Unconscious Bias:

A Psychodynamic Exploration

By

Sarah Jane Crosby

The thesis is submitted to the Quality and Qualifications Ireland (QQI) for the degree

MA in Psychotherapy from Dublin Business School,

School of Arts

Supervisor: Heather Moore

June 2019

Dublin Business School

Table of Contents

ACKNOWLEDGMENTS

To Heather Moore, for her boundless enthusiasm and confidence
To Ann Gleeson, the tonic to all research malaise
And finally Claire Kennelly, who's unwavering love aided the keying and capturing of each and every letter

Thank you all, so very much

ABSTRACT

This thesis will present a psychodynamic exploration into unconscious bias. The angle taken will focus on the unconscious bias of the psychotherapist, as well as the lived experience of the client who encounters it. Unconscious bias is alive within us all. It affects the way we perceive and process our daily life as well as the manner in which we respond and react. Unconscious biases are the actions and judgments made automatically to which we are not cognizant. Beliefs, attitudes and behaviours shaped by our lived experience cause recognition of perceived differences; a separation. We create an Other, and subsequently, a Self. The psychotherapeutic community and the Psychotherapist are not exempt from such a process. Unconscious bias at the hands of practitioners has been experienced by many based on many factors such as race, skin tone, social class, gender identity, sexuality, body size and countless others. The experience of the client is one of internalized shame, invisibility and a reaffirming of the life they lead outside the walls of the therapeutic space. Clinician's bias emerges without conscious intent but stands to impede the relationship. Keeping this in mind, this paper touches on the early field, or rather the early acknowledgment of weight bias. Although in its infancy, there is an argument to be made for the importance and need for understanding how the early work of psychotherapeutic pioneers furthered the rhetoric associated with bodies of size, and the self-work needed by the clinician to understand the extent of their countertransference.

Psychoanalytic theories have much to say about the construction of the Self, Other, bodies and evidently, countertransference. In this way they are well positioned to present a perspective on the presence of unconscious bias.

INTRODUCTION

When we reflect on the word 'bias', what comes to mind? Possibly we think of our personal lives and the predilections we employ on a daily basis. We may consider our early life. There might have been a perceived 'favourite' in the family home or a 'teacher's pet' in the classroom. Perhaps we think of clinical work; the client who brings an involuntary smile to our face, or on the contrary, a frown? Bias is regarded in many forms. On one level, bias is sometimes harmless; a partiality to oat milk over almond. In other ways, as is the focus of this research, bias is oft denoted as a separating of Self from Other. A distinction between 'Me' and 'You'. Other and Othering.

Biases are beliefs based in individual and societal thoughts and perceptions, many of which are unconscious. The consequence of unconscious bias typically stands to reinforce prejudice; bias can stigmatize, shame and discriminate the recipient(s) on which these belief systems are touted. Prejudice, stigma, shame and discrimination: the four horsemen of malevolence. Four hurdles, or *Everestian* feats, in the ability to empathize while maintaining a stance of unconditional positive regard.

While psychotherapists usually do not display conscious biases, it is clear from the research they can still have strong unconscious ones (Boysen, 2009). As psychoanalytic and psychotherapeutic theory lends itself so well to an exploration of the unconscious human experience, how can we understand the formation of unconscious bias from this lens? The first section of research will consider just this by unpacking the first experience of Self and Other, between that of infant and

caregiver.

It has been documented that the therapeutic process is influenced by the values and biases of the practitioner, in spite of phantasies concerning therapeutic neutrality (Lopez, 1989; Murray & Abramson, 1983). The therapist and client both have their own lives outside of the room. They both exist in a society shaped by unconscious bias and therefore bring forth their own biases and prejudice into the therapeutic space. Individuals considered minorities, or Other, due to race, sexuality, gender identity, religious beliefs, body size and many other factors, may experience the unconscious bias of the therapist in myriad ways. Therefore, the middle section of this paper will hone in on the documented experience of clients who have been exposed to the unconscious bias of the therapist. From the outlook of the client, it will explore how a therapist's unconscious bias may render a client invisible while giving attention to the emergence of bias through parapraxis.

In relation to this paper but specifically Chapter 3, this researcher has chosen to use the word 'fat' as a descriptive word. Using the term 'fat' in its original and descriptive capacity is to deconstruct the pejorative use of the word, and rather utilize as a word akin to describing someone as tall or short. References to fat, as well as other terms associated with fat used by other authors, are also utilized in order to preserve the original intent of the literature studied in constructing this essay. During the research process, there has been much use of medical terminology in relation to fat bodies such as 'obese' and 'overweight', terms often used to pathologize people living in large bodies. It is therefore important to this researcher that the use of the term is recognized as a way of participating and contributing to the paradigm shift happening in respects to fat acceptance and intersectional diversity movements.

In the medical arena, there is a plethora of literature surrounding the issue of fat, in particular, fat women. These areas are explored through the lens of the 'obesity epidemic', with much to say in the way of health implications and methods of losing weight. The primary focus of mental health literature is on behaviours and reasons behind the 'cause' of fatness, rather than exploring the lived experience of fat individuals or fat clients in therapy. The latter part of this thesis will therefore consider the emerging research concerning weight bias and prejudice against people living in larger bodies.

The definition of weight stigma is the negative outlook toward others, and beliefs about others due to their weight (WHO, 2017). At risk of breaking the fourth wall, this researcher asks kindly of the reader, to take a moment to reflect on a question:
What feelings and thoughts arise while envisioning fat-bodied people?

In the age we live in, arguably not a day goes by without an expressed fear of fat. These may not be quite so 'on the nose' as the decrees of 'Slimming World' and 'Weight-Watchers'. It can also be as simple as applying a moralistic view to food consumed. Newsfeeds and food aisles are awash with messages such as 'treats', 'indulgences', 'cheat meals' followed swiftly by 'low fat', 'zero calorie' and the not so subtle, 'syns'.

Considering the question above, fear of fat can appear through unconscious bias, such as believing that a large body is a result of moral failures, a result of laziness, emotional ill-health and a lack of willpower (Gilman, 2008; Gracia-Arnaiz, 2010a). With all of this in mind, how does unconscious weight bias come into therapeutic

training and space?

In a time in which social groups are actively addressing and unpacking various forms of prejudice, with debatable levels of success, this research aims to shed light on the aforementioned issues and through a theoretical examination ascertain how unconscious bias enters the therapeutic process.

AIMS & OBJECTIVES

Aims:

The aim of this thesis is to explore unconscious bias. It will primarily focus on the unconscious bias of the therapist and seeks to show the lived experience of clients who encounter therapist unconscious bias. It will explore the creation of Other and Self, from a psychodynamic perspective, looking at the work pre and post Freud, as well as from the lens of object relations, attachment and further contemporary research.

It will consider how unconscious bias emerges in the therapeutic encounter with clients, looking specifically at clients who are often categorized as 'minorities'. It will gauge how unconscious bias pageants itself in the therapeutic space, by means of avoidance and parapraxis. Finally, it will investigate the matter of weight bias. Is this an issue the therapeutic community play a role in? If so, where did it come from? How is it emerging today? This thesis aims to examine these issues via the lens of psychodynamic theory, theory that is well situated to make observations on the human condition.

Objectives:

- To conduct a theoretical desk-based exploration on unconscious bias drawing from academic research and literature
- To draw on both psychotherapeutic and psychoanalytic perspectives as models of enquiry which are concerned with unconscious processes and the human

experience. In this way they are well positioned to consider a Psychotherapist's unconscious bias

- To explore the ways in which unconscious bias may be communicated to clients, regardless of intent
- To consider psychotherapy's place in light of the emerging research and acknowledging of weight bias

APPROACH AND CONTEXT

Many studies have been conducted into the experience of bias within the mental health arena. Observational studies, within the realm of socio-cultural and anthropological fieldwork, have also been piloted. Unconscious or *implicit* bias (as it is referred to in social justice theory) is typically considered from a sociological viewpoint. The underpinnings of which are, naturally, based on the work of social theorists and social psychologists, most notably the work carried out by Kenneth Gergen who authored *The Saturated Self* (1991) and *Relational Being: Beyond Self and Community* (2009).

This thesis is concerned with approaching the topic of unconscious bias from a psychodynamic perspective; exploring the concept of the Self and Other as it emerges from these unconscious processes, and how this might impact the therapeutic encounter. The scope of unconscious bias is much too large a subject to take into account every aspect and angle involved. It is not feasible within the remit of this research paper to conduct a large-scale study intended to measure the presence, impact and experience of unconscious bias on that of the clinician, the client and the therapeutic relationship. It is also not considered possible to evaluate the experience by focusing research on practicing and retired psychotherapists, as the very nature of the topic is an exploration of *unconscious* bias.

Likewise, given the contemporary nature of the research surrounding weight bias, the willingness to engage with the topic was low. Weight bias has been and is considered a controversial topic by some, with many not knowing or misunderstanding the need for further psychotherapeutic research in the area.

Theoretical study allows for an exploration of the theory upon which contemporary research is built and paves the way to assess the need to carry out further qualitative research in the future. For these reasons, it was felt that a desk-based research model would work best to begin exploring unconscious bias from a psychodynamic framework, with acknowledgment that there is opportunity for further investigation into this area utilizing field-based research models.

In many ways, the experience of minority groups can only ever be fully understood by those who experience it. Likewise, one person cannot speak for the experience of the group. Therefore, for those of us as researchers, awash with our own unconscious biases, we can only ever study and ponder what the subjective experience of each individual person may be. This is the constraint and limit to this type of investigation.

CHAPTER 1 UNCONSCIOUS BIAS, SELF & OTHER

1. Unconscious Bias

"In the most primitive societies, in the most antique mythologies, one finds a duality, that of the Self and the Other…"
(de Beauvoir 1949, p.18)

Research on unconscious bias has produced a host of terms used to convey the same meaning. Implicit is used in tandem with unconscious. Bias is often denoted as prejudice, stigma, Other and Othering. Going forward, in order to retain the validity of the primary research, this enquiry will also use these terms in their original context. Biases are beliefs that are not founded by known facts about someone or about a particular group of people. For example, one common bias is that women are weak despite many being exceptionally strong. A gay man is assumed as promiscuous, when he may be in a committed, monogamous relationship. Another is that individuals living in large bodies are lazy, when they may be incredibly active. People often are not aware of their biases, which are called an unconscious or implicit bias. Such unconscious biases influence our decisions whether or not we mean for them to do so.

Greenwald, McGhee, and Schwartz (1998) outlined unconscious bias as "actions or judgments that are under the control of automatically activated evaluation, without the performer's awareness of that causation" (p.1464). Beliefs, attitudes, and behaviour are influenced by early experiences, which affect individuals in an implicit or

unconscious way, unaware of the experiences that have formed their beliefs and behaviour (Greenwald & Banaji, 1995).

Mendonza-Denton & Perez (2016) refer to unconscious bias as an Othering and a differentiation from the Self; a set of dynamics, processes, and structures that engender marginality across the full range of human differences. Ways in which individuals garner a Self and an Other typically include the dimensions of religion, sex, race, ethnicity, socioeconomic status, disability, sexual orientation, body size and skin tone. Unconscious bias may then show itself in subtle Othering ways, through microaggressions that receivers of bias experience; most of which occur without the contributor's intent (Constantine, Smith, & Owens, 2008; Sue, Capodilupo, Torino, Bucceri, Holder, Nadal & Esquilin, 2007).

