not employ member-checking, as our previous experiences have shown busy professionals rarely respond with feedback. However, the larger research team as well as this smaller author group, are comprised of individuals who identify with the social groups included in the study. Lived experience informed every aspect of the study, from inception through analysis and writing. Weekly meetings throughout the study enabled reflexive discussion and analysis of emerging interpretations, a form of research triangulation. This “thinking together,” holding up a reflexive mirror to one another to make assumptions explicit, has been termed “transpersonal reflexivity” (Dörfler & Stierand, 2020). At the same time, we presented our preliminary results to a therapist audience to ensure the results resonated with therapists from marginalized groups.

## Results

The study participants thought their lived experiences of oppression and discrimination were valuable to their work, helping them connect with an array of clients. They noted that negative experiences with clients were less common than those with colleagues and managers, but experiences with clients were challenging to navigate when social power was uncoupled from professional power. Below we explore three main themes: experiences when clients mobilize social power, challenges to therapist professional power, and balancing social and professional power through selective identity disclosures for client benefit. Finally, the fourth theme examines how acceptance of client-centeredness made confronting hostile clients near impossible.

### Clients Enacting Social Power

The therapists described hostility from clients based on the therapists' non-dominant identities. One participant referred to frequent "name calling." One described being screamed at by the son of a client who did not meet equipment funding criteria: "I remember her son just being completely irate and yelling at me in the hallway, like, 'If I was [Asian], you would be getting a scooter for my mom!' and saying things like that, which was completely racist." Several of the participants spoke of clients refusing to work with them.

There were a few clients who were probably not comfortable working with somebody who was a different race from them, who were different. So, some clients flatly refused and said that you know what, I am not talking to you.

One participant was told by a case manager that a client was "feeling uncomfortable because I was Black" and preferred a new therapist. Possible rejection became a constant concern when seeing new clients: "That extra question in the back of my head, as to whether or not I'm going to be accepted." Other therapists were rejected for their accents:

One incident where a client was blatantly racist with me, and she told me that I had an accent and she couldn't understand me, which, clearly I don't have an accent. And it was clear that she just didn't like me, for whatever reason. And I can only attribute it to the fact that I am visibly Asian.

Potential hostility left some participants concerned for their personal safety. For example, one LGBTQ+ therapist described not being "out" at one job for safety reasons: "I didn't know how people would react. Would they be violent? Would they be aggressive? Would they report me to my boss?" Another LGBTQ+ therapist stated, "I have had bad experiences with clients. And I'm still nervous with—I've had bad experiences with men. Male clients." One Jewish therapist described feeling very unsafe disclosing her identity when working with clients who had been members of the German SS during World War II, or even in highly conservative rural and remote communities.

Therapists also described incidents of indirect hostility, where clients said or did things not aimed at them, but nonetheless hurtful: "They'll just make some sort of comment, sort of making conversation with me, but not even realizing that their opinion might actually be impacting me personally." Racialized and ethnic minority therapists routinely heard assumptions and stereotypes about their ethno-racial group or about racialized people more broadly:

There's a lot of times where clients will say, not directly to me, but it is a racist comment about 'Well, all these people come into the country and they don't pay taxes and they get all these free things. I've paid taxes all my life and I can't get these things.' You know? You get really tired of hearing that, over and over again.

LGBTQ+ participants spoke of overhearing homophobic comments from clients. Jewish therapists spoke of working with clients who had swastika tattoos or made anti-Semitic comments: "It doesn't even occur to them that the person they're talking to might be Jewish."

### **Using Social Power to Challenge Professional Power**

One of the key ways clients disparaged therapists from marginalized groups was to undermine their credibility and professional authority. For example, several Asian therapists described being seen as "too young" to be legitimate professionals, suggesting this is a distinctly gendered experience for Asian women.

I'm a small Asian woman, and I look really young, maybe they don't take me as seriously . . . One guy I can think of basically told me to go away, like I don't know what I'm doing or what I'm saying . . . He was like, 'Well what do you know? You're not a professional. You're just a girl' or whatever. And other people just thought I was, like, their granddaughter's daughter, coming in to visit them. [Or] they thought I was selling Girl Guide cookies!

