Progressive Social Change Perspectives and Therapy: Mapping the Interfaces

Part 1: From Progressive Social Change Perspectives to Therapy

PLURALISTIC PRACTICE

THEORY ARTICLE

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ABSTRACT

The pluralistic approach to therapy is grounded in principles of progressive social change. This paper is the first part of a review that maps the interfaces between progressive social change perspectives and therapy. This first part introduces the review and focuses on the contribution of the former to the latter. Building on previous maps by Totton and Sanders, the aim is to develop a comprehensive, integrated framework for understanding these interfaces: stimulating further writing, research, and practice. A systematic search of two key journals and related literature was conducted, resulting in the construction of seven main domains, several of which were further divided into sub-domains. Domains and sub-domains for the first part of this framework are: the existence of *therapy-as-a-whole*, *therapeutic practice* (subdomains: *understanding clients and formulation*, *therapists' self-understandings*, *the therapeutic relationship*, *methods and techniques*, *therapeutic interventions*), *supervision*, *training* (subdomains: *curricula*, *process*, *access*), *research* (subdomains: *topics*, *methodology*), *access to therapy*, and *the therapy profession*. Literature and practices in each of these areas is described and illustrated. This paper also considers key traditions of progressive social change thought and action in the therapy field and discusses the challenges of mapping these interfaces. By bringing together a wide range of literature and traditions, this paper supports pluralistic therapists, and others with a progressive social change perspective, to reflect on, and develop, the social justice elements of their thought and practice. Part 2 of this review, to be published, will look at the contribution of therapy to progressive social change perspectives, and integrated psycho-political approaches.

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INTRODUCTION

BACKGROUND

From the earliest days of therapy, there has been interest in its interfaces with progressive social change perspectives (Totton, 2000). Many of the earliest psychoanalysts identified themselves as Marxists, socialists, and anarchist: including, for instance, Reich, Adler, Fenichel, and Gross. Research, today, indicates that most therapists position themselves on the political left or centre-left. One US study, for instance, found that 62% of therapists self-identified as Democrat, 23% as Independent, and only 7% as Republican (Solomonov & Barber, 2019; see also Steele et al., 2014) In recent decades, too, therapeutic approaches have emerged with an explicit integration of social justice ideas, values, and practices, including liberation psychology (Martín-Baró, 1996), re-evaluation co-counselling (Kauffman & New, 2004), process-oriented psychology (Mindell, 2014), and relational-cultural therapy (Jordan et al., 1991).

Pluralistic therapy can be considered another contemporary approach with progressive social change values at its core (Brown & Smith, 2023; Cooper & Dryden, 2016; Cooper & McLeod, 2007, 2011; McLeod, 2018; Smith & de la Prida, 2021). While the pluralistic approach is sometimes critiqued as an 'anything goes' relativism (e.g., Ellingham, 2023; Ong et al., 2020), Cooper and McLeod (2011) explicitly describe the approach as 'normatively pluralistic' rather than 'foundationally pluralistic' (Stanford Encyclopedia of Philosophy, 2006). This means that its deepest roots lie in a set of specific, non-negotiable set of values—an 'ethics of care' (Levinas, 1969) —from which then springs a desire to acknowledge and celebrate diverse perspectives: across clients (as personalisation), across clients' cultures (as cultural sensitivity), and within the therapeutic dyad (as collaborative practices, Cooper & Dryden, 2016). In the recently published *Handbook of social justice in psychological therapies*, the pluralistic approach to therapy has been explicitly recognised as aligned to social justice principles and practices (Charura & Winter, 2023; Gabriel, 2023).

THE OVERLAP BETWEEN THERAPY AND PROGRESSIVE SOCIAL CHANGE PERSPECTIVES

There is very little research on the reasons why therapists tend to align with progressive social change perspectives, and it may well be that the association is an indirect—rather than causal—one. For instance, as with the pluralistic approach, it may be that both the tendency to train as a therapist, and the development of progressive social change perspectives, are embedded in a common set of values. Many therapists come into the profession out of a desire to help and care for others (Farber et al., 2005); and, equally, individuals may gravitate towards progressive social change perspectives out of a concern with others' wellbeing. Hence, individuals with a value-base centred around care may be both more likely than others to train as therapists, and also more likely than others to adopt progressive social change perspectives (see Figure 1). This may be particularly true of therapists who align with specifically care- or relationally-oriented therapy, such as pluralistic therapy and the person-centred approach. It may also be that individuals with a particular 'critical' predisposition—who want to see under the surface of things to what is 'really' going on—may be drawn towards

therapy (in this case, a more psychodynamic approach), and also towards political standpoints which question taken-for-granted norms (Totton, 2000). Again, then, an association may emerge between therapeutic practice and social justice perspectives that is driven by a common, 'third variable'.

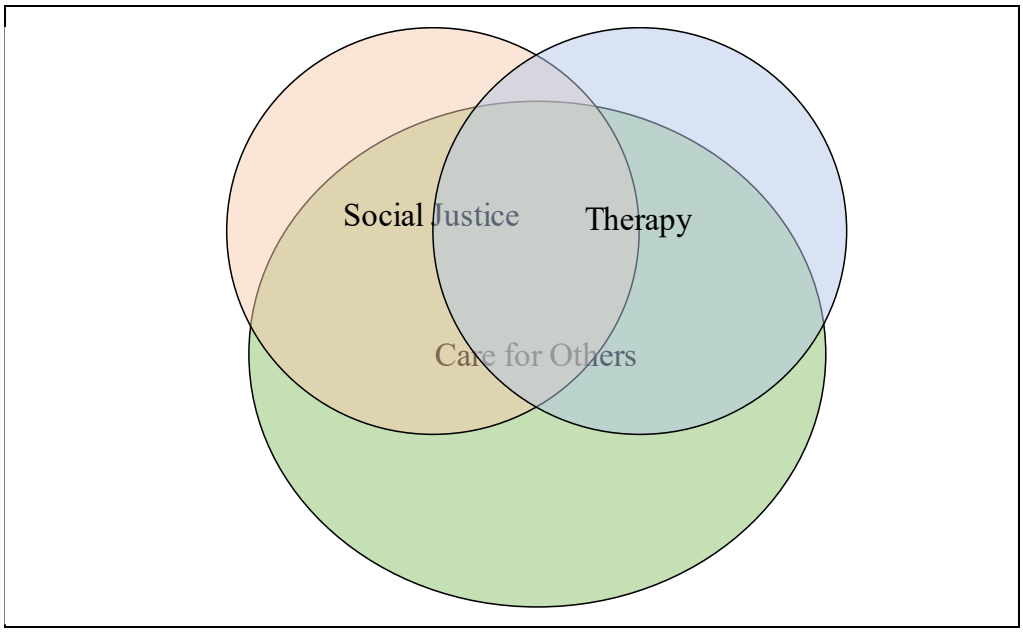

Figure 1.