It can be surmised from the plethora of research carried out on the topic, that nobody is without bias, in some shape or form (Staats, 2015). Many psychotherapists are able to cultivate awareness around their biases given the importance placed on self-development, multicultural competencies as well as the diverse backgrounds of trainees in certain programs; however, their ability to hone stigma-free skills may prove more complex (Chao & Otsuki-Clutter, 2011). While psychotherapists usually do not display explicit and strong biases, it is likely that they can still have strong unconscious biases (Boysen, 2009). Research on unconscious processes has shown that a person does not need to consciously support a stereotype or be consciously mindful of that stereotype in order for their actions or responses to be affected (Dovidio, Gaertner, Kawakami, & Hudson, 2002, Sue et al., 2007). Furthermore, people may not be aware of the individual attitudes to which they assent. For this reason, a person may not realize when they experience negative stereotypical

opinions, rendering them unaware to the psychological impact that bias may have on their beliefs and behaviours. Given that implicit is unconscious, it is difficult to prevent or stop the process of Self and Other, particularly as this assumed instinctive reaction is not vying for resources that control attention (e.g., Devine, 1989; Gawronski, Hofmann, & Wilbur, 2005; Wittenbrink, Judd, & Park, 1997). It would seem a review then, of psychodynamic theory may prove indispensable when considering such unconscious processes.

According to psychoanalytic and psychodynamic theorists, the self is unconscious and conscious. It is the result of complex psychological processes with the environment through mutual mirroring (Kohut, 1978). It is our experience of our mother's body and internalized representations of such. It is our attachment, our genetics and the architecture of experience. Without Other, we are not a Self. How then, do we form a 'Self', and how do we form an 'Other'?

With bias and otherness characteristically considered from a social theory perspective, it is the aim of this chapter to highlight how a psychodynamic viewpoint can enhance our understanding of unconscious bias, through an examination of the formation of Self and Other. Psychotherapy and psychoanalysis offer rich insight into the concept of the inner unconscious world. Given that bias is indicative of a separating of Self from a perceived Other, a psychodynamic perspective is a valuable tool to explore the inevitability and the manifestation of the first experiences of individuation; that of infant and Mother.

2. Formation of Self and Other

Before the birth of psychoanalysis, philosophers such as Aristotle, Kant and Plato thought of human beings as having an essence, which they termed the soul or 'self'. It was their belief that the soul or self formed the core of human beings and also that it was 'the subject'. Here the word subject is used to mean the action of the verb, rather than the psychodynamic understanding of the term. The self was thought as the subject of our mental and physical actions; the feeler of our feelings, thinker of our thoughts, initiator of our actions. We are both the essence and the subject, and through this sprouted the concept of a singular being, undivided and whole. As a result, the self is always referred to by the word 'I'. I feel a chill. I find that silly. I slept in late. It was only when Freud came along, the idea of being something other than an undivided entity was seriously considered. Freud (1895b) did not accept that the *single being* could satisfy the questions of "Who and what am I?" He challenged this model, believing human beings to be an array of parts; a theory, which went on to shape the burgeoning field of psychotherapy through to what it is today.

2.1 Psychoanalysis

Sigmund Freud

Freud's divvying up of the unified being begins with his earliest writings on hysteria. His patients appeared both to know and also to not know certain things.

"With regard to these feelings, she was in the peculiar situation of knowing and at the same time not knowing", Freud writes of Elisabeth von R's love for her brother-in-

law (1895b, p.165). As well as this, while in conversation with Lucy R, he recounts how when asked if she knew of her love for her employer she replied: "I didn't know, or rather I didn't want to know. I wanted to drive it out of my head and not think of it again; and I believe latterly I have succeeded" (Freud 1895b, p117). Freud was presented with evidence, of what would later underlie his legacy. His belief? We are not a unified 'self' but divided. We are conscious and unconscious. His patient's unconscious self knew, but censorship prevented such knowledge from passing to the conscious self.

Jacque Lacan

Lacan (1966) also believed claiming a unified self to be misleading as it neglects the unconscious. For both Lacan and Freud, the ego, or in German, 'Ich,' which is just 'I', is something that is created largely by material put on us by our parents and others; our self, according to Lacan (1988), is an imagined creation. Whereas Freud saw the unconscious as our deepest desires and a better candidate for our 'true self' than the ego-creation, Lacan (1988) saw the unconscious as syntax with no semantics. The unconscious is a set of strings; symbols that for one reason or another have settled below conscious awareness and now sit above main stage as the puppeteer. What they both seem to highlight in their own way, is that both the unconscious and the ego are the result of experienced language that has crossed our desires and labelled them. What remains, the 'unthinkable,' is called by Lacan (1977) 'the Real'.

Lacan's (1977b) concept of the mirror stage of human development, formulated from the theories of Freud, lies at the core of psychoanalytic theory. Fundamental

components of the mirror stage include the concepts of Otherness and Identity. Kurzweil (1981) explains that Lacan finds that a child's first and usually jubilant response to its own reflection in a mirror, "…which is said to happen between six and eighteen months, is of fundamental importance [it] is the child's initial awareness of itself as a biological organism, as an entity bound up with the human species…" (p.425). Gallop (1982) adds that Lacan saw in the mirror stage "the root stock…of later identifications" (p.119). Malin (2011) echoes Gallop (1982) where he writes, "Lacan's mirror stage proper takes up the beginning development of the sense of self or personal identity… and describes the developmental achievement of the infant and toddler acquiring his first felt sense of identity…" (p.65).

Therefore, Lacan's mirror stage and early theories centre on the imaginary register. The imaginary is the register of meaning, and all that is known thought and fantasized, whether conscious or unconscious; the imaginary is variable within shifting contexts of signifiers (Lacan, 1977b). Therefore, all meaning and knowledge of Self and Other is subject to countless interpretations, both subjectively and intersubjectively (Malin, 2011, p.65). According to Malin (2011), "…our consciously held sense of self and identity, along with the entirety of our subjective experience, are therefore all imaginary; never absolute, and forever ephemeral, changeable, illusory, and deceptive" (p.72). Ultimately, Malin (2011) elucidates that "Lacan's distinction between the terms Other and other is that the former represents the abstract metaphysical concept, while the latter refers to people and/or fantasies of and about people" (p.72). The mother-child relationship proves helpful in clarifying the Lacanian model.

Current psychoanalytic theories focus on predictable developmental sequences where

the early experiences of the self alter in relations to an expanding awareness of Other. Once such self-other patterns develop, it is thought these experiences are taken with us and influence our later interpersonal relationships.

2.2 Object Relations

Object-relations theory explores the internalized interpersonal relationships represented intrapsychically. Freud (1905) used the term object to refer to that which satisfies a need, or to the individual or thing that is the target of one's drives. In theoretical literature, the terms 'object' and 'other' are often used interchangeably to refer to an important individual whom the child and later the adult becomes attached. Rather than being distinct individuals with personal identities, the infant views the other as an object for fulfilling needs (Klein, 1997).

Klein

Klein (1952) was influenced by Freud's ideas about the unconscious, and continued to explore the inner life (Segal, 1992/2004, p.28). She considered the caregiver as the object of love or hate for the infant, and this becomes implicit in the infant's experience of loving and hating (Klein, 1997). Klein developed her work from the Freudian psychoanalytic foundation, which was concerned with the early formative years. She considered the strong connection between the conscious and unconscious life (Klein, 1997). The infant was engaged with two conflicting impulses; love and hate, or as her later work would elaborate, the life drive and the death drive. Her

observations were about anxiety, symbolism and phantasy - the components of everything as she saw it (as cited in Mitchell, 1986/1991, pp.11-21).

Therefore, the paranoid-schizoid position can be understood as a type of splitting, which occurs in the infant (Klein, 1997). According to Klein (1952) for the infant, life is organized and commandeered as a result of the persecutory anxiety, which stems from the death drive; a factor that Klein proposed plays a greater part in the life of the infant, than that of the Freudian libido (Klein, 1997).

Although not a conscious worry, the baby fears death and annihilation moreover, they unconsciously phantasise about it (Klein 1952, p.433). These persecutory emotions are further perpetuated day to day through the discomforts of living, be it experiencing hunger, needing to be changed or feeling sick. These everyday discomforts create a frustration in the baby and the baby believes they are being attacked "by hostile forces" (1952, p.433). In contrast to this, the feelings that are experienced as comforting and caring such as feedings are experiences as coming from good forces. It is at this stage of three to four months old, Klein (1952) believed the splitting processes are at their peak.

It is important to mention here the other central ideas of the Kleinian split, particularly those of objects and object relations, introjection and projective identification, which all play their part in the paranoid-schizoid stage (Klein, 1997). In order for the baby to manage the discomfort of the hostile forces, the infant introjects the idealisation of the good forces into good objects, more often read as the good breast. For example, as the infant's need for food is repeatedly met again and again, over time, the mental image of the nipple or bottle will bring with it feelings of comfort and soothing (Gerhardt

2004, p. 24). In so doing, the infant is better able to create a sense of regulation and protection, which satisfies the developing ego. Therefore, for this sense of safety to occur, the denial of the hostile forces is a subsequent consequence. These negative feelings are projected outward onto the mother and become the bad objects, or the bad breast. This splitting of good and bad, in essence, is of one of the fundamental concepts of Klein's (1997) theory of early development, and pivotal to the infant's ability to form a sense of Self and Other. The fact that all bad is projected outwards, coupled with drives to destroy the bad, causes the infant to become paranoid that the hostile forces will return an attack. In order to cope with this anxiety, the infant begins a cycle where in order to attain a sense of control, some negativity is introjected and some good is projected unto the primary care giver so that they may protect the infant from harm.

These "rapid fluctuations between love and hate" continue until the ego of the infant cultivates the ability to integrate the good and bad fragments (Klein, 1952, p. 203). This development leads the infant to the realisation that the good and bad object are one, and furthermore, to the understanding that the self and objects, possess both good and bad. In other words, the infant realizes the bad mother (bad breast), who they phantasized of destroying in the paranoid-schizoid stage, is the same person who they love, the good mother (good breast) (Klein,1952;1997). The destructive desires the infant experienced for the bad mother were also directed towards the good mother. Likewise, the infant who phantasized about destroying the parent is the same infant who loves the parent (Klein, 1952).

The fear of annihilation, which played its part in the paranoid-schizoid stage, is replaced by a fear of destroying the object. It is the subsequent guilt that arises from

the unity of these fragments and consequent realisation, which make up the depressive position (Klein, 1997). The infant's ability to integrate these complexities, the good and bad fragments of both self and object, involve an appeasement effort, to restore and fix the object they love, which they were planning to destroy (Klein, 1997). Furthermore, it is in the ability to integrate such fragments, communicate with the mother through a symbolic language and restore balance, which according to Klein, form the basis for the development of wholesome connections in later life (as cited in Casement 2014, p.28).

Winnicott

As with Klein, Winnicott emphasised the importance of the mother-infant dyad as well as embracing and expanding on Klein's object relations theory. Winnicott (1964) placed greater emphasis on the early relationship between mother and child, stating "there is no such thing as a baby" (Winnicott 1964, p.88). By this he meant that both infant and mother are united; the infant, indistinguishable. At this early stage, the baby is utterly reliant on and cannot be thought to exist without mother. Although Klein also paid significant attention to the mother-infant dyad, Winnicott (1953, p.90) placed additional focus on the environment of the infant, most notable from his concepts of the 'good-enough' mother and the 'holding environment'. According to Winnicott (1967), the self is characterized by its intricate experience of the mother's body and representations, from which the child has to separate. Winnicott's (1986) thoughts on the development of the self, proposed that the infant battles with the concept of a shared reality, their developing sense of self compounded by the mother's ability to contain and hold the infant (Rodman, 2003, p.326-328). By

maintaining a symbolic link to the mother's representations, the self becomes a place to seek refuge, to be able to relax and to feel that one is real.