She worked hard to dress more "authoritatively" to compensate: "There's certain things that I can't wear . . . Because I look young I have to overcompensate and dress like I'm like 40 (laugh)." One Asian therapist reported frequently being mistaken for a support worker, or a masseuse, denying her professional status through the deployment of stereotypes. Some therapists had clients directly question their competence ("Do you even know what you're doing?"), including demanding to see their college registration and asking about their practice experience: "Some clients did ask me about my college registration to prove that I'm an actual occupational therapist . . . One client would say, 'When did you finish school? How long have you been practicing?'" One therapist thought her accented English meant clients were unable to see her as a professional: "They wouldn't say directly but it was the impression that I had, that because of my accent they didn't then see me as a professional."

Potential loss of credibility was also a concern. One racialized therapist debated including a self-photo on a practice website, questioning whether it would deter clients. Some LGBTQ+ therapists, especially early in their careers, worried about the potential impact of disclosure on their credibility: "With clients, I would worry that they would think less of my capability, trust me less, just have an opinion of some sort that could potentially be negative." The disabled therapists generally thought their experience of disability was valued by clients; one participant suggested if clients observed her doing things differently without her having identified as disabled, they might doubt her competence: "I think it could undermine my reliability, their confidence in me as a health professional."

One participant thought a disability identity enhanced her credibility with clients, yet worried that actual evidence of symptoms might undermine credibility:

I would definitely be afraid that they would not open up as much to me . . . It's one thing to know it, but it's another to see the symptoms. I would be afraid they would shut down or think, "This person's not professional enough."

This participant learned to “suck it up a little and fake it a little bit more . . . for the sake of clients, so that they have confidence that their OT knows what she’s doing.” This took significant work:

There’s still so much hiding . . . The hiding of the symptoms, which is really hard to do, but you get to become a master at it. You know, if you’re sitting with a client and you’re face-to-face in their home, and you’re exhausted, if they turn to show you something out the window then you can sneak your yawn in . . . I can hide anything. I can walk behind people. There’s even times when I feel so tired or unstable on my feet, and I’ll just make a joke to the client, “You go first. I have to watch your gait.” Meanwhile, I’m staggering along, holding on to their own railings. Like, so much time and energy is spent hiding aspects of the disability that continue that you don’t want the client to see.

### **Balancing Social and Professional Power**

Some of the participants had no choice about conveying marginalized identities to clients: race is often self-evident, as are some disabilities. Others had to constantly navigate potential disclosures, trying to ascertain if their identities would prove “a potential barrier” to connecting with clients. One ethnic minority therapist never disclosed to clients, saying it was irrelevant to therapy and might compromise her safety; on the rare occasions it might arise, she would “divert the subject.” A Jewish therapist stated, “I just would never discuss it or share it. It just wouldn’t come up.” She avoided wearing symbols or anything that would disclose her ethnicity. Similarly, some therapists from working-class or impoverished family backgrounds avoided letting clients find out about their class origins to avoid judgement: “I keep that to myself. . . there’s like, a little bit of embarrassment there.” Some LGBTQ+ therapists simply never disclosed sexual or gender identity to clients to avoid “potential conflict” where they might get hurt: “Honestly, I usually just try and avoid the subject, unless I’m sure that they’re open to it.” Like not wearing symbols of Judaism, most LGBTQ+ participants spoke about monitoring their appearances, striving not to look “too flamboyant” or “too butch.”

The major concern regarding identity disclosure was about potential harm to therapeutic rapport. The participants described a potential double-bind, harming therapeutic rapport by disclosing marginalized identities or by not disclosing, and many reported using disclosure only when it might be of therapeutic benefit. For example, one participant spoke of the harm to rapport after disclosure to clients:

It’s more subtleties. I’ve never had an experience where they were overtly homophobic. It’s more people would stop opening up to me, or they would become suddenly very awkward and standoffish, and my rapport with them changed. You know, there was no overt homophobia, like they weren’t saying anything against me, but the relationship and the dynamic changed, and I could feel that they were uncomfortable.