Social Justice and Therapy Motivations Underpinned by a Care for Others

Of course, as the research indicates, not all therapists identify with progressive social change perspectives (Solomonov & Barber, 2019; see also Steele et al., 2014). As Figure 1 suggests, there are therapists who may hold a deep care for others, but not locate this within a commitment to wider social justice. For instance, they may be focused on just the wellbeing of their particular clients or those in their particular service—as a surgeon or a physiotherapist might be—without any commitment to wider social wellbeing. There may also be therapists who see their work as entirely outside both social justice concerns and an ethic of care (coming into the profession, for instance, solely out of a desire for financial reward). Moreover, while few therapists have explicitly aligned with a right of centre ideology, 'Many therapists, theories and writers espouse the view that helping—counselling or psychotherapy—is benign and apolitical' (Sanders, 2006, p. 7). Such a perspective may be rooted in a belief that a therapist's primary function is to be 'non-directive' (person-centred) or 'neutral' (psychodynamic) in the therapeutic relationship, such that any opinion—political or otherwise—is out of place. Indeed, in 2020 an organisation 'Critical Therapy Antidote' (https://criticaltherapyantidote.org/) was set up with the explicit agenda of championing 'the long-established apolitical…tradition in talking therapies', based on concerns about, 'the rapid and uncontested encroachment of Critical Social Justice (CSJ) into talking therapies' (https://criticaltherapyantidote.org/about/, see also Thomas, 2023). Totton (2000) also makes the point that the therapy field may seem more aligned to progressive social change perspectives than it actually is because progressives tend to be more vocal about their perspective (as, for instance, with the recently launched Therapy and Social Change Network (https://therapyandsocialchange.net/).

AIMS

The aim of this review is to map out the potential interfaces between therapy and progressive social change perspectives: where they have been found to meet, interact, inform, and influence each other. My hope is to help develop a comprehensive, clear, and practically-applicable framework. As part of this, I am keen to integrate literature from across a range of traditions: in particular, bringing the US-based multicultural work together with the wider global literature. In contrast to my previous writings at this interface (see, for instance, Cooper, 2006, 2019b, 2021; Cooper, 2023) my aim is not to be prescriptive (arguing, for instance, that therapy and social justice perspectives *are* closely aligned), but to be descriptive: reviewing what these interfaces can be. Nevertheless, in creating such a framework, my hope is that it will stimulate—and help to coordinate and organise—thought and practices at these interfaces: both the incorporation of progressive social change perspectives into therapy (this paper, Part 1), and therapeutic thinking into progressive social change politics (Part 2). My hope is also that this map will stimulate research: forming a robust starting point from which future researchers, practitioners, and trainees can map out particular domains and sub-domains at greater levels of detail and nuance. The map developed here, therefore, is in no way intended to be definitive; but a tentative and provisional structure that is open to further refinement, development, and expansion.

PREVIOUS MAPS

This work builds on two previous maps of the interfaces between therapy and politics (Sanders, 2006; Totton, 2000). Terminologically, these previous maps have focused on the interfaces of therapy with 'politics', rather than with 'progressive' or 'social justice' perspectives. However, their use of the term 'politics' has almost entirely referred to progressive viewpoints and actions. Totton (2000, pp. 6-7), in his classic book *Psychotherapy and politics*, identified four main domains: (a) *psychotherapy in politics* (interventions by therapists to the political process itself, such as advocating particular political programmes), (b) *psychotherapy of politics* (analysing political life through therapeutic concepts), (c) *politics of psychotherapy* (power relations and structures within the therapy profession), and (d) *politics in psychotherapy* (the ways in which political concepts are used to inform therapeutic practice, such as feminist therapies). Sanders (2006, p. 6), in his six categories, also identifies the politics of the helping professions as an area for consideration (Totton's domain (c)). However, he bifurcates Totton's 'politics in psychotherapy' into theoretical and practical contributions. Sanders also distinguishes between *the helper as citizen* (i.e., individual therapist contributions to political life) and the contribution of *helping theories* to politics (as compared with Totton's distinction between (a) interventionist and (b) analytical contributions of therapy to politics). Finally, Sanders adds the domain of training.

Totton's (2000) and Sanders's (2006) maps provide valuable starting points for examining the therapy–politics interfaces. The present review adds to these maps in several ways. First, most basically, it draws on the large body of literature that has been produced since these maps were developed, 20 years or more ago. Second, it is grounded in a systematic and transparent search of the literature, so that the framework developed is as representative as possible, and personal biases are reduced. Third, the present framework looks at the interface between therapy and specifically progressive political perspectives—not the whole of politics, per

se. My hope is that, in doing so, it will make it of particular relevance to advocates of social justice in the therapy field: both those of a pluralistic orientation and otherwise.

CHALLENGES IN MAPPING THE INTERFACES

Developing a map of the interfaces between therapy and politically progressive perspectives faces several major challenges. A first issue is the sheer magnitude of literature, particularly when one strives to be inclusive of, for instance, all feminist, multicultural, and LGBTQIA+ writings on therapy. Second there are definitional issues: What is and is not a progressive social change perspective? This becomes particularly challenging when one considers the numbers of approaches, such as person-centred therapy (e.g., Cooper et al., 2013; Rogers, 1957), that have an implicit social justice-orientation (e.g., a focus on client empowerment) if not an explicit one. A third challenge is that work from different areas of the world can be quite region-specific, with little connection—or reference to—literature from other areas of the globe. Multicultural writings from the US (e.g., Ratts et al., 2016), for instance, have almost no cross-referencing to the more conceptual and analytically-based work in the UK (e.g., Samuels, 1993), and vice-versa. Related to this, much of the work (as published, for instance, in *Psychotherapy and Politics International*) is relatively fragmented and dispersed, with low citation counts across papers and limited commonality across themes. A fifth challenge is that, at the present time, evidence to evaluate many of the practices associated with progressive viewpoints—such as 'broaching' and 'cultural humility'—is limited, and likely strongly influenced by researcher allegiance effects (Luborsky et al., 1999).