Winnicott described three stages in infant development- the first stage of absolute dependence, the second stage of transition and thirdly, the stage of relative independence (as cited in Jacobs 1995, p.37). In the first stage of undifferentiated unity, the infant needs an illusion of connection with the mother in order to feel omnipotent and in complete control of the mother. This is confirmed for the infant when the mother is reciprocal to the needs of the baby and the baby in turn experiences its own body as a secure place in which to live (as cited in Jacobs 1995, p.38).

In the transition stage, a period of disillusionment occurs. The infant becomes aware of others' needs placed upon the parents. If such frustrations are introduced in a graduated way, the ego is strengthened. However, if disappointments occur abruptly, it can be traumatic for the infant, and can result in damage to development and the sense of self. The parent must allow the child to project their anger and frustration onto the parent, while the parent's response will determine whether the infant will accept these emotions as parts of themselves or deny them entirely.

> The good-enough mother...starts off with an almost complete adaptation to her infant's needs, and as time proceeds, she adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure (Winnicott 1953, p.90)

The 'good-enough' parent will meet the cues of the infant, knowing when to allow rest and recovery, and when to re-engage. In this case, the parent and infant enter into

an affective resonance; a synchronicity of positive arousal and interactive repair, the building blocks of attachment (Winnicott, 1953). Caregivers, Siegel (2003) articulates, "…are the architects of the way in which experience influences the unfolding of genetically preprogramed but experience-dependent brain development" p.37). Therefore, it is the cumulative effect of the parent's responses, which start to form well-trodden pathways leading to the formation of the not only secure or insecure attachment, but the organisation of the developing brain (Gerhardt, 2015). Genetics potentiate, experiences shape.

If every need of the infant is met in exactly the right way at the right time, then the infant will not move beyond this sense of unity to the development of individuation and separateness. It is this relationship with the primary caregiver that firstly shapes the development of self, identity and ability to individuate. The holding environment aims to provide the necessary background to allow for the growing child's disillusionment with the parents and the world, without destroying their appetite for life and ability to accept reality (Jacobs, 2017). So important is such holding, that Casement (1985) says it is also integral to the therapeutic process in order to "recover or discover maybe for the first time, a capacity for managing life and life's difficulties without continued avoidance or suppression" (p.133). In essence, the balance between providing for the infant and a normal level of frustration forms the basis of healthy holding, containment and a secure attachment.

In order to support this period of transition toward independence, the infant will acquire a transitional object (Winnicott, 1971). This is an alternative to the mother, a replacement when the carer leaves from time to time. This may take the shape of a soft toy or blanket; something comforting which is reminiscent of the comfort

bestowed by the 'good enough' mother. As mentioned previously by Klein (1953, p.93), the infant engages in this form of splitting, dividing the mother between the mother and the transitional object. The object assists in the development of the sense of self and other, allowing the infant to let go of the early need for a 'magical' sense of omnipotence, providing a pathway to independence. As examined above, the transitional object runs parallel with Klein's (1952) concept of the depressive position.

If the infant passes through the transition stage effectively with a healthy early relationship with the parent, the child will enter relative independence, developing a functional, healthy false self - one they are comfortable with presenting to the world and one that can experience compliance without feeling they have betrayed their true self. An environment where there is a lack or an impingement, risks an unhealthy false self, "a schism in the mind that can go to any depth – at its deepest it is labelled schizophrenia" (Winnicott 1964, p.66).

2.3 Attachment & Contemporary Research

Bowlby

In most contemporary psychotherapeutic modalities, a sense of self and identity are capacities, which bear the imprint of the early relationship with the primary caregiver. It is thought that through these means, the child acquires their own capacity to feel and think, thereby establishing what self and identity mean. To examine a psychotherapeutic theory, which speaks to the inner world, Bowlby's attachment theory is possibly one of the most significant.

From an attachment stance, developed upon the formative works of Bowlby and Ainsworth, it is again the quality of the connection between parent and child that influences the development of Self and Other (Bowlby, 1969). Similar to Lacan, the internal working models are mental *symbols*, which in turn represent the self, and others, which help individuals envisage, comprehend and endure their environment.

Bowlby (1969) suggested that an infant's longing for its mother's love is greater than the child's desire for food. In absence of the mother's presence, the effect on the infant's relational and attachment response, is profound. Bowlby (1969, p.xiii) concentrated on the ways in which a baby responds to the loss of the mother and to the reunion with the mother. He witnessed that the impact of the infant's environment at these early stages of life is such that when there is disturbance or deficiencies in it, it will have a bearing on the life of the adult person (Bowlby, 1969, p.45). A general critique of the formative works of Freud, is that he did not give enough attention to social influences throughout the life span. However, Bowlby (1969) emphasised such social influence on the development of Self and Other. He connected levels of separation anxiety and independence with defensive processes linked to the infant's environment.

Ainsworth (1978) labelled the attachment styles as ambivalent, avoidant, disorganised, and secure (Bretherton, 1990, pp.765). She also developed the Strange Situation, a practice used to gauge patterns of secure and insecure attachment (as cited in Sonkin, 2005). Such early attachment experiences will habitually establish the infant's attachment style. It was determined that a parent who disguises emotion will likely generate an avoidant attachment style in the child. Moreover, a child who

experiences volatility and unpredictability can form an ambivalent attachment style and responds to feelings of uncertainty by continuously reaching out (Gerhardt, 2004, p.26).

Siegel (2015) describes the brain as an anticipation mechanism. It is designed to help steer our way, providing anticipations of likely results and holding information of our environment. The baby slowly begins to catalogue their experiences with other people, unconsciously discerning common qualities (Diamond 2007, p.144). Early traumatic relationships can have a detrimental effect on the development of the brain, the core of the human unconscious and the glue that holds together a sense of self. Schore's (2016) call for a need for early intervention strategies are not only justified, due to the emerging findings in neuroscience and neurobiology, they are clearly supported by decades of research carried out by those that have gone before him. As Siegel (2015) believes, in essence it is "…through signs and signals, we come to know each other and by knowing each other we come to know ourselves" (p.245).

To conclude, the aim of this chapter is to shed light on what unconscious bias is and how we can understand it from a psychodynamic perspective, by looking at what is a Self and Other. Examining theories deriving from Psychoanalysis, Object Relations and Attachment, we can gather the formation of Self and Other is in itself a multiplicity of processes and systems. It is unconscious and conscious. It is our experience of the primary care giver, the 'good-enough' parent as well as the internal representations of such. Self and Other is found in our attachment, in our genetics and in the architecture of our experiences. Without Other, there is no Self.

Unconscious biases are the beliefs and behaviours we have or perform in relation to

an Other. From a psychodynamic examination, the separating of Self and Other can be viewed as an inevitable process, one of the utmost importance in every modality, for the developmental health of the child and the adult they will grow to be. This fundamental splitting of Self and Other seems to support the historical and contemporary research, which acknowledges that nobody is without bias; we are all a Self, formed in relation to an Other. We all have bias 'blind spots' when it comes to detecting stigmatizing viewpoints or conduct in ourselves. It is a subject that may garner more questions than answers as when exploring the subjective experience of bias, one is still simply exploring what it is to be human, with the addition of what is a 'Self' and what is an 'Other' in an ever-changing cultural landscape. How then does an unconscious and seemingly inevitable process, impact the therapeutic relationship?

CHAPTER 2 UNCONSCIOUS BIAS & THE THERAPEUTIC ENCOUNTER

"When they approach me they see only my surroundings, themselves, or figments of their imagination—indeed, everything and anything except me".
(Ellison 1947/1990, p.3)

It has been documented that the therapeutic process is influenced by the values and biases of the practitioner, in spite of aspirations of therapeutic neutrality (Lopez, 1989; Murray & Abramson, 1983). Therefore, the focus of this chapter is on highlighting how unconscious bias appears in the therapeutic environment. From the perspective of the client, it will explore how a therapist's unconscious bias may render a client invisible while giving attention to the emergence of bias through parapraxis. The aim is to highlight how unconscious bias has and continues to present itself in the therapeutic encounter between Self and Other. In order to emphasize how unconscious bias appears, this chapter will reference empirical research carried out examining prejudice and stigma in therapy, with clients from minority groups and diverse backgrounds.

1. Influence of The Psychotherapist

Both the therapist and the client bring with them their own personal biases, prejudices, cultures, and histories into the working relationship. The undertaking of the therapist who is of the dominant culture, particularly therapists with no familiarity

of persecution, is to recognize their own personal privilege and concurrently manage the accompanying sense of guilt or shame they feel; such changes can have a substantial impact on the therapeutic relationship, development of connection, the client's experience, and effectiveness of therapy (Kelly & Greene, 2010; Dyche & Zayas, 2001).

Shonfeld-Ringel (2001) states that an understanding of the effect of the therapist's power and clout on the therapeutic process on a social, political and psychological level, are important variables in the therapeutic alliance. Given the significance and enormity of the task placed upon the therapist during the initial sessions, it becomes imperative for the therapist to adequately equip themselves with knowledge, sensitivity and a willingness to be open. The social researcher Dewane (2006) argues that it is the point at which the client and therapist's belief systems meet which enables therapeutic growth to ensue, but that a meticulous and watchful eye must be kept on the unfolding power dynamics, in order to avoid clinician proselytizing or indeed the arrival of a 'Messiah'. Therefore, Dewane (2006) defines the relationship as fundamentally reciprocal, consisting of genuine affection and intimacy between both client and therapist. Dewane (2006) links this to the concept of the first split between infant and caregiver, and the corrective emotional experience, first cited by Alexander & French (1946) to show how both the therapist and client are bound within a relational dynamic. Importantly, the therapist's own fallibility and humanness are brought to light in this dynamic. Change processes in the therapeutic relationship can, therefore, be as intensive and anxiety provoking for the psychotherapist as they may be for the client. The therapist's anxiety must be recognised as a normal part of the therapeutic process (Casement, 1985), and that it can provide an opportunity for therapists to observe and confront their internal

dialogues, in order to avoid it influencing the client towards the therapists own bias and unconscious fears (Dewane, 2006).

There is also little agreement about the degree or the means in which it is ethical and suitable for a psychotherapist to act as an influence on the client (Spong, 2012). Variances arise between the theoretical modalities, in particular between cognitive behavioural therapy (CBT) and Rogerian psychotherapy. Those practicing from a person-centred perspective can see CBT as imposing a particular rationalistic standpoint. Classical person-centred therapy would have no place for challenging prejudices directly, trusting to the power of unconditional positive regard to facilitate the client's growth (Bozarth, 2007). As Rogers (cited in Witty 2005) stated: "One of the cardinal principles in client-centred therapy is that the individual must be helped to work out his own value system with a minimal imposition of the value system of the therapist". (p.10). Nevertheless, Witty (2005) discusses, it is the exact nature of this minimum that is the essential subject for the person-centred therapist. For some other psychotherapeutic approaches such as psychodynamic psychotherapy, the issue may be less directly addressed as the psychodynamic clinician may foray into the uncharted territory of the Rogerian clinician; by challenging a client's perspective or behaviours (Proctor, 2002). Perhaps more pertinent to this study is the proposal that influencing a client, through avoidance of certain issues or an ill-timed slip of the tongue, towards observed social norms or values of particular therapeutic modalities can be more easily accommodated within psychotherapeutic discourse given the powerful position a therapist is often given (Spong, 2007b).

