Indian Journal of Health, Sexuality & Culture

Case Series

Anti-Indian Bias and Homophobia: A Psychotherapy Case Study

Marty A. Cooper
Department of Psychology, State University of New York (SUNY) College at Old Westbury, New York, USA

Abstract
Anti-Indian bias can influence clients seeking psychotherapy. It is further complicated when this bias is experienced from a parental figure. It can lead to an internalised anti-Indian bias that may affect the individual for many years. It may be further complicated by having one or more intersecting minority identities. This article will review psychotherapeutic case-study with a self-identified gayclient, who experiences anti-Indian bias within his family of origin. The article will present an integrated relational framework that can be utilised to assist clients with similar difficulties.

Keywords:Indian, Gay, Psychotherapy, Intersectionality

Date Received:14th March 2019
Date Accepted: 30th May 2019

Correspondence should be addressed to:
Marty A. Cooper, SUNY Old Westbury, Department of Psychology
P.O. Box 210, Old Westbury, NY 11568 USA
Email- cooperm@oldwestbury.edu

Introduction:
This article explores a psychotherapy case study utilising an integrated relational framework. The case focuses on the intersections of sexual orientation, internalised anti-Indian bias, and their impact on identity. Throughout this article, the client will be referred to as Scott. This pseudo name was chosen to protect the client's identity but also to capture the essence of his name. This may be important to appreciate the central identity issue that will be discussed. This article will review the case progress and how an integrated treatment utilising aspects of relational, gay affirmative, and multicultural therapies have been utilised to facilitate treatment.

Identifying Data
Scott is a gay-identified male in his late 30's. At the beginning of treatment, he identified as white. However, five months into treatment, Scott was asked to complete the Quickview Social History (QVW, Giannetti, 1993) to obtain psychosocial history that may have been omitted during the treatment. While completing the QVW, he identified his race as 'other'. This discrepancy will be discussed later in this article in the upcoming sections. He currently does not identify with any specific

religious affiliation. His history with religion will be further discussed later in this article. He lives with his husband in a major metropolitan city in the United States.

Mental Status

Scott presents as a relatively stable person. He denies any history of suicidal or homicidal ideation. He also denies any history of delusions or hallucinations. He does, however, have a history of depressive symptoms, including sleep disturbance, isolation, and changes in appetite. Additionally, he displays current symptoms of anxiety and panic attacks. Specifically, he endorses repetitive thought, sleep disturbance, and feeling overwhelmed in social situations.

Medical Status

Scott obtains requisite medical treatment in a timely manner. Recently, he reports an increase in appetite, nocturia, concerns with sexual ability, arousal, and performance. He also reports drinking alcohol several times per week with increased tolerance. There is no other significant substance use.

Developmental History

Scott grew up with his biological parents and two siblings. He is the middle child. Scott reported a history of difficulty speaking correctly as a child. The aetiology is unclear, and he does not recall many details. There were no special accommodations made at that time, and he caught up with his peers in language ability. He denies any other developmental delays. His academic performance was strong, and he was engaged in many extracurricular activities, including athletics, clubs, music, and drama. He reports a happy childhood with a strong social network. Scott reports sleep walking stomach aches and diarrhoea as a child. He also recalls a specific fear of monsters and being kidnapped. Scott recalls physically maturing faster than his peers.

Although he reports a happy childhood, his relationships with his parents were complex. He reports that his mother loved him too much and was overly attentive. He recalls that he could usually talk to his mother about she accepted him but criticised him when necessary. She always praised him for his accomplishments. She was very strict, although reasonable in some areas, and allowed him little freedom. His mother usually punished him when he misbehaved. Punishment included yelling at him, taking away privileges, telling him that she was ashamed of him, making him feel that he had hurt her, or putting him in "time-out". Physical punishment typically included spanking or slapping and pinching. He reports that his father loved him but gave him insufficient time and attention. He was never able to talk to his father about problems. He claims that his father criticised everything he did. He reports that his father ignored his accomplishments. His father was an extremely strict disciplinarian who allowed him little freedom. Punishment rarely resulted when his father discovered that he had misbehaved. Punishment included

his father would yell at him, taking away privileges, telling him that he was ashamed of him, or putting him in "time-out".