Yet, the participants also raised concerns about how avoiding disclosures might harm rapport with clients. They had to avoid chatty conversations: “I definitely don’t share much with my clients, just surface things.” When clients asked direct questions or made assumptions about the therapist’s ethnicity, disability status, or personal relationships, therapists were forced to decide whether to evade, ignore, or disclose: “I would always shut that door very, very quickly. And yeah, I feel like it doesn’t allow for as natural an exchange.” This could thwart therapeutic relationship-building:

Being able to establish that therapeutic relationship with your patient, it does require like a give and take in terms of information. So if you don't talk ever about yourself . . . You know, I've worked with some people for like, a year. So over a year, you see them once or twice a week, and they still don't know. And I don't know if they feel that, but it, definitely, I think, conflicts with that therapeutic rapport that you're supposed to be able to establish with your patients, because you're always hiding something.

One participant struggled overtly with “hiding something,” saying she wanted to be more fully integrated: “I don't feel good if I feel like I'm purposefully evading disclosing, don't like that . . . that's definitely uncomfortable for me.” Another therapist had learned quickly in school that disclosing her ethnic identity, particularly regarding religion-spirituality, was considered unprofessional: “I went through a serious struggle where I felt like I couldn't be me in all that I am.” She struggled with “therapeutic use of self” while trying to completely “cut off” an important part of herself.

If both disclosure and non-disclosure may threaten therapeutic rapport, the participants settled on only disclosing if it seemed valuable therapeutically. One disabled therapist noted, “I almost never disclose to clients, unless I feel that it has some bearing on my, I guess, connection with them or their sense of trust in me, or their understanding that I actually empathize with them and their child.” Similarly, an LGBTQ+ therapist who rarely disclosed to clients qualified, “Sometimes I've actually been open because it's been helpful therapeutically with a client, to be open about my sexuality.” One participant readily shared her working-class origins with clients to help her connect with those who had work-related injuries because of manual labor.

The participants had to figure out for themselves how to navigate disclosure and non-disclosure: “Just over the years, that's sort of been where my comfort level has fallen.” None said this was addressed in their education. In fact, one therapist described working with a student on field placement who wore hijab, yet no one ever spoke with her about how that might affect her encounters with clients: “It was just a non-issue . . . But then I think, ‘Well, wait a minute. It wasn't a non-issue for her!’ And we, I never talked to her about it, no one ever really talked about it.” The participants were left to figure out how to navigate disclosure and non-disclosure of unexpected, and possibly unwelcome, identities, and the potential impacts on therapist-client encounters. As one therapist noted, the ability to choose regarding identity disclosure was a privilege, but also required constant work: “[It's] still a painful thing, the fact that I even have to do that, to make that decision.” This was echoed by another participant who said, “I'm always sort of conscious and aware of that, when I'm speaking with clients, and trying to gauge honestly, whether or not they would accept me if I was open to them about my identity.”

### **Accepting and Challenging Client-Centeredness**

Generally, the participants endorsed the notion of keeping therapy always focused on the client, not disclosing marginalized identities, or disclosing only when beneficial to clients, and not confronting clients who were hostile to them. Repeatedly, the participants said they avoided letting anything get “too personal”: “Therapy's not about me. It should be about them.” A disabled therapist used her own experience very carefully: “Ethically, I don't want to ever tell them too much, because I don't want it to become about me . . . You can really cross those lines, into revealing too much.” One participant clearly articulated professional obligations:

My professional obligation as an occupational therapist, that when you have a client you shall do no harm, you have to provide the best possible care. If you feel you weren't able to do that based

on your own personal core values, then you have to bring it forward, discuss with the manager and look for alternatives.

Numerous participants repeated the language of “professional responsibility,” “altruism,” “client comfort,” and “best possible care.”