There may also be a fundamental difference in the acceptability of psychotherapists influence between directive and traditional approaches. Directive therapy can contain

an explicit intention to challenge existing social power relationships, which is interpreted by some other clinicians as a breach of the therapist's duty and power, whose job it is to work from and facilitate the client's world view rather than imposing the therapist's outlook (Totton, 2000; Spong, 2007a). Considering the influence of the therapist, and the means by which a clinician may influence, is significant in understanding the client's response to what they have perceived as a therapist's unconscious bias.

2. The Invisible Client

The arena of psychotherapy emerged from predominately white, male, middle class contexts (Gerig 2014; Ratts, 2014). According to Wade (2006) and Butler & Shillingford-Butler (2014), clients who do not originate from such dominant groups fundamentally do not align with the foundational heritage of analysis. This may apply to individuals from ethnically and socially diverse populaces. Sue & Sue (2013) examined the experience of Black clients attending counselling. They found that Black clients present unique and complex situations which counsellors from Western, socially privileged groups may not be prepared to encounter (Sue & Sue 2013; Nadal, Griffin, Wong 2014). Butler & Shillingford-Butler (2014) found that Black clients face struggles with stereotypes, racialization and deleterious media depictions of Self. Psychotherapists who unconsciously ignore the bearing such factors place on the lived experience of Black clients as well as the Self and Other in the therapeutic encounter, can inadvertently lead clients to perceive they are invisible (Sue & Sue, 2013).

Although it is not every psychotherapist who undervalues the influence of

stereotyping and racialization on clients, research carried out by Vereen, Hill & Butler (2013) denotes that a number of clinical practitioners underestimate and do not give space to contemplate the impact of discrimination.

Although this enquiry is concerned with the psychotherapeutic aspects of client's experience, it is important here to note research conducted by Ashley (2014) and Williamson (2014). From a pychiatric perspective, they found Black clients are routinely misdiagnosed due to unconscious misconceptions held by practitioners, subsequently further biasing Black clients' sense of psychotherapy, which deterred individuals from seeking further mental health support (Williamson, 2014). As a result, the cohort of Black clients who did not reach out for counselling and support services, perceived the media as an accurate depiction of what psychotherapy entails. It has been found time and again, that with an absence of correct information, there is a negative influence on the level of participation and consistency in psychotherapy as well as an increase in the felt sense of invisibility (Sirey & Franklin 2014; McKenzie, Ghosh & Raue 2014).

In a sample population studied by Butler & Shillingford-Butler (2014), they found many Black clients believe psychotherapists are unaware and unable to understand the extent of the circumstances affecting them, consequently advancing the feeling of hiddenness. Experiencing an inadvertent avoidance by practitioners, inhibited persons of colour to disclose a fuller picture of the reasons for attending counselling. For Black clients, cultural penchants may prohibit them from speaking about personal issues to others (Butler & Shillingford-Butler, 2014).

In terms of unconscious gender bias, Mizock & Lundquist (2016, pg. 149) carried out

a study on the treatment of Transgender/ Non-Conforming clients in psychotherapy in the US and identified key psychotherapist errors, which were experienced by many individuals. Some of the negative experiences defined in the study state that the key concerns were gender inflation, where the therapist only focused on gender, avoiding other aspects of the client's life. Intriguingly, other clinicians used gender avoidance, concentrating exclusively on aspects other to gender.

Avoidance may also be present at the systemic level. Heteronormative intake forms in a psychotherapy office, which do not question gender identity or preferred pronouns; or the absence of therapists of colour in a community agency that serves a diverse client base. These 'colour-blind' and heteronormative perspectives deny the importance of power and privilege in the lived experiences of people of colour and gender non-conforming clients and contribute to a sense of invisibility (Sue et al., 2007).

A notable study by Pearson, Dovidio & Gaertner (2009), found therapists may not overtly discriminate against people of colour as they are motivated to:

> …avoid feelings, beliefs, and behaviours that could be associated with racist intent…however, the non-conscious feelings and beliefs will produce discrimination in situations when the guidelines for appropriate behaviour are unclear or when one's actions can be justified or rationalized on the basis of some factor other than race (p.319).

These acts have a substantial impact across all forms of discrimination; causing harm to clients from minority groupings, regardless of the original intention of person (Sue,

2003; Sue et al, 2007).

A similar experience was found with those who identify as part of the LGBTQIA+ community. In Ireland, since the declassification of homosexuality in 1993, mental health professionals have played a leading role in trying to reduce the stigma and prejudice created by the pathologization of Queer identity. This has largely been achieved through the establishment of a more evidence-based view of human sexuality, challenging the unscientific basis of Anti-Queer bias and by establishing standards for being LGBTQIA+ inclusive and affirmative in mental health service provision. However, sexuality bias in mental health services is still an integral factor in the silencing of clients. As Ridley (2009) points out, there is a consistent stream of challenges to one's morals, orientation, experience, fantasies, excitations and prejudices when one embarks on the topic of sexuality and sexual expression with a client. One's feelings are tested to their limits ranging from fear to joy, shame to stimulation, guilt to power. As identified in Chapter One, it is integral for the safety of both therapist and client, that the psychotherapist is able to hold the boundaries of Self and Other in a clear, strong and safe way.

Anti-Queer bias amongst mental health professionals, while often inadvertent, result in clients receiving inadequate care, as well as experiencing indirect discrimination and exclusion from support services (Denenberg, 1995; Rankow, 1995). According to the Group for Advancement of Psychiatry (2018), unconscious avoidance of identity, relationship and community can have unfavourable effects. McIntyre, Wickmam, Barr and Bentall (2018) found that avoidance of discourse surrounding the impact of sexuality on the lived experience of clients, had an adverse influence on the willingness of the client to disclose personal information and concerns. In research conducted by (McIntyre et. al., 2018), they found bias by way of avoidance with

LGBTQIA+ clients can take many forms. Avoidance appears by presuming clients are heterosexual, by stereotyping, failing to empathise, as well as failing to acknowledge family and community (Denenberg, 1995).

According to Hays (2008), if sexuality goes undiscussed and explored in one's training as a psychotherapist, the knowledge and confidence in addressing the topic with clients may often be missing. Studies carried out by Kirkpatrick (1980), McConnell (1979) and Zwibelman & Hinrichseen (1977) found that detailed training in the area of sexuality facilitates the therapist to explore and question their own comfort, feelings, beliefs, biases, attitudes and personal relationship with all things related to the topic of sex and sexuality. Avoidance of such is indicative of a therapist who practices from a heteronormative perspective (Ridley, 2009).

In Psychotherapy, under the shadow of heteronormativity, which assumes everybody to be heterosexual, clients who identify as part of the Queer community become eclipsed at best or even attacked in more extreme cases. Isolation, invisibility and silence around Queer identity, often leads to individuals internalising their experience of 'homonegativity' present in a one to one basis as well as the larger society (Mizock & Lundquist, 2006). It is therefore apparent how important psychotherapy is to the exploration of the topic of societally-biased topics in an individual's life. The therapeutic alliance is an intimate, diverse and deeply personal meeting of two minds. It engages an individual into an exploration of the most profound questions of our human experience (Orbach, 1999)

1.2 Parapraxis

Parapraxis, also known as a Freudian slip, is defined as any mistakes in speech, memory or action that occurs due to an unconscious thought (Freud, 1905). Freud (1905) believed such slips of the tongue revealed a return of the repressed, and a clue to the secret functioning of the unconscious mind. On the surface, unconscious verbal verbiage may be viewed as a simple oversight or accident. From a psychoanalytic perspective however, they are symbols that have much deeper personal significance. Freud believed that when a person utters something other than what they proposed to say, it is no mishap but rather their unconscious beliefs and thoughts, breaking through the censorship of the mind and emerging into consciousness.

Contemporary research has not demonstrated any measurable improvement in the experiences of Transgender/Non-Conforming individuals in therapy. McCullough, Dispenza, Parker, Viehl, Chang and Murphy (2016) confirmed that in a study of Transgender/Non-Conforming person's experience of therapy, mental health clinicians, while often well-intentioned, through lack of cultural sensitivity and competency or knowledge, unconsciously harmed their clients. Their research continues to show how clients view trans-affirmative counselling by psychotherapists as being accepting, authenticating and advocating, rather than pathologizing. Participants of the McCullough (2016) study felt better aligned with their therapists and more content in the process when they felt more accepted, cared for and when their therapist used inclusive language that made the client understand that their therapist understood transgender culture.

Many participants however, experienced a trans-negative approach, where therapists

misunderstood certain issues, lacked knowledge of gender fluidity and transgender culture, expressed personal bias and demonstrated 'transgender microaggressions', by posing tactless questions. An example of such is specified by one participant in the McCullough et al. (2016) study, when the therapist asked them their birth name or referred to them, 'in error' using this birth name.

This error by the therapist, of calling their client by their original birth name could be considered as a repressed, unconscious signal of non-acceptance by the therapist. Other participants experienced 'experiential invalidations' where they felt therapists refused to take them seriously, refused to use correct gender pronouns and assumed that their gender identity was indicative of something pathological. These therapists were unsupportive of their clients when they said they were contemplating disclosing their gender identity to family and friends. Other participants elucidated their concerns of being unable to bring all aspects of their identities to counselling. Instead they felt it necessary to compartmentalise and exclude parts of themselves, more often to facilitate the comfort of the therapist rather than their own desire to do so (McCullough et al., 2016).

Although slips of the tongue are the errors most popularly believed to carry hidden meanings, Freud's original use of the term 'parapraxis' included a wider range of mistakes in daily behaviour – errors in reading and writing, forgetting someone's name, mislaying an object, or failing to perform a particular action. Looking at unconscious bias in the Bondage/Discipline Domination/Submission Sadism/Masochism (BDSM) community, therapists who are misinformed about the consensual BDSM community have assumed physical or mental abuse in a client's history or current life or judge a client as an unfit parent without other evidence,

based solely on the client's BDSM practices (Moser, 2004). This is most likely due to historical writings in the psychological literature in which both sadism and masochism were described initially as personality disorders that might be manifested sexually (Freud, 1905/1957; Krafft-Ebing, 1886/1965). While the DSM-5 (APA, 2015) depathologized BDSM, the biases and misinformation borne from its pathologized history can result in unintentional harm being done to clients who identify sexually as sadists or masochists (Kolmes et al., 2006). Other mental health professionals may hypothesize a disorder around the client's sexual role, supposing that a desire to explore pain or power dynamics sexually translates by default into a tendency to carry out these experiences consciously or unconsciously in non-BDSM relationships. At the lesser extremes, the impact of such biases has led to empathic failures, misunderstandings between clients and psychotherapists as well as failures in making follow up appointments (Kolmes et al., 2006).

A similar experience has been found in studies with clients of colour. As a social construct, race was used to define, classify, categorize, control and perpetuate ideas of inferiority among men, thus making the Other a powerful symbol of difference, constructed as a result of perception and fear of difference (Clarke, 2003). Since therapy can be seen as a microcosm of race relationship in larger society, it can activate an array of unconscious beliefs through countertransference (Chang and Yoon, 2011). Bunkard & Knox (2004) found that clinicians who are unaware of their biases might inadvertently perpetuate oppression against clients during the therapeutic process. Psychotherapists may assume they are incapable of initiating microaggressions by way of parapraxis due to the nature of their training and their own individual journey, however research by Constantine & Sue (2007) show this is not the case.