Work history

Scott falls in a high-income bracket nationally and works in management. His work history shows a consistent direction toward upward mobility. His work has largely been involved in treatment to understand interpersonal interactions. He is not looking for a change in his work life now.

Presenting Problem

Scott presented concerns about a history of depression and anxiety. Specifically, he was concerned about increasing isolation and withdrawal from his husband.

Cultural factors

Scott was born to a white mother and an Indian father. This is an incredibly complex part of the treatment. He was recalling, that Scott came into treatment identifying as white. His mother encouraged an anti-Indian bias in Scott from an early age. She showed disdain toward his father. Scott recalls being at events with his Indian relatives and his mother telling him not to interact with the Indian children and not to be like them. An additional cultural factor is a religion in the family. His father does not espouse specific religious beliefs, whereas his mother is a devout Christian. Scott was raised with the Christian beliefs and attended church with his mother. This will be discussed further in the conceptualisation section. Of note, the specific Christian denomination had a clear and negative opinion about homosexuality.

Contextual factors

Contextual factors that impact treatment with Scott are largely due to integrated finances between him and his husband. Their money is jointly invested in property.

Conceptualisation

Scott is an excellent candidate for an integrated relational approach to therapy. He has a history of therapy and is inquisitive and open to self-exploration. Additionally, he has the means to engage in the therapeutic process. As of the time of the writing of this article, Scott has been in treatment for approximately five months. During this time, several themes have presented themselves. First, Scott foreclosed on a white identity early on in life. Second, his interpersonal relationships are significant for his gravitating toward people that have qualities he admires and then finding their flaws.

Foreclosed Identity

As mentioned, earlier, Scott had foreclosed on white identity. This presented itself on the first day of treatment. Although the clinician recognised this immediately, clinical experience suggested not to explore this in the first session. However, within a few sessions, there was an organic moment that allowed for the exploration of his identity. Through this process, Scott was able to recognise that his identity was largely influenced by his mother's dominance and anti-

Indian bias but also by the father's physical absence, due to work obligations, during childhood.

Additionally, his father only minimally engaged with Indian culture. These relationships informed Scott as to what an 'appropriate' identity would be. Scott also has phenotypical features that could easily be seen as white by some people he would interact with.

This part of the treatment has resulted in Scott processing his emotions regarding the messages he received from his mother and re evaluating his understanding of his father. It is unclear at this time how Scott will discuss identity at the end of treatment, but he may have access to his multiple identities from which he can choose.

Interpersonal Relationships

Scott has a long history of engaging in relationships with people that have qualities that he aspires to. He creates unobtainable expectations of the other, which, by design, the other party will fail to live up to. When this happens, Scott comes to see the other person as flawed. This elevates Scott's perception of his worth and lowers the value of the other party. In romantic relationships, he has typically sought a 'masculine', 'dominant' man. Scott will do this in several ways. In one relationship he began, sexually, as the receptive partner. Early on in the relationship, he became the insertive partner. This became 'proof' of his partner's inability to be the man that he needed. In work settings, he has asked his direct reports to complete tasks that they are ill prepared to do without much oversight. When the employee is incapable of completing the task, he again finds the 'proof' that they are not capable of living up to his expectations.

This process may function as a means of Scott elevating his value. If we recall his relationships with his parents growing up, we see that he received mixed messages from both parents. At times he was praised for his accomplishments, and at other times he was told that he was a disappointment. His mother, who was incredibly influential, not only denied his Indian identity but also expressed homophobic ideas early on. Although she has come to accept Scott's sexual orientation, those messages may have impacted his sense of self and value. This mixed with Scott's personality have resulted in an individual who finds himself unacceptable unless he is 'perfect'. Due to the discomfort that results from this self-judgement Scott projects this on to his interpersonal relationships.

Another element that has been discussed in treatment is that not all interpersonal relationships are equal. His proximity to the other person impacts how much he engages in this process. Those individuals that are closer to him or have a greater opportunity to see his vulnerabilities are more subject to this process.