Yet there is little recognition in the tenets of client-centeredness of the challenges this poses to therapists from marginalized and oppressed groups. For example, one therapist described a client whose delusions led to racist verbal attacks on her in a group setting. While she did not blame him, it became her responsibility to make sure the rest of the group was okay after such attacks: “I kind of limited the interaction more in a group setting because I didn’t want the clients to be uncomfortable, and I didn’t want other clients to, to kind of feel different about that client.” If it was an ongoing relationship, some would ask to have a client transferred to a different therapist, but only if it proved otherwise impossible to make the client comfortable. This expectation of professional altruism masks the pain that is distinct to and routinely experienced by therapists from oppressed groups: “With clients that have been sort of rude to me . . . of course inside I will be hurt from what they say, but I don’t think I will treat them differently after that.” Ensuring client comfort clearly takes precedence over the emotions of the therapist, even when the encounter activates ongoing oppressive hostility.

Responding professionally is particularly difficult when the disrespectful comments or actions are emotionally devastating:

I don’t react initially because it’s like a slap in the face. It’s a shock. So it takes time, before, right? At first, you just get this autonomic nervous system response, and you can’t really think clearly. And then, as you calm down, by the time you really, you’ve had a chance to process it, the conversation has moved forward. And once a conversation has moved forward, then I actually typically make a decision not to say anything directly.

As one therapist said, even in the face of overt hostility, confronting the client is not an option: “I wouldn’t have confronted them. There is still the feeling of I’m the therapist and I have to— That’s not my— My role is to do everything to make the client feel comfortable.”

### **Responding to Client Hostility**

Only in rare instances did the participants ever confront a client who had said or done something racist, anti-Semitic, homophobic, ableist, and so on. Rather, they found creative ways to absorb the harm, evade it, turn it into a joke, or leave. One participant said when clients expressed hostility toward her, “I would try to take it as a joke, I would laugh it off with them.” If clients could not respect her, “that hurts in the moment, but then, I always come home, and I try not to take it personally (laugh).” Another therapist had, over time, become “desensitized” hearing racism from clients and had learned to end conversations “that might be detrimental to me”:

When they’re just being particularly nasty . . . at that point, there’s really no conversation that can be had with somebody who’s very angry and being belligerent . . . I’ve sort of grown tired of listening to that, so I’ve become, I guess, more adept at cutting that conversation off and leaving.

One participant described trying to forge relationships creatively, even with clients who were directly racist:

With the clients, I couldn't explore why they said what they said, given that these were my clients, so I found a very creative way to work with them, to get them to know me as a person, how I could support them, rather than trying to explain myself as a racialized ethnic minority.

She insisted on engaging even when clients refused to speak to her. Another therapist also persistently built connections as a way to handle the anti-Semitism of clients who did not know she was Jewish: "This often is my strategy, is to establish a relationship with the person, and then, once I have a relationship, do that thing where I subtly let them know."

The participants rarely confronted clients. One therapist occasionally spoke up about overtly racist or homophobic comments by clients: "Sometimes, I will politely say to them, 'You know, I don't agree with that' and 'Can we move on?' But if it's something subtle and not harmful, then I usually just try and change the subject." Another participant had found a lighthearted way to challenge clients on some expressions of contempt: "I'm like, 'Dude, this is not appropriate here. Like, you gotta keep that somewhere else!'"

In only one incident did a participant directly challenge a client, who she overheard making overtly homophobic comments loudly enough for everyone to hear. As he was leaving, the therapist spoke with him, asking him to curtail such comments:

He was like, "Whatever. I'm going to say whatever I want" kind of thing. I tried to stress that our conversation, or basically what I'm saying to him is not going to impact his treatment in the clinic or anything else like that, but that, "This is really offensive to me, as a gay person. And you know, you don't know who else could hear." He just kind of brushed me off and walked away.

Though "satisfied" later, the participant described being "a little bit anxious to do it . . . to confront somebody and say, "Hey, this is not cool and I want you to stop doing that." The next day her boss questioned her about it, and "kind of wasn't overly supportive of it." Here the therapist seems to frame confronting a client as professional and client-centered, noting she was concerned about the safety of other clients.