In their most recent study, Constantine & Sue (2007) looked at microaggressions initiated by White supervisors overseeing African American doctoral supervisees in psychotherapy. The research found that the students experienced inadvertent invalidation of racial issues, supervisors initiating stereotypic assumptions about supervisees and their clients and a reluctance of the supervisor to give feedback in fear of being seen as racist. In addition, it was found the supervisor carelessly offered culturally insensitive recommendations (Constantine & Sue, 2007). Likewise, in a quantitative study carried out by Burkard & Knox (2004), 247 counselling psychologists were found to have colour-blind racial attitudes; they claimed not to perceive differences in race. There are two issues with such rhetoric. Research has continuously shown actual or claiming colour-blindness detrimental to counselling (Buser 2009; Sue & Nadal 2008). Also, in the Burkard & Knox (2004) study, it was found that the clinicians level of colour-blindness was directly related to capacity for empathy and to their attribution of responsibility for the solution to a problem with clients of colour, but not to clients of European American descent. Historically, studies on cross-racial dyads are usually told from the perspective of therapist or researcher resulting in a narrow scope and consideration of client's experiences (Knox et al., 2003).

One of the most frequently cited issues in providing mental health services to minority groups is the cultural and linguistic mismatch that occurs between clients and providers (Kelly & Green, 2010). Applying the concept of fit at the client–therapist level has generally meant that the more therapists who self-identify with minority groups ensures budding therapists are educated on different communities. As well as this, it safeguards against therapeutic approaches becoming pigeonholed,

allowing for modified and culturally sensitive practice accessible to all, not only the privileged few (Sue & Zane, 2009). The deepening of a therapeutic relationship based on respect and a readiness to recognize and understand the unique characteristics of the client is imperative for trust to develop and change to transpire (Kelly & Greene, 2010).

To review, and as a means to foreshadow the succeeding chapter, it is important to highlight in spite of the aim of therapeutic neutrality, the process between client and therapist (Self and Other), and further that this is influenced by the values and biases of the practitioner. Both the clinician and the client bring with them their own personal prejudices, cultures, and histories into the working relationship. From this chapter, by examining the empirical research, we can see therapists' unconscious biases emerging through the manner and modality they practice. Such biases can also appear in their avoidance of topics, as well as through parapraxis. It is interesting to consider what glaring subjects we currently avoid in the therapeutic space, and yet find ourselves confounded with in our day to day, lived environment. What is escaping our focus? What are we not addressing? It may be of no surprise then that the following chapter will subsequently focus on weight bias and psychotherapy.

CHAPTER 3 UNCONSCIOUS WEIGHT BIAS

Weight bias or weight stigma and prejudice against people in larger bodies has been widely documented and has been described as the last socially acceptable form of discrimination today (Puhl, 2001, 2009). The definition of weight stigma is the negative outlook and beliefs we hold about others due to their weight (WHO, 2017). Internalized weight bias is defined as the holding of negative beliefs about ones own weight or size (Latner 2014, p586). Discrimination due to weight and size is ubiquitous. Stereotypical narratives through media, family and peer groups, the workplace, educational settings, healthcare (which includes the arena of psychotherapy) perpetuates negative beliefs in relation to individuals living in large bodies (Brochu 2014; Cameron 2016; Kirk 2014; Puhl 2008; Rudolph 2009). These stereotypes reiterate time and again adverse attitudes such as large bodies being the result of moral failures, laziness, 'working class', and a lack of willpower (Gilman, 2008; Gracia-Arnaiz, 2010a). With all of this in mind, how does weight bias impact the psychotherapeutic process?

In Western society, there are many consequences faced by those living in a large body. Weight stigma is associated with significant psychological consequences such as depression, anxiety, disordered eating, body dysmorphia and maladaptive health behaviours (Kahan 2017; Puhl 2009). Weight stigma is also something experienced by those living in thin bodies. Although they do not face the systemic oppression of weight bias, it is oppression concealed in the form of fear – fear of entering a currently socially devalued group. For example, Garner (1997) found that 24% of female and 17% of male participants reported they would sacrifice three or more

years of their life in order to be their ideal weight.

Although prevalent for centuries, the acknowledgement of weight bias only recently emerged in response to a societal upheaval as a result of current fat activism. The fat acceptance movement has challenged the unaddressed bias faced by those living in larger bodies, the medicalization of fatness, as well as highlighting the pervasive discrimination stemming from a culture living in fear of the 'obesity epidemic' (Puhl, 2008; WHO, 2017). In an environment which is submerged in eating disorders and which not only normalized disordered eating but aligns with it in the form of weight loss therapy and weight management therapy, it is important to question the psychoanalytical interpretation of fat as well as examining how unconscious weight bias shows up in the therapeutic environment.

1. An Analysis of Weight

Freud

At the beginning of the twentieth century, Sigmund Freud (1906) began developing theories, which included the topics of fatness and fat bodies. Freud (1906) believed that unconscious motivations play a piece in the disturbance of normal functioning. According to Glucksman, Rand and Stunkard (1978), Freud as well as Freudian analysts emphasized the idea that people of size have at some point during the oral stage of psychosexual development, encountered severe emotional deprivation or onslaught. During the oral stage of development, emotional consistency became associated with nourishment. The mother responds to the emotional and physical needs of the child through inappropriate feeding. As a result, as the child matures,

they have difficulty distinguishing a sense of hunger, satiation and other emotional sensations outside the realm of nourishment (Freud, 1953). According to Stunkard (1976), this was one of the first steps in creating the pathology perspective which currently surrounds fat bodies.

Freud's theories denoted a disturbance in the oral stage as a cause of fatness. This served to cast aspersions and shift responsibility for becoming fat onto individuals in large bodies. According to Stunkard (1976), it gave permission to many sectors of society to shame and reject large bodies, mostly in the case of women, as could be expected of the time. As a result, fat women often internalized this narrative; shaming and blaming themselves and their body, which began affecting their sexual expression.

How is Freud's work relevant to how we experience fatness and fat bodies today? Freud's work was and continues to be a major intellectual force in the psychoanalytic community and beyond. Stunkard (1976) states:

> Psychoanalysis was just reaching its position of pre-eminence in American psychiatry when I began my career (1945). It had already become the dominant theoretical system in the field, and for good reason. A new and fundamental understanding of the human condition seemed at hand-not just the relief of symptoms, but the very transformation of human nature itself. At a time when most medical research was leading away from the patient and into the laboratory, psychoanalysis held forth the promise of the most basic kind of clinical investigation into the human condition in the context of deep and meaningful personal relationships (p.196).

Thus, it is not surprising that psychoanalytic thought should impact thinking about fat. Freud's influence extends beyond the realm of psychoanalysis, impacting the ways in which society and individuals experience larger bodies today. Freud's theories set the stage upon which many analysts developed. After his death, analysts continued to identify fatness with oral sexuality claiming people in large bodies did not experience genital gratification. Analyst's proposed fat individuals are unable to handle mature sex, and because of this they searched through food for what Rado (1926) termed the 'alimentary orgasm' (p. 577). Although over time the notion of the alimentary orgasm faded from analytic writings, with Rado himself becoming disillusioned with it, the idea of fat individuals being unable to experience sexual gratification did not (Stunkard, 1976).

Post-Freud

In the 1950's, Kaplan and Kaplan (1957) compiled psychoanalytic theories from the beginning of the twentieth century on the psychosomatic concept of fatness. Some of the analytic theories around fatness and the consumption of food included a way in which to alleviate anxiety, achieve pleasure, relieve frustration, express hostility, diminish feelings of inferiority, a way in which to reward oneself, diminish guilt, defiance, justifying self-depreciation, avoiding adulthood, and a means of which to handle the anxiety from infantile oral frustration (Kaplan & Kaplan 1957, p.196). In addition to compiling theories regarding what fat and consumption of food may serve, they also found 'overeating' may be a symbol of pre-oedipal mother conflict, unsatisfied sexual craving, expression of penis envy, expression of a fantasy where

overeating results in impregnation, a defence against threatening unconscious feminine or masculine wishes, and an indication of a fraught mother-child relationship (Kaplan & Kaplan 1957, p.195).

As Kaplan & Kaplan (1957) elucidate:

> It is difficult to describe all the many specific psychological factors that have been proposed as being associated with obesity...it appears that the only psychopathological generalization that can be made with confidence about obese patients is that they are individuals whose life pattern is conflicting and anxiety ridden...the people affected by obesity typically have some degree of personality disturbance and/or emotional conflict which may be of any type or severity (p.199).

However, Areton (2002) argues against these findings, believing the studies both ambiguous and contradictory. According to Areton (2002), "...all the obese people who came to the psychoanalytic authors felt a need for therapy. Obese people who did not feel a need for therapy were not taken into account" (p.190). Thus, in the creation of these theories, the studied cohort was those living in larger bodies that had sought out analytic treatment. Furthermore, in Kaplan & Kaplan's (1957) research, there is reference to fatness creating 'personality disturbance', and no consideration as to the supposed disturbance occurring before weight gain or indeed, all along (p.196). Through their findings they believed weight gain to cause feelings of inferiority, inadequacy and shame. They found such feelings and subsequent interpersonal issues were a *result* of obesity; "... [the feelings] may be used as a rationalization to avoid further contact with people…" (p.196). Naturally, this synopsis proved highly

contentious and was met with a backlash from other members of the psychoanalytic community.

Upon these results, Stunkard and colleagues carried out a series of studies to ascertain whether people living in large bodies were more neurotic than individuals in smaller bodies (as cited in Areton, 2002). The first round of studies showed no difference. Glucksman, Rand and Stunkard (1977) joined surveys completed by 104 analysts on 147 patients, and again found very little to no change in pathology between the two groups. In 1976, Stunkard and his colleague Goldblatt conducted a meta-analysis, which involved collecting information on 1660 individuals. The study had collected their weight as well as their psychological condition but had yet to examine if a link were present. The research concluded fat individuals scored marginally higher on tests for anxiety in childhood, withdrawal, depression, anxiety, suspiciousness and immaturity than those who did not meet the clinical criteria of obesity, however the differences found were "...not statistically significant" (Goldblatt 1976, p.145). These findings could not be ignored, and the analytic community began to tentatively question the gospel according to Freud. Further studies by Crisp (1976), Wise (1978) and Wooley (1984) aligned and corroborated with Goldblatt's (1976) results above, showing little to no difference in the prominence of pathology in one particular weight category.

Indeed, in a study conducted by Wadden and Stunkard in 1996, they state that any psychopathology observed in larger bodied individuals is interpreted as a consequence of pathology, rather than a cause of pathology; a consequence of "...prejudice and discrimination to which the overweight are subjected" (p.163). Rubin's (1967, 1970, 1978) work provides another example of thought regarding people in large bodies

slowly changing over time. As a weight loss 'expert' in the psychiatric field, he once claimed all people in large bodies had sexual problems, and once repressed anger dissipates, so too does fat. By 1978 however, Rubin's (1978, p22) view had changed, stating he believed his earlier view was due to his unconscious prejudice against both himself and other fat people.

Contemporary Views

The underlying presumption that fatness is rooted in pathology has not faded from psychoanalysis. Woodman (1980) contributed to this rhetoric in the early 80's when she claimed that fat women and her own body take on the projection of the shadow and "...is experienced as evil. Sexuality becomes evil. Femininity and sexuality are confused" (p.41). She felt that anger and an inability to adjust to reality were expressed through food cravings and tension could be released through eating (Woodman 1980, p.41). Hollis (1994) in her book *Fat and Furious*, supported the Freudian perspective on weight claiming to have never met an eating disordered person who was not "raging within" (p.xxvi). In addition to this, theorists began finding a correlation between obesity and childhood sexual abuse, a women's need for nurture and a way for women to supress their feelings (Blume 1991; Woitiltz 1989).