TRADITIONS AND DIMENSIONS

An additional major challenge in mapping the literature on therapy and progressive social change perspectives—albeit, perhaps, a strength for the field—is the diversity of traditions from which people have attempted to bring these two perspectives together. As indicated above, for instance, a first major strand could be considered the person-centred, humanistic tradition (e.g., Rogers, 1942), which draws on philosophical humanism and American liberalism to promote an ethos of freedom and growth for all. From the US also comes the tradition of multiculturalism—expressed, for instance, through the civil rights movement and, more recently, 'critical race theory' (see, Delgado & Stefancic, 2023)—where advocates such as Martin Luther King Jr. fought for the rights of marginalised, dispossessed, and discriminated against communities (Ratts & Pedersen, 2014). Closely aligned to multiculturalism are political traditions that advocate rights for such marginalised groups as women, LGBTQIA+ individuals, and disabled people. A different entry point to the therapy and social justice interface is the Marxist tradition, particularly in its critical, analytical form (e.g., Parker, 2014; Pavón-Cuéllar, 2019). There is also a more humanist Marxist tradition (e.g., Fromm, 1965), which tends to draw on Marx's earlier works (e.g., Marx, 1988; Marx & Engels, 1998), and comes closer to the liberal humanism of Rogers and colleagues. Another body of activity and writings at the interface between therapy and progressive social change perspectives seems informed—implicitly if not explicitly—by an anti-establishment, 'anarchistic' tradition (e.g., Postle, 2007): challenging, for instance, state regulation of psychotherapy practice. Recent years have also seen the

emergence of ideas and practices informed by environmentalism and concerns about climate catastrophe (Budziszewska & Jonsson, 2022).

Across these traditions, there are several key dimensions along which they tend to vary. Most basic is the distinction between work that focuses on practical, in-session therapeutic activities (primarily from the US); as compared to more conceptual, theoretical, and analytical writings (primarily outside of the US). A second dimension is between perspectives that hold an essentially positive view of human nature (a 'hermeneutics of trust', like the humanistic traditions) to those that hold a more critical, questioning view of human motivations and drives (a 'hermeneutics of suspicion', like the Marxist-psychoanalytic traditions). Somewhat related to this, there is also a distinction between those traditions that emphasise the avoidance of oppressive and discriminatory practice, primarily through self-reflexivity (that is, a focus on what we *shouldn't do*, e.g., the humanistic approaches), and those that place more emphasis on a proactive striving to counteract pre-existing inequities (that is, a focus on what we *should do*, e.g., the multicultural tradition).

In some cases, there are also differences in which of the 'Big 7 intersectional identities'—race (inclusive of ethnicity and culture), gender, class, sexual orientation, disability, age, and religion (Oulanova et al., 2023)—are focused on, and in some instances prioritised as the core social injustice.

TERMINOLOGY

Therapy is used throughout this paper as an umbrella term for counselling, psychotherapy, psychoanalysis, and all forms of mental health intervention delivered by a trained practitioner. *Progressive*, *progressive social change*, and politically *left* are used synonymously, referring to a broad spectrum of political standpoints—including socialist, feminist, postcolonial, and liberal humanist (Cooper, 2023)—that prioritise equal rights and the possibility of movement towards a better, fairer society (2016a, pp. xix-xx).

A belief in *social justice* can be considered the *sine qua non* of this progressive standpoint, defined as a basic value and desire for:

> fair access to societal institutions, laws, resources [and] opportunities, without arbitrary limitations based on observed, or interpretation of, differences in age, color, culture, physical or mental disability, education, gender, income, language, national origin, race, religion, or sexual orientation. (Davis, 1996, p. 1)

In this paper, however, I use the term 'progressive social change' to refer to something slightly broader than social justice, per se. While a progressive perspective is rooted in a belief in social justice, it also holds this as a genuine possibility for the future. With a progressive social change perspective, there is also a desire for greater overall human thriving: maximising wellbeing, as well as equalising it. Progressive social change perspectives are also inclusive of concerns for our environment and the animal world: implicit in the concept of social justice, but not quite reducible to it (Cooper, 2023; Nandy et al., 2016b).

Because the focus of this paper is on the interfaces between therapy and *progressive* social change perspectives, rather than with politics as a whole, I have focused only on those interfaces with politics where the latter has a specifically left-wing element. This means, for instance, that I have not reviewed the literature

on discussing politics in therapy sessions with clients (e.g., Farrar & Hanley, 2023), on the political viewpoints of therapists (e.g., Solomonov & Barber, 2019), or on therapy's interfaces with more reactionary perspectives (e.g., Thomas, 2023). Note, I am also using 'politics' here in the broad sense—the everyday structuring of power in society (small 'p' politics)—rather than in the narrower sense of electoral, party Politics alone (large 'P' Politics, Winter & Charura, 2023).

METHOD

A full systematic search of literature on the therapy and social justice interface was not considered feasible. However, I attempted to identify a representative and manageable sample through which an evolving framework could be developed. To achieve this, I used a number of strategies. First, I handsearched articles in two key journals: *Psychotherapy and Politics International* and the *Journal of Multicultural Counseling and Development* (the latter from 2010 onwards); and also in the *Journal of Clinical Psychology* Special Issue (2018): '"Clowns to the left of me, jokers to the right": Politics and psychotherapy' (74: 5). In addition, I conducted a title and abstract search on PsychInfo for the first 500 hits using the search string:

> TI (psychotherapy or therapy or counseling or counselling or intervention or treatment) AND TI (social justice or activis* or social change or progressive or Marx* or multicultural* or advocacy or refugee* or antiracis* or microaggress* or climate change or climate crisis or climate emergency or marginali#ed)

I also examined several key texts in the field and their reference lists, including Totton's (2000, pp. 6-7) *Psychotherapy and politics*, Duan and Brown's (2015) *Becoming a multiculturally competent counselor*, Ratts and Pedersen's (2014) *Counseling for multiculturalism and social justice*, and Ratts, et al.'s (2016) Multicultural and social justice counseling competencies.

Literature from the broader psychological field—without specific links to therapeutic theory, research, or practice—was excluded.

As the literature was scrutinised, a framework for its organisation was tentatively constructed. References, ideas, and practices were placed within various over-arching domains, domains, sub-domains, and sub-sub-domains: organised and reorganised in an iterative, thematic analysis-like process. Totton's (2000) and Sanders's (2006) domains were drawn on, but not strictly adhered to. The framework was then presented in a series of workshops and talks during the first part of 2023, so that any major inconsistencies or omissions could be identified, before being written up.

OVERVIEW OF THE FRAMEWORK

As with Totton's (2000) and Sanders's (2006) taxonomies, the present framework holds a basic divide between progressive social change contributions to therapy and therapeutic contributions to progressive social change (Table 1). A third overarching domain, however, has been added to the present map, 'Integrated psycho-political frameworks', which covers those approaches that seek a wholly integrated, bidirectional account of the therapy–progressive social change interface. The focus of this paper, Part 1 of the review, is on the first overarching domain: progressive social change contributions to therapy. This is Totton's domain of 'politics in psychotherapy' and Sanders's domains of 'the politics of helping

theories' and 'the place of politics in helping practice'. In the present framework, this over-arching domain is divided into seven key domains: *therapy-as-a-whole*, *practice*, *supervision*, *training*, *research*, *access*; and finally, as with Totton and Sanders, the politics of *the therapy profession*.

Table 1.