### **Client-Centeredness Assumes Dominant-Group Membership?**

The ambivalent support by the boss echoes the narratives of the other participants, who were urged to continue engagement with clients who had treated them poorly. One racialized therapist who had left when a client refused to work with her reported the situation to her manager and was asked to go back next time for follow-up, "which I wasn't really happy with." Another participant whose client did not want to work with a Black therapist returned to the home a few times at the case manager's insistence. She said, in retrospect, she should have insisted the manager do something about the racism displayed by the client, "'cause it's not okay for me to have to carry that burden by myself." In all instances where therapists were asked to leave or clients refused to work with them, they were expected to continue to work with the clients, except in one case where the client was transferred to another therapist. Only one participant commented that their agency had "a zero tolerance policy" wherein "people cannot just ask for a new provider, because they don't like their color, or they don't like their race. Like, that's not a reason to ask for a new provider. That's not tolerable."

A few participants cast doubt on some of the expectations of client-centered practice itself. Even those who endorsed, repeatedly, the trope that disclosing anything is "too personal" raised doubts about

the ways this intersects with dominance and oppression. For example, one participant avoided wearing symbols that would convey her religion, but noted no one else did:

I'd look around me and my colleague OTs didn't even think about wearing a cross that way. I think that's about cultural-centrism, when you're part of that dominant culture. Like, I think it never even occurred to them, that that provides information about them.

Similarly, while LGBTQ+ therapists carefully navigated disclosures, striving to stay on the surface with clients, they all pointed out that heterosexual colleagues routinely talked about personal matters: "My colleagues can say 'Oh my husband, my kids- ' And nobody's going to say, 'Ohhhh, you said your sexual orientation!'" One participant stated quite bluntly that the stance that disclosing sexual or gender identity is "too personal" is "really just homophobia disguised as concern for clients," as long as heterosexual therapists are not equally cautioned to hide their identities: "I think it's bullshit." LGBTQ+ participants refuted the notion that impacts on clients would be negative, suggesting that out therapists provide positive role models.

### Discussion

Client-centered practice is a hallmark of occupational therapy, and we in no way disregard its importance. Clients should always be at the center of their own therapeutic processes, taken seriously, and involved in decision-making. Therapeutic relationships should always be grounded in mutual respect, and therapists should remain attentive of and work to mitigate the operation of power relations, both professional power and systemic, socially structured power relations of privilege and oppression. What we are arguing is that power relations can be multi-directional, particularly when therapists are not members of dominant social groups.

As Badwall (2014) found among racialized social workers, the occupational therapists in this study experienced direct hostility and disrespect, including client refusal to work with them, as well as indirect hostility such as comments about others of their social group and clients undermining their authority and credibility. These experiences were painful and upsetting, even if routine. To maximize their own safety and prevent loss of credibility, the therapists engaged in stigma management (Goffman, 1963). Some who could "pass" as members of non-stigmatized groups avoided identity disclosures to clients, though they worried this harmed therapeutic rapport. Some disclosed selectively, when beneficial to clients, or disclosed identity while masking or toning down the implications of that identity, such as actual symptoms of chronic conditions. Passing and minimizing the impact of stigmatized identities (or "covering") have a long history in the professions (Yoshino, 2006).

Returning to Rogers' (1959) dictums for client-centered practice, the narratives of our study participants pose distinct challenges to the notion of conveying unconditional positive regard and empathy for clients while remaining integrated, congruent, genuine, freely, and deeply oneself. Is this really possible for therapists from oppressed groups? When they must shut down their feelings or hide their identities in the face of hostility? When occupational therapists are exhorted to engage in "collaborative power sharing" with clients, to "invite clients to exert their power" (Townsend & Polatajko, 2013, p. 107–108), to critically reflect on their own social privilege, does it matter that the therapist may hold little social power in that encounter?