Diagnoses

Diagnoses are provided in accordance with the Diagnostic and Statistical Manual of Mental

Disorders (DSM-5) (American Psychiatric Association, 2013). However, the codes utilised will conform to the International Classification of Diseases (ICD-10) (World Health Organization, 1992).

[F 34.1 Persistent Depressive Disorder (Dysthymia) with Anxious Distress Early Onset with Pure Dysthymic Syndrome; F 10.10 Alcohol Use Disorder – Mild]

Treatment

Due to the complexity of the case, the individual diagnoses are not treated separately. Rather, they are treated as a linked set of symptoms associated with his history and subsequent experience in the world. Therefore, his use of alcohol is seen as a behavioural response to uncomfortable effect. As the work has continued, Scott has been able to tolerate his effect with less use of alcohol. The therapist introduced mindfulness skills like diaphragmatic breathing to help ameliorate an uncomfortable effect prior to relying on substances. Similarly, depressive symptoms and obsessive thoughts are being reported less frequently as the treatment listed below continues.

A key aspect of the relational theory according to Wachtel (2017) is that 'each person's experience must be understood not just as a remnant of the past but in relation to the relational matrix that is the context for its expression in the present'. This has informed this treatment from the beginning. With regards to the client's foreclosed identity, the therapist has attempted to provide an environment where the client has the opportunity to explore multiple identities without being encouraged to foreclose by the therapist.

Figure 1 provides a visual representation of the relational treatment process. We can see that in section A, the client is impacted by both his father and his mother as well as her religious views. These influences impact the client' sinternalised sense of self and expectations of the environment. In section B, after leaving home, the client interacts with the environment with respect to this internalised sense of self and the environment. For Scott, this resulted in the interpersonal difficulties presented in this article. In section C, the client starts to work with the therapist. The integrated relational approach provides real-time opportunities to have different relational outcomes. As the client shows success in utilising novel ways of navigating the relationship, he is then challenged to attempt this in his outside interpersonal relationships. This process repeats itself until the client is having more successful interpersonal relationships outside of therapy and reduced symptomatology. Section D represents the client after the termination of treatment, having more flexible interpersonal relationships, improved sense of self, and more realistic expectations of the world.