Interfaces between Therapy and Progressive Social Change Perspectives: Domains, Subdomains, and Sub-Subdomains

Progressive political contributions to therapy
Therapy-as-a-whole
Practice
Understanding clients and formulation
Therapists' self-understandings
The therapeutic relationship
Methods and techniques
Therapeutic interventions
Supervision
Training
Curricula
Process
Access
Research
Research topics
Methodological and epistemological issues
Access
The therapy profession
Therapeutic contributions to progressive politics
Theory
Practice
Therapy, per se
Therapy-informed practices
Activism
Integrated psycho-progressive frameworks

Note. Interfaces to be discussed in Part 2 of this review are in grey

MY POSITIONING

Finally, for the Introduction, a few words on my own positioning in relation to this topic. I have a deep and life-long commitment to progressive social change (see Cooper, 2023). This underpins both my engagement with therapy and my involvement with the development of the pluralistic approach (Cooper & McLeod, 2007, 2011). However, I believe that insights from the therapeutic field—particularly around the value of empathy, care, and acceptance—have much to contribute to progressive social change perspectives. I also believe that pluralism, as a philosophy (e.g., Berlin, 2003), has much to contribute to progressivism in its own right; and this review has been written very much from a pluralistic standpoint. By that, I mean a desire to welcome multiple, and potentially contradictory

perspectives, and to explore—with an open mind—the different understandings and positionings across the field.

THERAPY-AS-A-WHOLE

Perhaps the most fundamental place to start, when reviewing progressive social change perspectives on therapy, is literature on the issue of whether therapy should exist at all (e.g., Smail, 2005). Here, the principal charge has been that, by analysing psychological distress and healing in individual terms, therapy focuses attention away from real political injustices and inequities. In relation to the September 11th attacks on the US, for instance, Seeley (2005) writes that:

> By providing their patients with private spaces in which to speak, and by encouraging them to create personal narratives of trauma, therapists have helped their patients drain global events of collective political meaning. Despite their best intentions, therapist may have contributed to the makings of a passive and silent citizenry. (p. 27)

In this way, it has been argued, therapy and its professional bodies (Slaney, 2016) are complicit in creating, maintaining, and supporting oppressive practices (Saleem et al., 2021)—consciously or unconsciously serving to maintain the neoliberal, capitalist status quo (e.g., Bazzano, 2021; Parker, 2014; Totton, 2023). Pilgrim (1992) puts this bluntly when he writes, '[a]ny attempt to privilege a psychological explanation over a social one is a victim-blaming insult and a comfort to reactionary elements who sustain poverty in their own interests' (cited in Totton, 2000) One recent example, in which therapy was seen as serving the interests of capitalism, was the recruitment of psychologists in the UK into monitoring, modifying, and 'punishing' people who claim social security benefits (Friedli & Stearn, 2015).

Closely related to this, it has been argued that therapy, as an institution located in a particular sociocultural nexus, will inevitably take on the values, prejudices, and norms of that nexus. That is, it will be institutionally racist (Clarkson, 2004)—just as it will be institutionally prejudiced and institutionally discriminatory in other ways. And, through its interactions with clients, the therapy field can then serve to reify and legitimate those norms. Moon (2011), for instance, writes that therapy perpetuates heteronormative versions of social, sexual, and emotional life. They go on to state, 'therapists not only act as the purveyors of oppressive social systems but are patrolling the very borders of citizenship for the gendered and sexual "other" through a quiet, but violent, set of practices' (p. 204).

For Mason (1990), the imbalance in power between therapist and client means that, inevitably, therapy will function to oppress rather than liberate: imposing on the client worldviews and procedures without adequate informed consent. And, indeed, psychotherapy research indicates that, even in the most non-directive of therapies, clients will tend to defer to their therapists and take on a submissive and compliant role (Rennie, 1994). For Totton (2000, p. 142), as with Masson, this makes therapy 'open to massive exploitation' (p. 142), including financial and sexual abuse.

THERAPEUTIC PRACTICE

For Mason (2000), the problems in therapy run so structurally deep that he sees the institution as, essentially, un-reformable. For most other therapists from a

progressive social change perspective, however, such critiques do not disbar the possibility of a revised and reformed therapeutic practice. Indeed, the largest domain of writings on therapy from a progressive social change perspective are those that directly relate to practice. This includes how we understand clients, how we use our own self-awareness, the therapeutic relationship, the particular methods and techniques we use, and the macro-level therapeutic interventions available to us. Needless to say, 'social justice practice in the psychological professions is *not* about forcing one's belief on electoral politics onto those that we work with' (Winter & Charura, 2023, p. 67). Rather, it is about understanding that clients' experiences are rooted in a social-economic-cultural-political context. Hence, just as we might work with clients' difficulties in terms of their childhood experiences or their present relationships, so we might draw on understandings and practices related to this wider socio-political context to help them address their life challenges.

In the US, a range of competence frameworks for this work has been developed: both generally (e.g., Chung & Bemak, 2011; Owen et al., 2011; Ridley et al., 2021) and for work with specific marginalised groups (see, for instance, Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals (ALBGTIC LGBQQIA Competencies Taskforce et al., 2013); and Counselling Competences for Transgender Clients (American Counseling Association, 2010)). One of the most influential and comprehensive general frameworks is the Multicultural and Social Justice Counseling Competencies (MSJCC), developed by Ratts and colleagues (2016) for the American Counseling Association. These competences build on the Multicultural Counseling Competences developed by Sue et al. (1992). The MSJCC are organised into four domains: (a) counsellor self-awareness, (b) client worldview, (c) the counselling relationship, and (d) counselling and advocacy interventions. Each of these are then sub-divided into four subdomains of 'aspirational and developmental competencies': (i) attitudes and beliefs, (ii) knowledge, (iii) skills, and (iv) action.

UNDERSTANDING CLIENTS AND FORMULATION

One of the principal ways in which progressive social change perspectives have been brought into therapy is through understandings of clients and their difficulties. This is Ratts et al.'s (2016) domain of 'client worldview', and Sanders's (2006, p. 6) 'The politics of *helping theories*'. These understandings may emerge informally, or they may be developed and introduced more formally into the therapeutic work as *case formulations*. Literature, here, can be seen as having two sides: the advocacy of progressive social change-informed perspectives, and critiques of more traditional therapeutic understandings.

At the liberal-humanistic end of the spectrum, this may involve the promotion of growth-oriented, strengths-based, and agentic understandings of clients: as beings of equal worth and intelligibility to their therapists (e.g., Bohart & Tallman, 1999; Cooper, 2019a; Duncan & Sparks, 2010; Rogers, 1942). Implicitly or explicitly, there is a challenge here to deficiency-based, pathology-oriented understandings.