In the context of oppression, the credibility and competence of therapists were always under threat, requiring extra work to prove themselves. Client comfort was paramount, meaning clients' mobilization

of social power should not be challenged, and therapists should absorb all of the discomfort of racism, heterosexism, ableism, and so on. The therapist's responsibility to build rapport meant presenting as "normally" as possible and not disclosing differences from expected norms. Providing the "best possible care" meant stepping outside those normative expectations only when it was likely to result in better care, with no guidance on how to make that decision, nor on what it means to "respond professionally" to oppressive hostility by clients.

We are in no way suggesting the therapists in this study failed to engage in client-centered practice, nor that therapists from marginalized groups are less capable of client-centered practice. In fact, the participants expressed overwhelming endorsement of its principles, enough to demonstrate the dominance, even hegemonic status, of this professional value. But this is much harder when clients are racist, classist, ableist, ethnocentric, or heterosexist. In Badwall's (2014) study, social workers who detailed client racism to their colleagues were advised to be more client-centered, not to let their feelings interfere, and to continue working with these clients while reflecting on personal and professional power. This resolute return to the normative discourse constructs the systemic power relations of racism as individual failings with individual potential solutions. In our study, therapists seemed to do this themselves, seeing their experiences as personal failings in their implementation of client-centeredness and taking responsibility for reparation. The very few participants who confronted clients on their deployment of oppressive power emphasized confrontation was done "politely," carefully. They justified it by the potential harm done to other clients and worried about whether they had been unprofessional. Also, as in Badwall's (2014) study, the therapists did not feel particularly supported by managers, typically being sent back to work with clients who had been hurtful to them. Only one participant reported an agency policy that supported therapists who experienced discrimination from clients. No one reported agencies checking to see if they were okay.

Despite the endorsement of client-centered practice, there were also hints of ambivalence regarding the idea of some things being "too personal" to convey to clients. This is where Jaima's (2019) "discursive orientation" toward an implied dominant-group reader is most evident. Most of the participants retreated to the idea that being themselves in the therapeutic relationship, being fully and genuinely themselves as Rogers (1959) insists, is too personal, making therapy "about" them instead of about the client. Yet some of the participants also critiqued this notion, observing that therapists from dominant groups are never exhorted to keep private their heterosexuality or cis-gender identity, their able-bodiedness, their middle-class backgrounds, their white, Western, anglophone selves. That discursive absence marks their dominance. Again, we are not arguing that therapists should make themselves the center of therapy; we are suggesting the need to examine critically the professional scripts that say some therapist identities are disruptive or abnormal and must remain hidden and private.

It is also time for critical recognition of the practice dilemmas distinctly raised for therapists from marginalized groups when working with clients who are actively mobilizing systemic oppression. Though they embody professional power, not all therapists are members of powerful, dominant social groups. Some may experience oppression and exclusion in many facets of their lives. They are left to figure out for themselves how to enact client-centered practice in the face of client hostility. They are left to figure out what an "integrated self" looks like and how to genuinely show unconditional positive regard for clients who are disrespectful, demeaning, and hurtful. Client-centered practice is not the same for therapists from different social locations. When the discourse of client-centered practice speaks (implicitly) only to therapists from dominant groups, it conveys a subtle message that therapists from

marginalized groups are, at best, unexpected. As Jaima states, “we need to actively displace the normative, [dominant group] subject that has colonized the rhetorical space” (2019, p. 222) if we want to create alternatives.

## Conclusion

There is an inherent tension in client-centeredness when social power is uncoupled from professional power, as is the case for occupational therapists from socially marginalized groups. When faced with racism, ethnocentrism, ableism, classism, heterosexism, and/or cisgender binarism expressed by clients, how does the therapist display unconditional positive regard for the client, while remaining genuine, congruent, integrated, and authentic? In the face of these structural power inequities, client-centeredness is a very different “ask” than it is for therapists from dominant groups, exacting a very different toll. Developing a more comprehensive understanding of client-centered practice means shifting the discursive orientation of the profession to include (or begin from?) the experiences of marginalized therapists.

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