Woititz (1989, p.64) found the compulsion to overeat a common result in women who had experienced sexual abuse. She proposed that because nurture was something, which could not be experienced at the hand of an Other, trust is placed in food to self-nurture. She stated that obesity serves a purpose and if one is obese, they feel less desirable. As a result, the individual does not have to face the advances or sexual

interest by another. “Obesity enables you to avoid the problem of having to deal with your sexuality” (Woititz 1989, p.65).

There is an important note to make here. If fat bodies were not culturally constructed as unhealthy or undesirable, or something to fear, would larger bodies be an issue? Also, as Areton (2002) expounds, while there are many fat women who have experienced sexual and childhood trauma, there are also many other women who have and who do not live in larger bodies. Similarly, there are also women in fat bodies who have not experienced sexual abuse.

2. Countertransference

“…No psychoanalyst goes farther than his own complexes and resistances permit, and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his own observations on his patients…” (Freud 1909, p.141).

In the early days of psychoanalysis, Freud (1909) viewed countertransference as a permanent problem, an obstacle for the analyst, which ultimately ought to be dominated. It is assumed that Freud’s early attitude developed as a response to the behaviour of his colleagues; Ferenczi and Jung among them, whom had gotten involved with patients and families of patients. Likewise, Freud had experienced how in response to Anna O’s erotic transference, how his colleague at the time, Joseph Breuer had left analysis completely. In a letter to Jung, Freud expressed how feelings for patients can help the analyst develop a better understanding and how clinically

they constitute a “blessing in disguise” (Freud 1909, p.231).

At the time, what was deduced from Freud’s words is that countertransference is to be avoided (Heimann, 1950). Many others developed upon Freud’s concept, with critical views. Ferenczi (1919) unsurprisingly perhaps considering the commotion above believed countertransference a valuable asset in clinical work. He espoused that an attempt to master countertransference only stands to impede the analyst in his process (Ferenczi, 1919). It was a divisive concept, upon which many continue to claim their position on. Stern (1924) proposed the presence of two types of countertransference; the analyst’s personal conflicts and that arising in response to the patient’s transference. He elucidated that the analyst must meet the patient’s transference with the analyst’s own transference, allowing fantasies and feelings to appear, letting the unconscious resonate with the client in order to notice what is being conveyed unconsciously in the therapeutic space.

Winnicott (1949) published his seminal piece ‘Hate in the Countertransference’ outlining how he believed countertransference inevitable, much like the inevitability of any emotion appearing in the therapeutic alliance. Winnicott normalised the feeling of hate and anger toward patients by pointing out the ambivalence of hate and the way in which analysts boundaries may be encroached upon. Winnicott’s outlook informed much of what was to come later such as Isakower’s (1963) concept of the analytic instrument, Reich’s (1951) views on countertransference and neurosis as well as Sandler’s (1976) view that the analyst exists with freely hovering attention and responsiveness.

Heimann (1950) however, took another interpretation from the words issued by Freud

to Jung, one in which she believed Freud intended to share with the analytic community. Heimann argued that avoidance of countertransference is not something Freud was advocating; recognizing and mastering countertransference involved continuously consulting rather than evading the analysts own feelings in order to deepen the analytic process. Additionally, Heimann stated that countertransference ought to be continuously examined to further insight and understanding. "If an analyst tries to work without consulting his feelings, his interpretations are poor." (Heimann 1950, p.82).

But what is the relevance of countertransference and clients in larger bodies? Since the turn of the twentieth century, Western culture has attempted to ascertain a sense of control over the female body (Bordo, 1993). As Douglas (1966) argued, the body is a powerful symbolic form on which rules and structural commitments are placed and can also act as a metaphor for society. The size of a woman's body is reinforced by the culture in which women live, which in Western culture is glorifying the 'thin ideal' and discriminating against people in larger bodies (Council on Size and Weight Discrimination, 2009; National Association to Advance Fat Acceptance, 2009; Saguy, 2007). Given societies history of prejudice against women as well as the growing issue of weight stigma, it is integral to acknowledge the bias held against women in larger bodies which may present itself in countertransference.

Countertransference is a point of contention to some in the mental health field. Not all are in agreement that it exists. There is also some debate regarding the definition of what constitutes countertransference (Rosenberger & Hayes, 2002). However, empirical results have shown that regardless of the clinicians stance, patterns of countertransference are consistently present in the therapeutic encounter (Southern, 2007). Ultimately, there is always a response, however obvious or subtle, in relation

to an Other. Being aware of the response enables the analyst to utilise this affective information to deepen the therapeutic process. Left unacknowledged, countertransference can remain unresolved and hinder therapeutic process (DeVaris, 1994; London, 2007; Rosenberger & Hayes, 2002; Southern, 2007).

2.1 Countertransference and Weight

Countertransference is a phenomenon experienced by all therapists in clinical practice. Depending on the individual, psychotherapists can, and are hopefully often, seen as empathetic, understanding, safe and compassionate. During training and beyond, therapists are trained to unpack their own prejudices while becoming aware of how these may impact the relationship with clients through countertransference. The therapeutic relationship is reciprocal in nature. Each individual, both therapist and client, experience myriad emotions as a result of being in relation to the Other. The emotional reaction a therapist has with a client, the countertransference, when utilised appropriately, can facilitate rather than hinder the therapeutic process (Betan, 2005). Although there are seemingly great strides taken to attempt to unload personal biases; individual beliefs, values and biases come in to the therapeutic environment with the psychotherapist. These outlooks and experiences of the therapist may be quite similar to that of the client, or vastly different. It is the job of the therapist to be aware of said predispositions and unpack certain aspects of each social bias in personal therapy and supervision (Hayes 1995; Kwan 2006; McKinley 2004; Puhl 2008; .

But how is this relevant to weight and psychotherapy? Globally today, there are a

number of ‘Othered’ groups, which exist in various societies and cultures. As explored in Chapter One, ‘Other’ is a way in which a person affirms One’s sense of ‘Self’. When a group affirms itself, it typically has at least one perceived similarity among its members. People and groups are habitually othered on the bases of gender, sexual orientation, class and race as well as religion, age and size. Although research on the various experiences of gender, LGBTQIA+ and race are currently prevalent in the psychotherapy field, the intricacies of body size and the experience of bodies of size in the therapeutic dyad have gradually begun to garner attention .

3. Yalom’s Bias

Bias plays a particularly strong part in the construction of countertransference. It can inform the reaction a therapist may experience with a client and has the potential to impede the therapeutic process, particularly if the therapist is not aware of the prejudices to which they unconsciously hold on to or to one which they have not fully processed. As highlighted in Chapter Two, psychotherapy has a long history of replicating the prejudices of the outside world in the therapy room to the detriment of clients. There is also the likelihood that the therapist may not be aware of the presence of bias until the client is sat in the chair across from them. In the book *Love’s Executioner and Other Tales of Psychotherapy*, Yalom (1989) recounts the story of working with his client Betty, and the tumultuous countertransference he experienced as a result of her size. The account given by Yalom (1989) is both congruent and candid, reflecting his honest countertransference toward both Betty and fat women as a whole.

I have always been repelled by fat women. I find them disgusting: their absurd

> sidewise waddle, their absence of body contour, breasts, laps, buttocks, shoulders, jawlines, cheekbones, everything, everything I like to see in a woman, obscured in an avalanche of flesh (p.94).

After a lengthy stint with his client, Yalom (1989) sensed that he had effectively "gotten away with" not enlightening Betty of his thoughts about her and did not disclose his outlook about how he felt about her weight till the end (p123). Nonetheless, Betty astounds Yalom and tells him what he already knew but failed to see because he was too close to it. Betty affirms herself in this final session as Yalom (1989, p123) tries to tell Betty of how his original feelings were toward her, and how these have changed over time: "What I mean is that my attitude about obesity has changed a lot. When we started, I personally didn't feel comfortable with obese people…"

However, much to Yalom's surprise, Betty interrupts him:

"Ho! Ho! Ho! 'Didn't feel comfortable' – that's putting it mildly. Do you know that for the first six months you hardly ever looked at me? And in a whole year and a half you've never – not once – touched me? Not even for a handshake!" (Yalom 1989, p.123).

Many praise Yalom for addressing his strong bias and for being so open about his prejudice. A critical analysis of the piece highlights issues, which extend beyond acknowledging his weight stigma including Yalom alluding to the loss of weight by Betty to a sign of therapeutic success. Although Yalom addresses his bias, one could argue that he failed to address his countertransference. Evidence of this can be seen when Yalom says he "…hadn't expected [Betty] to notice" that he was unable to touch her and found it very difficult to look at her, for the first six months of their

sessions (Yalom 1989, p. 123).

Here one could argue that Yalom's unconscious bias of fat equating to inferior intelligence resulted in strong countertransference. In terms of why Betty continued to work with Yalom, one could deduce perhaps Betty's transference found an all too willing counterpart in Yalom's countertransference. Betty, an individual used to living in a world, which villainizes and denigrates her for the size of her body, meets exactly this phenomenon in Yalom.

Yalom speaks of the barriers he faces with Betty; times in which the barriers impede the therapeutic process and times in which it facilitated it. Although Yalom's reflections may appear abhorrent given the context, his thoughts and reactions are representative of the ubiquitous thoughts and reactions to fat and fat bodies, in society. Further, Yalom explains that his prejudice toward Betty and fat women goes beyond social norms, our society as a whole has an explicit hostility towards fat bodies (Triplett, 2007). Yalom's account of his experience of weight stigma is so far the *only* sole account of a Psychotherapist's exposition of countertransference toward fat clients, and it leaves many questions on bias open for consideration.

How is weight bias different or similar to the biases felt toward those of different sexual orientations, races, genders or religions? How does weight stigma affect the relationship with clients in larger bodies? As aforementioned, Yalom is not alone in his thoughts. Negative personality traits are typically applied to women living in larger bodies (Kwan 2006; Puhl 2008; Triplett 2007). Research also shows that within the medical community, as well as the realm of social media, negative characteristics and imagery of fatness are reinforced (Cossrow, 2001).

According to Winnicott (1949), it is important that therapists are conscious of their own "fear and hate" and however much a therapist may love the client, they "...cannot avoid hating them, and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does…" (p.18). Winnicott's concept may be integral in the understanding of weight bias and fat stigma. In regard to Betty, Yalom displayed an intense countertransference however he was not only aware of it, he was excited by the opportunity to work through his affect with Betty on the, somewhat ethically debateable basis that it would help him grow as a therapist.

The contributions of psychoanalysis directly construct and influence today, how those in all facets of the mental health community place themselves in the therapeutic relationship. Countertransference is not only a fundamental element to the work, it is inevitable. Therefore, it is important to understand how countertransference appears with client's living in larger bodies. Psychotherapists, psychoanalysts and their clients live in a fat-phobic society, in which fat and 'obesity' is ridiculed and shamed on a daily basis (Rothblum, 1999). The information circulating in society affects everyone, be it consciously or unconsciously, implicitly or explicitly. The psychotherapy community is not an exception to this. As a part of society, it is also a part of the cultural milieu surrounding the morality of fat, and as a result, people living in large bodies.

CONCLUSION

This thesis has explored and illustrated the issue of unconscious bias from a psychotherapeutic lens. It has examined how we understand unconscious bias from a psychodynamic perspective by looking at what is a Self, and what constitutes an Other. By considering the theoretical modalities of psychoanalysis, object relations, attachment and contemporary research, the formation of Self and Other is a multiplicity of systems, both conscious and unconscious. It is the experience with the primary care giver. It is the experience of the 'good enough' parent, as well as the internal representations of such. Without Other, there is no Self.