This challenge is particularly evident in the work of progressive therapists, from Laing (1965, 1967) to Davies (2014, 2022), who have questioned bio-medical models of psychological distress and the 'reality' of mental health diagnoses and labels. In contrast to this, however, are those progressive forces—such as the

modern recovery movement (e.g., Davidson, 2016)—that do see mental illnesses as 'real', but nonetheless push for people who experience such challenges to be de-stigmatised: seen as worthy of respect, dignity, and a right to self-determination. Somewhere in the middle of this spectrum are authors such as Totton (2023) who see non-typical ways of being, such as autism and ADHD, as real and distinctive, but with their own unique sets of capabilities, strengths, and wisdoms.

Moving towards more multicultural perspective, clients' psychological distress has been conceptualised in terms of their cultural identities and the consequences for this in a socially unjust environment. This includes, for instance, the stress, hurt, and damage to self-esteem that can be caused by such social forces as oppression, discrimination, and *microaggressions* ('subtle, stunning, often automatic, and non-verbal exchanges which are "put downs" of blacks by offenders'; including 'microassaults', 'microinsults', and 'microinvalidations') (Duan & Brown, 2015; Pierce et al., 1977, p. 66; Ratts & Pedersen, 2014). There is also the way that oppressive voices can become *internalised*, such that minoritized clients may come to relate to themselves in abusive, hurtful, or undermining ways (e.g., Nasrat & Riaz, 2023). Understandings and formulations may also be in terms of the development of identities for marginalised groups. Atkinson et al. (1979) for instance, propose the following five stages: 'conformity', 'dissonance', 'resistance and immersion', 'introspection', and 'integrative awareness'.

All of these perspectives are closely aligned to contextualised, relational, and 'ecological' conceptualisations of human being (see, Al-Murri & Childs-Fegredo, 2023; e.g., Bronfenbrenner, 1977; Jordan et al., 1991). This involves a rejection of the individualistic Global North worldview underlying most classical models of therapy. Hoffman et al. (2020) explain, 'It is not that the focus on the individual is bad, but rather that the focus on the individual to the neglect of the social, cultural, and systemic influences is an oversimplification of the human condition and experience' (p. 6). These perspectives also reject the ethnocentric, monocultural assumption that such a Global North worldview is, de facto, the only and 'correct' way to understand people (Duan & Brown, 2015). Latinx or African American cultures, for instance, may be more emotionally expressive than Euro-American ones, and it is important that such cultural ways of being are not pathologized as 'too emotional' or 'too out of control' (Vallejos & Johnson, 2020).

While the US literature has tended to focus on ethnicity and race (though explicitly inclusive of other marginalised identities), literature from other parts of the world has centred on class oppression and the damage wreaked by capitalism (e.g., Fromm, 1991; Laing, 1967). Early psychoanalysts and socialist humanists such as Reich (Totton, 2023), Fromm (1961), and Marcuse (1966) understood psychological repression and self-denial as a product of capitalism—a system that needed repressed, psychologically domesticated subjects to legitimise and reproduce itself. The more recent *Power threat meaning framework* (Johnstone et al., 2018), developed within the Division of Clinical Psychology of the British Psychological Society, understands clients' difficulties in terms of a range of oppressive power structures and relationships. It encourages therapists to ask such core questions as 'How is power operating in the client's life?' 'What kind of threats does this pose?' and 'What did the client have to do to survive?'

Across much of the contemporary literature, there is also a recognition that clients need to be understood in terms of how different forms of marginalisation intersect (e.g., Turner, 2021). This concept of *intersectionality*, explicitly labelled as such in

the late 1980s (Crenshaw, 1989), holds that the experience of marginalisation for people who inhabit multiple oppressed identities (e.g., a Jewish, disabled woman) is not simply additive (e.g., being Jewish + being disabled + being a woman). Rather, these forms of marginalisation interact and mutually shape one another, giving each combination a unique profile. Being a disabled woman within the Jewish community, for instance, may lead to very different experiences from being a disabled woman in other communities.

From a progressive standpoint, it has also been argued that clients' distress may need to be understood in terms of real-world political events and injustices (e.g., Avissar, 2016; Frosh, 2007). Much of this has focused on the despair and hopelessness that clients might experience around climate crisis (e.g., Budziszewska & Jonsson, 2022; Prentice, 2003). Budziszewska and Jonsson (2022), for instance, write, 'Citizens' worries about climate change are often realistic and legitimate,' and they go on to state that, 'these worries can also become a source of distress so severe as to impair everyday functioning and prompt someone to seek psychotherapy' (p. 606). Other real-world sources of psychological distress for clients may be international conflicts (e.g., the Ukrainian war), world hunger, or the suffering of animals (e.g., Mindell & Mindell, 2003). Such a perspective, then, challenges traditional intra-psychic models of distress: the assumption that psychological pain, ultimately, is rooted in our own mental processes and projections.

THERAPISTS' SELF-UNDERSTANDINGS

To some extent, simply an emphasis on the need for therapists to develop self-understanding—the MSJCC domain of 'counsellor self-awareness' (Ratts et al., 2016)—can be considered aligned to a progressive social change-informed perspective. Here, the therapist, like the client, is considered someone with blind-spots, challenges, and areas for development. Such 'equivalence' is particularly emphasised in the person-centred and humanistic therapies (e.g., Rogers, 1957), which call on therapists to be congruent and real in the therapeutic relationship: not 'white-coated professionals', but the flawed, vulnerable human beings that they inevitably are (Mearns & Cooper, 2018).

From a more multicultural perspective, however, there may be a particular emphasis on therapists—both in training and in practice—recognising their unconscious biases and assumptions. While many therapists may feel that they do not hold prejudiced beliefs or act in prejudicial ways, 'Many researchers have documented clients' experiences of microaggressions and discrimination in counselling and psychotherapy spaces' (Winter & Charura, 2023, p. 64). As just one example, for instance, research suggests that therapists may perceive same-sex domestic violence differently than heterosexual domestic violence: assuming for instance, that victims of same-sex violence exaggerate the severity of the abuse (Banks & Fedewa, 2012). From a multicultural perspective, then, it would be important for therapists to recognise—and challenge—such biased worldviews in themselves. A major focus of self-understanding from a multicultural perspective is also on therapists acknowledging their cultural identities and examining what this may mean in terms of engagement with clients (Duan & Brown, 2015; Ratts & Pedersen, 2014).

Therapists may be encouraged to consider, for instance, the ways in which they may be members of oppressor/privileged/dominant, 'border', or oppressed/

marginalised groups; and how this may then interact with particular clients' identities (Ratts & Pedersen, 2014). For White therapists, this may mean recognising their *white privilege*: 'an invisible and weightless knapsack of unearned assets granted to White people that can be cashed in each day for advantages that are unavailable to those who do not resemble the people who are in power' (Duan & Brown, 2015, p. 163). Recognising such privileges, when working with marginalised clients, can help therapists to recognise that their clients' experiences may be very different from their own. As with the development of identities for marginalised groups, it has been proposed that members of privileged groups may also go through stages of identity development: from no conscious awareness of differences, to acceptance of the dominant groups' view, to questioning and resistance, to redefinition of self, and finally to internalisation of social justice understandings and a willingness to act accordingly. This final stage is closely aligned to the concept of *cultural humility*, 'an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual's cultural background and experience' (Hook et al., 2013, p. 353).