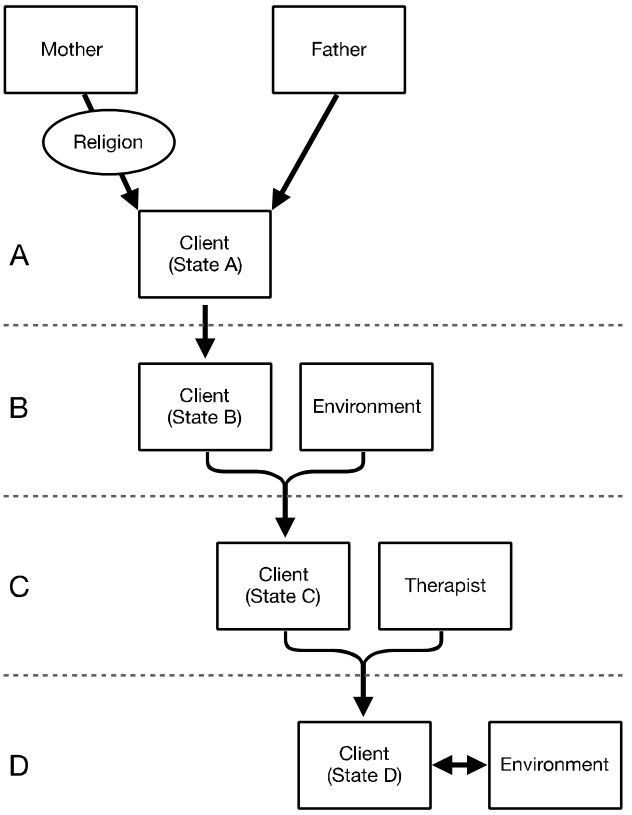

Figure 1: Integrated Relational Treatment Approach

Due to the intersectionality of Indian, male gender, and gay sexual orientation, the therapist has an integrated aspect of gay affirmative therapy. According to Johnson (2012) "Gay affirmative therapy is an approach used by psychotherapists to show understanding, to demonstrate cultural competence, and to create a positive therapeutic alliance". Utilizing this approach requires competence on behalf of the clinician. Specifically, in this particular dyad, the therapist is acutely aware of research that suggests that male psychologists do not self-report as much competence as female psychologists when working with sexual orientation (Cooper, 2015). Although Scott's sexual orientation has not been seen as a concern up to this point, he may have internalised negative messages about being a gay man from his mother and through the church. A gay affirmative stance may allow the client to discuss any negative views he holds and provide for a corrective experience.

Regarding the theme of interpersonal relationships, this is where the history, or client's object relations, and the present relationship with the therapist come together in a way that may result in a new outcome. Recently, in treatment, the therapist inquired of Scott in what ways he has seen flaws in the therapist, much like he finds flaws in other interpersonal relationships. The client stated that he was waiting

for the therapist to ask this and then stated, "I think this is the first thing I do not want to share with you." At this time, the client was not pushed to disclose this information. Instead, the therapist explained to the client that our relationship is an in-vivo opportunity to explore how he finds flaws in others, utilises these flaws to devalue them, and increases his sense of self-worth.

Scott continues to be open to the therapeutic process and has tolerated the discomfort brought on by this particular approach to treatment. It is hoped that continuing this line of treatment will first allow Scott to define his identities as he sees fit. Specifically, the anti-Indian bias and homophobic messages from childhood will be challenged. It aims to have then a corrective interpersonal experience that challenges his old ways of interpersonal relating and find new ways to relate to others. Through this process, we look to then further explore his sense of self, self-esteem, and self-value. Scott will be encouraged to challenge the negative internalisations and replace them with new ideas of self and acceptance.

This case provides an example of the use of relational theory as it pertains to working with a gay, bi-cultural Indian client who internalised anti-Indian bias. Sue & Sue (2008) stated that multiracial clients "…experience unique stressors related to their multicultural racial/ethnic identities…" These authors also suggest that these clients be allowed to choose their own identities. These concepts were central to the approach necessary to facilitate improved functioning in this case. Utilising an integrated relational approach may help clinicians to make adjustments in the therapeutic approach as the client is shifting within their identities. This particular case illustrates how many of the symptoms (alcohol use, anxiety, obsessional thoughts) were part of a larger, more complex experience of the world. Addressing the totality of the clients' experience prevented a myopic, symptom-specific treatment approach and has facilitated development and symptom reduction in the client. Figure 1 provides a visual aid to understanding the theoretical approach outlined here. Clinicians may consider utilising this figure as a tool to navigate an integrated approach like this when working with complex cases.

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®). Washington, DC: Author.

Cooper, M. A. (2015). Sexual Orientation Competence: Psychologists' Perceived Competence and Relationships to Multicultural Competence, Training, Engagement, and Exposure to Lesbian, Gay, and Bisexual Individuals.

Giannetti, R. A. (1983). Quickview Social History. Retrieved from http://search.ebscohost.com.proxy.library.nyu.edu/login.aspx?direct=true&db=mmt&AN=test.1569&site=eds-live

Johnson, S. D. (2012). Gay affirmative

psychotherapy with lesbian, gay, and bisexual individuals: Implications for contemporary psychotherapy research. American Journal of Orthopsychiatry, 82(4), 516–522. https://doi-org.proxy. library. nyu. edu/10.1111/j.1939-0025.2012. 01180.x

Sue, D. W., & Sue, D. (2008). Counseling the culturally diverse. Hoboken, NJ: Wiley.

Wachtel, P. L. (2017). The Relationality of Everyday Life: The Unfinished Journey of Relational Psychoanalysis. Psychoanalytic Dialogues, 27(5), 503–521. https://doi-org.proxy. library.nyu.edu/10.1080/10481885.2 017.1355673

World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.