From a psychodynamic outlook, the separating of Self and Other can be assumed an inevitable process for the development health of the infant and their adult life. This splitting, this construction, this formation of Self from Other, is fundamental, furthering the theory which as it currently stands states nobody is without bias. There is always an Other. Granted, this does not justify discrimination or prejudice, conscious or unconscious, but rather opens the topic for further exploration. It is a subject that may create more questions than there are solutions. Given the ever-changing cultural landscape, one can assume what constitutes 'Self' and what forms 'Other' exists in a state of constant flux, outside the parameters of social convention.

The aim of this thesis was to explore unconscious bias, one area of interest being how a therapist's bias impacts the experience of the client. Despite the aim of therapeutic neutrality, the process between client and therapist is shaped and influenced by the values and biases of the practitioner. Dewane (2006) links this to the experience of the first split between infant and caregiver, and the 'corrective emotional experience',

(Alexander & French,1946) to demonstrate how the psychotherapist and the client are bound inside a relational dynamic. Notably, the therapist's own imperfection and humanness are highlighted in the relationship. The change processes in the therapeutic relationship is an anxiety-provoking encounter for the psychotherapist, perhaps as much as it may be for the client. Both the psychotherapist and the client bring with them their own particular preconceptions, values, and histories into the working relationship.

By examining the empirical research, we can see therapists' unconscious biases emerging through the manner and modality they practice. Such biases can also appear in their avoidance of topics. As Vereen & Hill (2013) highlighted, therapists tended to underestimate and not give space to the impact of discrimination faced by clients. In research conducted on issues of race and mental health treatment, it was found that in the avoidance of discussions surrounding race: beliefs or behaviours that could be associated with racial intent led to a negative effect on the level of participation and consistency, as well as an increase in the felt sense of invisibility. Unconscious misconceptions further deterred Black clients from fully disclosing their reason for seeking support, and indeed the rate in which individuals sought support at all. Isolation, invisibility and silence were also factors with clients who identified as LGBTQIA+, often leading to individuals internalising their experience as well as receiving inadequate care and exclusion from support services. (Denenberg, 1995).

Furthermore, this enquiry highlighted that unconscious bias also emerges in the form of parapraxis. Freud believed that when a person utters something other than what they proposed to say, it is no mishap but rather their unconscious beliefs and thoughts, breaking through the censorship of the mind. Studies carried out with various

minority groups have found such an experience to increase the sense of invalidation, stereotyping and pathologizing. The therapeutic alliance can be an intimate, distinct and intense meeting of two human beings. It can inspire an individual into an exploration of the most profound questions of our human experience; an opportunity which is missed if the therapist avoids or unsuccessfully represses bias.

A final objective of this study was to highlight the emerging issue of weight bias in relation to psychotherapy. Weight stigma and prejudice against people in larger bodies has been widely documented and has been described as the last socially acceptable form of discrimination today (Puhl, 2001; Puhl, 2009). Discrimination due to weight and size is ubiquitous with bodies of size consistently associated with laziness, low socio-economic status as well as moral failures.

Weight bias has recently begun coming to the forefront of many theoretical disciplines and for good reason. Weight bias is correlated with significant emotional consequences such as depression, anxiety, disordered eating, body dysmorphia and maladaptive health behaviours (Kahan 2017; Puhl 2009). By examining the literature, there is an evident focus on the cause and to some degree, a pathologizing of fatness within psychoanalytic and psychodynamic literature, rather than the lived-experience of the client. In many cases, the assumption is made that weight has caused a decline in mental health. This seems both stigmatizing and reductive, both for the diversity of body shapes and sizes as well as to the field of psychotherapy.

Likewise, by observing the impact of countertransference as well as the case study of Yalom, there is also the likelihood that the therapist may not be aware of the presence of bias until the client is sat in the chair across from them. Countertransference is not

only an important component of the work; it is unavoidable. Although it is evident Yalom attempts to unpack his countertransference, the ethical factors and conclusions he makes are rather disputable. Psychotherapists, psychoanalyst's and their clients live in a fat-phobic society, in which fat and 'obesity' is ridiculed and shamed on a daily basis (Rothblum, 1999). According to Winnicott (1949), it is important that therapists are conscious of their own "fear and hate" and however much a therapist may love the client, they "...cannot avoid hating them, and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does…" (p18).

Now that a theoretical underpinning of unconscious bias has been presented, it would be the recommendation of this researcher to further the exploration of the subject through field-based methods. The investigation has also shown the impact training can have in the prevention and unpacking of unconscious bias, particularly in the areas of race, sexuality and gender identity. Although some institutions explore these areas, the need for detailed training should not be undermined and the presence of unconditional acceptance should not be assumed. In fact, from this study we can assume that there are many areas in which we are not fully accepting, and in the acknowledgment of this we stand to unpack more of our unconscious bias, than the denial of it.

Furthermore, the topic and issue of weight stigma is a new and developing issue gradually coming into awareness. It is the responsibility and duty of care of each clinician to address their prejudices. Leaving the body out of this in a field where the body is paramount to our understanding of the human experience, we risk harming our clients and do a disservice to the psychotherapeutic community itself.

Today, the contribution of psychoanalysis and psychodynamic theory openly form and impact how those in the field place themselves in the therapeutic encounter. The information circulating in society affects everyone, be it consciously or unconsciously. The psychotherapeutic arena is of no exception. Although there are many questions unanswered and much room left for further research, this paper has conveyed the issue of unconscious bias and the implications of both individual and collective silence. Perhaps going forward, we may better recognise our shadow, by surveying its contours under the light.

REFERENCES

Ainsworth, M. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Alexander, F., & French, T. (1946). Psychoanalytic therapy: Principles and Application. New York, NY: Ronald Press.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.

Areton, L (2002). Factors In the Sexual Satisfaction of Obese Women in Relationships. History and Development of Analytical Studies on Obesity and Sexuality. Journal of Human Sexuality. Vol(5).

Ashley, W. (2014). The angry Black woman: The impact of pejorative stereotypes on psychotherapy with Black women. Social Work in Public Health, 29, 27–34.

Betan, E. (2005). Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. American Journal of Psychiatry. 162 (5) pp.890-898

Bowlby, J. (1969). Attachment and Loss,Vols I - 3, Hogarth Press, London

Boysen, G. A., Vogel, D. L., Cope, M. A., & Hubbard, A. (2009). Incidents of bias in college classrooms: Instructor and student perceptions. *Journal of Diversity in Higher Education, 2*(4), 219-231

Bozarth, J. D. (2007) Unconditional positive reagard. In M. Cooper, M. O'Hara, P. F. Schmid & G. Wyatt (eds) The Handbook of Person-Centred Psychotherapy and Counselling. Basingstoke: Palgrave Macmillan

Bretherton, I. (1990). Open communication and internal working models: The role in the development of attachment relationships. In R. Thompson (Ed.), Socioemotional development. pp. 765).

Burkard, A. W., & Knox, S. (2004). Effect of Therapist Color-Blindness on Empathy and Attributions in Cross-Cultural Counseling. *Journal of Counseling Psychology, 51*(4), 387-397

Butler, S. K., & Shillingford-Butler, M. A. (2014). Counseling Black clients. In M. J. Ratts & P. D. Pedersen (Eds.), Counseling for multiculturalism and social justice (4th ed., pp. 143–157).

Casement, P. (1985). *On Learning from the Patient.* London: Routledge Taylor & Francis Group. pp133-144.

Casement, P. (2014*). Further Learning from the Patient*: *The Analytic Space and Process.* Hove: Routledge. pp28-30.

Chang, D & Berk, A. (2009). Making Cross-Racial Therapy Work: A Phenomenological Study of Clients' Experiences of Cross-Racial Therapy. Journal of counseling psychology. 56. 521-536. 10.

Chao, R. & Otsuki-Clutter, M. (2011) Racial and Ethnic Differences: Sociocultural and Contextual Explanations. Journal of Research on Adolescene. 21(1) pp47-60

Constantine, M. G., Smith, L., & Owens, D. (2008). Racial microaggressions against black counseling and counseling psychology faculty: A central challenge in the multicultural counseling movement. *Journal of Counseling & Development, 86*(3), 348-355.

Constantine, G., & Sue, D. (2007). Perceptions of Racial Microaggressions Among Black Supervisees in Cross-Racial Dyads. Journal of Counseling Psychology. 54. 142-153.

Cossrow, N. H. F., Jeffery, R.W. J., & McGuire, M. T. (2001). Understanding weight stigmatization: A focus group study. Journal of Nutrition Education, 33(4), 208- 214.

Council on Size and Weight Discrimination (n.d.). Working to end discrimination against people who are heavier than average.

Crisp, A. H., & McGuiness, B. J. (1976). Jolly fat: A relation between obesity and psychoneurosis in general population. Journal of British Medicine, 1, 7-9.

De Beauvoir, S (1949). Woman As Other. The Second Sex. *The Second Sex*. Alfred A. Knopf. Pp18

DeVaris, J. (1994). The dynamics of power in psychotherapy. Psychotherapy, 31(4), 588-593.

Denenberg, V.H. (1995) A Role for Ovarian Hormones in Sexual Differentiation of the Brain. 6(6) 78-85

Devine, P. G. (1989). Stereotypes and prejudice: Their automatic and controlled components. *Journal of Personality and Social Psychology, 56*(1), 5-18

Dewane, C. J. (2006). Use of self: A primer revisited. Clinical Social Work Journal, 34(04), 543-558

Diamond, A. (2007), Interrelated and interdependent. Developmental Science, 10: 152-158

Dovidio, J. F., Gaertner, S. L, Kawakami, K. & Hodson, G. (2002) Why can't we just get along? Interpersonal biases and interracial distrust. Cultural Diversity & Ethnic Minority Psychology. New York. 8 (2). PP88-102

Dyche, L., & Zayas, L. (2001) Cross Cultural Empathy and Training the Contemporary Psychotherapist. Clinical Social Work Journal. 29 (3). 245-258

Ellison, R. (1990). Invisible man. New York, NY: Vintage International. (Original work published 1947)

FREUD, S. (1895b). On the grounds for detaching a particular syndrome from neurasthenia under the description "anxiety neurosis." S.E. 3.

Freud, S. (1905). Three Essays on the Theory of Sexuality (1905). The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VII (1901-1905): A Case of Hysteria, Three Essays on Sexuality and Other Works, 123-246

Gawronski, Bertram & Hofmann, Wilhelm & J Wilbur, Christopher. (2006). Are "Implicit" Attitudes Unconscious?. Consciousness and cognition. 15. 485-99.

Gerhardt, S. (2015) *Why love matters*. London & New York: Routledge. pp.23-206.

Gerig, M. (2014). Foundations for clinical mental health counseling: An introduction to the profession (2nd ed.).

Gilman, S. L. (2008). *Fat: A cultural history of obesity*. Cambridge: Polity Press.

Glucksman, M. L., Rand, C. S., & Stunkard, A. J. (1978). Psychodynamics of obesity. Journal of the American Academy of Psychoanalysis, 6(1), 103-115.

Goldblatt, P. B., Moore, M. E., & Stunkard, A. J. (1965, June 21). Social factors in obesity. Journal of the American Medical Association, 192(12), 97-102.

Gracia-Arnaiz, M. (2010a). Fat bodies and thin bodies. Cultural, biomedical and market discourses on obesity. *Appetite, 55*(2), 219-225. doi: 10.1016/j.appet.2010.06.002

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review, 102*(1), 4-27.