THE THERAPEUTIC RELATIONSHIP

Unsurprisingly, perhaps, the interfaces between the therapeutic relationship and progressive social change perspectives shows substantial overlap to the latter's interfaces with understandings of clients and of self. At the liberal-humanistic end is an emphasis on the democratisation of the therapeutic relationship: client and therapist as equals rather than as inferior and superior, respectively. This can take many forms: for instance, an emphasis on the therapist's non-directive role (e.g., Rogers, 1942), a focus on relational practices rather than expert-based techniques (e.g., Eichenbaum & Obach, 2003; Spinelli, 2015), a recognition of the 'real relationship' between therapist and client (Gelso et al., 2018). In the pluralistic approach, it is expressed through an emphasis on collaboration, shared decision-making, and *metatherapeutic communication*: assessing, with clients, their goals and preferences, and striving to tailor the therapeutic work to their individual wants and needs (Cooper & McLeod, 2011; Norcross & Cooper, 2021; Winter & Charura, 2023). Pluralistic therapy also encourages routine outcome monitoring (ROM, aka 'systematic feedback') as a means of accessing and amplifying the voice and experience of the client (e.g., Chesworth et al., 2017; Minieri et al., 2015).

Closely related to this are those humanistic and psychodynamic positions that reject mechanistic, manualised therapeutic practices emphasising, instead, the genuine, spontaneous, and unknowable elements of the therapeutic relationship (Loewenthal, 2011). This critique is particularly directed towards cognitive behaviour therapy (e.g., House & Loewenthal, 2008) and other forms of 'neoliberal psychotherapy': 'a cheaper, more quantitative, more standardized, and more coercive endeavour than that which existed before the neoliberal era' (Ferraro, 2016, p. 19). As part of this, however, and contrary to pluralistic approaches, these authors have also vehemently rejected evaluation processes such as ROM (House, 2008, 2010) on the grounds that they are part of 'audit culture' and 'scientism'.

From a multicultural standpoint, there is also an emphasis on recognising power structures and dynamics within the therapeutic relationship, but particularly in terms of cultural identities. Ratts and Pedersen (2014) map our four possible quadrants of relating: (a) oppressor client–oppressed therapist, (b) oppressed client–oppressed therapist, (c) oppressed client–oppressor therapist, and (d)

oppressor client–oppressed therapist. However, as both clients and therapists will hold multiple identities, it is recognised that different power dynamics may exist across different dimensions. For instance, a white female therapist with a black male client may be privileged in terms of her race but not her gender. By becoming aware of these dynamics—and the intersections between them—therapists are then enabled to address them in the therapeutic relationship, and to ensure that the relationship does not simply become a forum in which oppressive dynamics are replicated and reified (Ratts et al., 2016).

METHODS AND TECHNIQUES

For many therapists from a liberal-humanist standpoint, therapeutic methods and techniques, per se, are associated with an authoritarian, 'power-over' stance (e.g., Mearns & Cooper, 2018). Hence, in the UK literature—which tends to be informed by a humanistic, person-centred ethos—the focus tends to be primarily on developing self-awareness, such that the therapist does not act in prejudicial or discriminatory ways (e.g., Winter & Charura, 2023). However, therapists from the US multicultural tradition have been more comfortable in articulating concrete methods and techniques from a progressive social change perspective.

Sensitivity to clients' experiences

At the most basic level, this may involve being sensitized to the kinds of experiences that clients from marginalised (and, indeed, privileged) groups may be expected to experience, such as racial microaggressions (see Understanding Clients and Formulation, above). From an analytical perspective, using these understandings to then offer clients interpretation of their experiences may be indicated. Eichenbaum (2004) gives the example, for instance, of drawing on feminist theory to name the feelings of desire that female clients may experience but have been socially conditioned to thwart. Ensuring the use of sensitive and appropriate terminology with clients may also be a basic implication of progressive social change perspectives in therapy (Ratts et al., 2014). This can include, for instance, 'people-first language' (e.g., 'people of colour' rather than 'coloured'), the avoidance of negative labels (e.g., 'handicapped'), and using the client's own desired pronouns.

Broaching

Broaching is one of the most widely discussed practices in the multicultural and social justice literature (e.g., Lee, 2022; King, 2021), with tools for its assessment (e.g., Day-Vines et al., 2013), and some evidence of positive impact (e.g., King & Borders, 2019). Broaching can be defined as the therapist's, 'deliberate and intentional efforts to discuss issues across racial, ethnic, and cultural domains that may impact the client's presenting concerns' (Day-Vines et al., 2021, p. 107). An example of a broaching statement might be, 'Your identity as Pakistani sounds really important to who you are, especially since you have experienced discrimination—I wonder how you think this could affect our relationship, given that I am White?' (adapted from, King, 2021). Broaching is intended to demonstrate to the client that the therapist is willing and comfortable to discuss issues of culture, oppression, and marginalisation with them. Given the power dynamic inherent in the therapist–client relationship and the tendency for clients to defer to their therapists (Rennie, 1994), without such explicit broaching, it is argued that clients may not feel safe or able to raise such issues for themselves.

Bridging

A complementary practice to broaching is *bridging*: discussion about shared identities with the client to connect or to anticipate something about their experience (King, 2021; Lee et al., 2022). This has similarities with the practice of 'self-disclosure' (Hill et al., 2019), though in specific relation to cultural identities and their impact. An example here might be to say to a client, 'I'm aware of the antisemitism that you've faced and, as a fellow Jew, I have a strong sense of that as well. In my experience, it's been really upsetting, particularly as it can feel shameful to talk about. How was it for you…'

Advocacy

Advocacy is a broad range of skills and methods in which the therapist strives to act as an agent of social change intervening, not just in the client's internal world, but also in the world around them (Chung & Bemak, 2011; Ratts & Pedersen, 2014; Toporek & Daniels, 2018). With the client's permission, for example, this might include, 'making phone calls together, writing letters to agencies, calling other professionals to determine the status of services and acquire information' (Chung & Bemak, 2011, p. 88). Advocacy competencies have been developed by the ACA (endorsed in 2003, and updated in 2018), and are organised across two dimensions. The first is 'Extent of Client Involvement', which ranges from advocacy done in collaboration with clients to advocacy conducted on behalf of clients. The second dimension is 'Level of Advocacy Intervention', ranging from advocacy for the individual client (microlevel), to advocacy for groups and communities (mesolevel), to large scale national change efforts in the public arena (macrolevel). Hence, advocacy interventions can range from supporting individual clients to identify, and challenge, the external barriers that affect their lives; through to the development—in alliance with the relevant communities, and other professional disciplines (Chung & Bemak, 2011)—of public policy campaigns to address and overcome social injustices (e.g., discrimination against transgender and gender-nonconforming clients in the workplace, dickey et al., 2017; Sangganjanavanich & Cavazos, 2010). This, then, is Sanders's (2006) domain of 'The helper as citizen'.