Greenwald, A.G., McGhee, D.E., & Schwartz, J.L. (1998). Measuring individual differences in implicit cognition: the implicit association test. *Journal of personality and social psychology, 74 6*, 1464-80

Hays, P. A. (2008). Addressing cultural complexities in practice: Assessment, diagnosis, and therapy (2nd ed.). Washington, DC: American Psychological Association.

Hatzenbuehler, M. L. (2014) Structural stigma and all-cause mortality in sexual minority populations. Social Science Med. 103: 33-41
Hayes, D. (1995). Size acceptance. [Abstract]. Healthy Weight Journal, 9 (2)

Hirschmann, J. and C. Munter. 1995. When Women Stop Hating Their Bodies. N.Y.: Fawcett Columbine.

Hollis, J. 1993. Fat and Furious. N.Y.: Ballantine.

Jacobs, M. [1995] Winnicott D.W. Sage Publications

Kaplan, H. L. & Kaplan, H. S. (1957). The psychosomatic concept of obesity. Journal of Nervous and Mental Diseases, 125, 181-201.

Kelly, J. F., & Greene, B. (2010). Diversity within African American, female therapists: Variability in clients' expectations and assumptions about the therapist. *Psychotherapy: Theory, Research, Practice, Training, 47*(2), 186-197.

Kirk SFL, Price SL, Penney TL, Rehman L, Lyons RF, Piccinini-Vallis H et al. Blame, shame, and lack of support: a multilevel study on obesity management. Qual Health Res. 2014;24(6):790–800.

Kirkpatrick, J., S. (1980). Human sexuality: A survey of what counsellors need to know. Counselor Education and Supervision, 19:276-282

Klein, M. (1952) '*The Origins of Transference*' in Mitchell, J. (Ed) The Selected Melanie Klein New York: The Free Press. Pp.433-437

Klein, M. (1997). *The Psycho-Analysis of Children.* London: Vintage. (Original work published 1932).

Klein, M. (1997). *Envy and Gratitude and Other Works 1946-1963*. London: Vintage.
Schore, A. (2012). *The Science of the Art of Psychotherapy*. London: W.W. Norton &

Company.

Kohut, H. (1978). The search for the self: Selected writings of Heinz Kohut: 1950-1978. In P. H. Ornstein (Ed.), (Vol. 2). Madison, US: International Universities Press.

Kolmes, Keely & Stock, Wendy & Moser, Charles. (2006). Investigating Bias in Psychotherapy with BDSM Clients. Journal of homosexuality. 50. 301-24.

Krafft-Ebing, R. (1965). Psychopathia Sexualis. New York: Bell Publishing Company.

Kurzweil, Edith (1981). Jacques Lacan: French Freud. _Theory and Society_ 10 (3):419-438

Kwan, S. (2006). Contested meanings about body, health, and weight: Science, social justice, and free market framing competitions. Paper presented at the annual meeting of the American Sociological Association, Montreal Convention Center, Montreal, Quebec, Canada,.

Lacan, J. (1966) Écrits. Paris: Éditions du Seuil.

Lacan, J. (1977) Écrits: a selection. London: Tavistock.

Lacan, J. (1977b) The Four Fundamental Concepts of Psycho-Analysis. Harmondsworth: Penguin.

Lacan, J. (1988) The Seminar of Jacques Lacan. Book 1, Freud's Papers on Technique 1953-1954. New York: W.W. Norton.

Lacan, J. (1993) The Psychoses. The Seminar of Jacques Lacan, Book III. London: Routledge.

Lopez, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological consideration. Psychological Bulletin, 106, 184-203

Malin M.D. (2011) Kohut and Lacan: Mirror Opposites, Psychoanalytic Inquiry,31:1, 58-74,

McConnell, L., G. (1979). An examination of the counsellor's skills when counselling clients with sexual problems. The Family Co-ordinator, 25:183-188

McCullough, R., Dispenza, F., Parker, L., Viehl, C., Chang, C., & Murphy, T. (2017). The Counselling Experiences of Transgender and Gender Nonconforming Clients. Journal of Counselling & Development, 95(4), 423-434.

http://dx.doi.org/10.1002/jcad.12157

McIntyre, J., Wickham, S., Barr, B., & Bentall, R. (2018) Social Identity & Psychosis: Associations and Psychological Mechanisms. Schizophrenia Bulletin. 44(3): 681-690

McKinley, N. M. (2004). Resisting body dissatisfaction: Fat women who endorse fat acceptance. Body Image, 1, 213-219.

Mendonza-Denton & Perez (2016) The Bias of Belonging. Psychological Review. (2) 48-57

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counselling and psychological practice. Psychology of Sexual Orientation and Gender Diversity, 3(2), 148-155.

Murray, J., Abramson, P. R (1983). Bias in Psychotherapy. New York: Praeger.

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. Journal of Counseling & Development, 92, 57–66.

National Association to Advance Size Acceptance [NAAFA]. (2009). Health at every size (HAES).

Orbach, S. (1999) The Impossibility of Sex. London, Routledge.

Pearson, A., Dovidio, J., & Gaertner, S. (2009). The Nature of Contemporary Prejudice: Insights from Aversive Racism. Social and Personality Psychology Compass. 3. 314 - 338.

Proctor, Gillian. (2002). The Dynamics of Power in Counselling and Psychotherapy : Ethics, Politics and Practice / G. Proctor..

Puhl, R. M., & Brownell, K. D. (2001). Bias, Discrimination, and Obesity. *Obesity,9*(12), 788-805.

Puhl, R. M., & Heuer, C. A. (2009). The Stigma of Obesity: A Review and Update. *Obesity, 17*(5), 941-964.

Rankow, E. (1995). Breast and cervical cancer among lesbians. Women's health issues : official publication of the Jacobs Institute of Women's Health. 5. 123-9.

Ratts, M. J., & Pedersen, P. B. (2014). Counseling for multiculturalism and social justice (4th ed.). Alexandria, VA: ACA.

Ridley, J. (2009). What every sex therapist needs to know. Journal of Family Psychotherapy, 20:95-111. DOI: 10.1080/08975350902967218

Rosenberger, E. W. & Hayes, J. A. (2002). Origins, consequences, and management of countertransference: A case study. Journal of Counseling Psychology, 49(2), 221-232.

Rothblum, E. D. (1999). Contradictions and confounds in coverage of obesity: Psychology journals, textbooks and the media. Journal of Social Issues, 55(2), 355-369.

Rudolph CW, Wells CL, Weller MD, Baltes BB. A meta-analysis of empirical studies of weight-based bias in the workplace. J Vocat Behav. 2009;74:1–10.

Saguy, A. C. (2007). Does this BMI make me look fat? Defining the bounds of "normal" weight in the US and France. UCLA Center for the Study of Women CSW Newsletter, 1, 4-5

Schore, A. (2016). *Affect Regulation and The Origin of The Self: The Neurobiology of Emotional Development*. London: Routledge Taylor & Francis Group.

Shonfeld-Ringel, S. (2001). A re-conceptualization of the working alliance in cross-cultural practice with non-Western clients: Integrating relational perspectives and multicultural theories. *Clinical Social Work Journal, 29*(1), 53-63.

Siegel, D. J. (2015) *The developing mind: How relationships and the brain interact to shape who we are*. Second edition. New York & London: The Guilford Press. 73-320.

Siegel, D. J (2003) An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma. In, Solomon, M. & Siegel, D. J., Healing Trauma (2003) W.W. Norton & Company. New York. P1-56

Sirey, J. A., Franklin, A. J., McKenzie, S. E., Ghosh, S., & Raue, P. J. (2014). Race, stigma, and mental health referrals among clients of aging services sho screened positive for depression. Psychiatric Services, 65, 537–540.

Sonkin, D.J., (2005). Attachment theory and psychotherapy, *The California Therapist 17*, 68-77.

Southern, S. (2007). Countertransference and intersubjectivity: Golden opportunities in clinical supervision. Sexual Addiction and Compulsivity, 14, 279-302.

Spong, S. (2012). The challenge of prejudice: Counsellors' talk about challenging clients' prejudices. British Journal of Guidance & Counselling - BRIT J GUID COUNS. 40. 113-125.

Staats, C (2015) Understanding Implicit Bias: What Educators Should Know. American Educator. 39(4), pp29-33

Stern. (1924). Bemerkungen ¨uber asymptotisches Verhalten von Eigenwerten und Eigenfunktionen. Diss. G¨ottingen.

Stunkard, A. J. (1978). Behavioral treatment of the eating disorders. In H. Leitenberg (Ed), Handbook of behavior modification and behavior therapy. Englewood Cliffs, New Jersey: Prentice-Hall. Pp. 45-73.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271-286.

Sue, D. W., & Sue, D. (2013). Counseling the culturally diverse: Theory and practice (6th ed.). New York, NY: Wiley & Sons.

Sue, S. & Zane, N. (2009). The role of culture and cultural techniques in psychotherapy:
A critique and reformulation. Asian American Journal of Psychology, S(1), p 3-
14.

Triplett, L. (2007). The blame game: A first glimpse at the socially acceptable causes of female Fatness. Paper presented at the annual meeting of the International Communication Association, TBA, San Francisco, CA, May 23, 2007

Vereen, L. G., Hill, N. R., & Butler, S. K. (2013). The use of humor and storytelling with African American men: Innovative therapeutic strategies for success in counseling. International Journal for the Advancement of Counselling, 35(1), 57– 63.

W.H.O (2017) Weight bias and obesity stigma: considerations for the WHO European Region.

Williamson, M.E. (2014). The reluctance of African-Americans to engage in therapy (Master's thesis, University of Nebraska). Retrieved from digitalcommons.unl.edu/cehsdiss/216

Winnicott, D. W. (1967). Mirror-role of the mother and family in child development. In P. Lomas (Ed.), *The Predicament of the Family: A Psycho-Analytical Symposium* (pp. 26-33). London: Hogarth

Winnicott, D. (1953). Transitonal Objects and Transitional Phenomena- A Study of the First Not Me Possession. International Journal of Psycho-Analysis.34: 89-97

Winnicott, D. (1971) '*Transitional Objects and Transitional Phenomena*' in Caldwell, L & Joyce, A (Eds) (2011) '*Reading Winnicott*' Routledge: London

Winnicott, D. W. (1964) The concept of the false self. In: Home is where we start from. Winnicott, C., Shepherd, R. & M. Davis (Eds.)New York:Norton.

Winnicott, D.W. (1996). *The Family and Individual Development.* (11th ed.). London: Karnac.

Wise, T. N. (1978, January). Massive obesity & sexual activity. Medical Aspects of Human Sexuality, 7-23.

Wittenbrink, B., Judd, C. & Park, B. (1997) Evidence of Racial Prejudice at the Implicit Level and Its Relationship With Questionnaire Measures. Journal of Personality and Social Psychology. 72(2) PP.262-274

Witty, M. (2005). Client-Centered Therapy. London. 5(4) pp.10.

Woititz, J.G. (1989). Self-Sabotage Syndrome: Adult Children in the Workplace. New York: Health Communication

Woodman, M (1980) The Owl Was a Baker's Daughter : Obesity, Anorexia Nervosa and the Repressed Feminine : a Psychological Study Studies in Jungian Psychology. Inner City Books.

Yalom, I. D. (1989). *Love's executioner, and other tales of psychotherapy*. New York, N.Y: HarperPerennial.

Zwibelman, B., B. & Hinrichsen, J., J. (1977). Effects of training on peer counsellor responses to human sexuality problems. Journal of Counseling Psychology, 24, 359-364.