Indigenous healing methods

Advocates of multiculturalism in therapy have also advocated for the integration of *indigenous healing methodologies* into mental health practices: a (culturally humble) recognition that indigenous practices may be as valid as those developed in the Global North (Chung & Bemak, 2011). In most cases, this involves therapists working collaboratively with practitioners of indigenous healing methods, such as acupuncture, yoga, or shamanism. Chung and Bernak give the example of an American therapist working with a highly religious Afghan woman who had lost family during the Russian invasion. The therapist was aware that, within Afghani culture, Qur'anic prayer and rituals (such as writing and burning verses) were considered to have healing potential. The therapist, recognising that these practices were beyond her training and ability, contacted the local mosque and formed a 'treatment partnership' for the woman, so that she could receive spiritual guidance alongside the therapeutic work.

Interventions for specific real-world concerns

Within the therapy practice and research literature, there are also methods and techniques that have been described for helping clients respond to specific, real-world political events and injustices that are affecting them. For instance, Bingley et al. (2022) reviewed a range of strategies that can help clients deal with climate

change anxiety, including climate activism, emotion management, and developing social connections. Here, Budziszewska and Jonsson (2022) also found that therapists could help their clients by acknowledging their clients' strong emotions around climate change and by supporting their clients to rediscover a sense of meaning. As another example, Mindell and Mindell (2003) offer a range of suggestions for processing feelings following the 11th September 2001 attacks on the US, such as 'finding your inward centre', and carrying out a conversation (akin to two-chair work) between the 'terrorist position' and the 'victim position'.

Challenging clients' prejudices

Clients, as members of society, inevitably come to therapy with their own prejudices and biases, and there is a small body of literature on how therapists can address such issues (e.g., Guiffrida et al., 2019; Lee, 2018; MacLeod, 2013). MacLeod, for instance, suggests that it is important not to personalise the issue to the client; exploring tensions, contradictions, and ambiguities in the client's narrative; and working with the transference and countertransference. Branco and Bayne (2020), in research with counsellors of colour, also describe possibilities for direct challenge, as well as the importance for therapists of buffering and bracing themselves against racial microaggressions. Tehara (2023), as a minority ethnic therapist, gives a powerful example of dealing with explicit, aggressive racism in the therapeutic encounter; and how he made sense of the experience using psychodynamic concepts of transference, countertransference, and projective identification.

THERAPEUTIC INTERVENTIONS

Segueing from the micro level of specific methods and techniques are more macro level therapeutic interventions. From a humanistic-liberal perspectives, a whole array of therapies have been developed and promoted, such as the person-centred approach (Rogers, 1951; Rogers, 1961), which are based around a relatively democratic, non-hierarchical client–therapist relationship.

Moving further from a hierarchical approach are a range of peer-based therapies which dispense with the therapist–client hierarchy altogether. Re-evaluation co-counselling is a well-known example here, in which partners take turns in client and therapist roles (Jackins, 1970; Kauffman & New, 2004). There are also a wide variety of leaderless therapeutic groups (e.g., alcoholics anonymous), therapeutic communities (e.g., Soteria, Mosher & Hendrix, 2004), and networks (e.g., the Hearing Voices Network, https://www.hearing-voices.org/), which are oriented around peers providing support to each other, as contrasted with 'receiving' support from a therapeutic professional.

From a more multicultural perspective, a range of therapies have been developed or articulated to be sensitive to the particular needs and cultures of marginalised groups. This includes, for instance, therapies for clients of particular ethnicities, such as Native American (Roysircar, 2012) and Maori (Isaac, 2018); feminist therapies (e.g., Chaplin, 1988; Jordan et al., 1991); LGBTQIA+ -affirmative therapies (e.g., Davies & Neal, 1996; Tanner, 2019); therapies for people living in poverty (Foss-Kelly et al., 2017); therapies for clients with particular disabilities, such as deafness (Wright & Reese, 2015); therapies for refugees, asylum seekers, and immigrants (e.g., Blackwell, 2005; Nwoye, 2009; Sohtorik & McWilliams, 2011; Taylor et al., 2022); and therapies for victims of violence, such as intimate partner violence (West, 2018) and post-election violence in Africa (Nwoye, 2013). There are

also therapies developed for clients at the intersections between different identities, such as Arab Americans with disabilities (Al Khateeb et al., 2014), Puerto Rican migrant women (Comas-Diaz, 2017), and African American women and gay men in the Black church (Heard Harvey & Ricard, 2018). A range of adaptations of established therapies also exist for clients from marginalised communities, such as mindfulness for racially and economically marginalised patients in the Bronx (Bhambhani & Gallo, 2022), CBT for African American youth (Wilson & Cottone, 2013), and antiracist adaptations to dialectical behaviour therapy (Pierson et al., 2022).

As well as advocating for particular forms of therapeutic intervention, it should be noted that, from a progressive social change perspective, certain forms of therapy have also been challenged or campaigned against. Most significant here is *conversion therapy*, which seeks to change a person's sexual orientation or gender identity (Stonewall, 2023). Opposition to this practice in commonplace in the therapeutic field, with a 2017 memorandum of understanding again conversion therapy signed by over 25 major professional bodies (British Association for Counselling and Psychotherapy, 2023).

SUPERVISION

Significantly less material has been generated, from a progressive social change perspective, on the practice of supervision. In part, this may be because supervision is not a requirement for qualified professionals in the US, where much of the literature derives. Nevertheless, in the multicultural work, clinical supervision—both group and individual—has been identified as a critical means by which trainees can develop their competences in this work. This can include reflecting on assumptions, biases, and identities; developing cultural humility and 'decentering'; discussing issues of culture, power, and prejudice; considering and developing social justice-informed ways of understanding their clients and formulating; receiving emotional support and guidance when working with clients who espouse discriminatory views; and evaluating (with or without structured measures, see 'Research', below) their implementation of MSJCC, including advocacy practices (Glosoff & Durham, 2010; Guiffrida et al., 2019; Mitchell & Butler, 2021; Ratts & Pedersen, 2014; Watkins et al., 2022).

Most recently, a 'Multicultural Integrated Supervision Model' has been proposed by Mitchell and Butler (2021), based on the 'integrated developmental model' approach to supervision developed by Stoltenberg and colleagues (2011). This focuses on the developmental journey of the supervisee from limited training and experience (Level 1) to proficiency (Level 3i), and the supervisor's capacity to identify and deliver developmentally appropriate tasks. At the most basic level, then, this may involve reviewing the MJSCC with the supervisee and focusing on knowledge and skills development; progressing on to support with multicultural conceptualisation and advocacy interventions, and a focus on the supervisee–supervisee 'parallel process'; and culminating with facilitation of the supervisee's integration of MJSCC into clinical practice.

As with the therapeutic relationship, prejudices, discrimination, and microaggressions may also be evident in the supervisory relationship: both from supervisees to supervisors and vice versa. At present, however, there does not appear to be any literature in this area.

TRAINING

Sanders (2006) identified the training of therapists as an important area for consideration when mapping the politics–therapy interface, and this can be divided into curricula issues, the process of training, and access to training programmes. Within the literature, various case studies and personal accounts of the development of such trainings, and the challenges met, have been given (e.g., Blundell et al., 2022; Chung & Bemak, 2011, p. Ch. 15; Crozier & Pizzini, 2020; Motulsky et al., 2014).

CURRICULA

To a great extent, the MSJCC and other competence frameworks can be considered as guides to training curricula (e.g., Muangkaew et al., 2022)—to be implemented both in the classroom, and through placement (or 'practicum') (Hage et al., 2020) and 'cultural immersion' (Shannonhouse et al., 2018) activities.

Writings on therapy training from a progressive social change perspective have also emphasised the need to *de-colonise* or *de-ideologize* the curriculum: freeing training programmes from the dominance of Global North, white, male worldviews (e.g., Brubaker et al., 2010; Crozier & Pizzini, 2020; Goodman & Gorski, 2015; Oulanova et al., 2023). Crozier and Pizzini (2020) give the example of developing a bicultural Masters in Counselling programme in Aotearoa New Zealand. Here, a progressive social change perspective meant going beyond stand-alone blocks of course content on Māori issues or the addition of Māori rituals into the programme, to a fundamental questioning of the underlying, Global North-derived assumptions of therapy—such as the Rogerian concept of the 'self-contained individual'. The challenge, as Crozier and Pizzini described it, was to fundamentally integrate Māori knowledge and values into the heart of their programme— 'alongside and in a dialogue with white/Western theoretical frameworks' (p. 6).

PROCESS

Despite some of the differences between humanistic–liberal and multicultural traditions, their views on the training process are relatively similar. In each case, as with pluralistic training programmes, there is a move away from hierarchical and authoritarian teaching structures towards a more egalitarian, trainee-centred approach (e.g., Brubaker et al., 2010; Chan et al., 2018; McLeod et al., 2016; Mearns, 1997; Rothman et al., 2012). Brubaker et al. (2010) write, 'social justice pedagogy involves the democratic and participatory creation of learning environments that promote self-agency and mutual responsibility in the realization of a community where resources and opportunities are shared equitably (p. 89). This may include trainees sharing responsibility for the design, delivery, and assessment of the course; co-produced training materials with service users and members of the community; the prioritising of experiential learning and self-reflection over pedagogic input (with a particular focus on experiences of privilege and marginalisation for programmes from a MSJCC perspective); and trainers' use of critical self-reflection and self-disclosure as teaching strategies (for instance, sharing personal experience of homophobia or racism to stimulate discussion on these topics, Blundell et al., 2022). As with the pluralistic approach, Brubaker et al. (2010) also suggests that the integration of social justice into therapy training

means advocate a stance of 'appreciating multiple viewpoints', along with helping trainees realise, 'existing strengths and grounded knowledge' (p. 90).

In addition to this emphasis, however, a multicultural perspective puts emphasis on exploring power dynamics within the programme itself. Which trainees (and trainers), for instance, identify with privileged positions (such as being White), which with marginalised positions, and what are the implications of this for the training experience (Chan et al., 2018; Proctor et al., 2021; L. Smith et al., 2021). This is particularly important given the pervasive reports by marginalised students of feeling that issues of culture and power were not adequately addressed during training (Barcus & Crowley, 2012; Proctor et al., 2021). For example, diversity issues may only be addressed when students from marginalised groups raised them, only examples from majority cultures are given, racial microaggressions are not acknowledged by trainers (or, indeed, are made by the trainers themselves, see Zahid, 2023), or students from marginalised groups are told that they are 'making a big deal about it' when they raise concerns.

ACCESS

From a progressive social change perspective, a third subdomain of training issues concerns access to training programmes. 'That counselling and psychotherapy are largely middle-class pursuits must be now beyond dispute', writes Sanders (2006, p. 13). Alongside issues of who can afford to train in the therapy professions, Sanders raises such access issues as level of entry (Is degree or doctoral level, for instance, accessible to all?), accessibility for disabled people, and the publicly-presented culture of the programme ('How does the training course from its publicity to its staff group and curriculum *speak* to people of different classes, ages, and ethnic groups?') (p. 13). To this can be added, overlapping with process issues, the demographic make-up of the staffing team. If they are all white, or all middle-class, what implications does this have for prospective applicants' sense that the course is 'for them'?

RESEARCH

Research activity informed by progressive social change perspectives can be roughly divided into two main subdomains: the topics that have been researched, and the particular methods and epistemological principles adopted.

TOPICS

'Outcome' and 'process–outcome' research

A large body of research exists, primarily quantitative and from the US, which covers each of the areas discussed in this paper. Much of this is 'outcome research': evaluating the effects of therapy, or different therapeutic methods and interventions, for clients from different marginalised groups (in particular, race/ethnicity). A recent randomised controlled trial for Afghan asylum seekers and refugees in Austria, for instance, looked at the impact of a problem management therapeutic programme (Knefel et al., 2022). There is also a large body of 'process–outcome research' here, which looks at the client, therapist, relational, and orientation factors that predict outcomes for marginalised groups (see, Zane et al., 2004). Various reviews and meta-analyses of such work have been produced:

Cowling et al. (2023), for instance, summarised the findings from 71 articles on the effectiveness of therapeutic interventions on psychological distress in refugee children. A growing body of research is also looking at the outcomes of specifically social-justice informed methods (see review by Clark et al., 2022). Choi et al. (2015), for instance, used an 'analogue' design to examine the effects of a broaching intervention.

'Training, supervision, and therapist-focused research

Closely related to process-outcome research, there has been a range of studies on the effects of training in social justice-informed practices (MSJCC, in particular), though this has primarily looked at the effects on trainees rather than clients, per se. Most basically, this has assessed whether MSJCC training does, indeed, lead to increases in MSJCC competences (e.g., Kuo et al., 2020; Lee et al., 2014) and, if so, the factors and experiences that may have been most impactful for such learning (e.g., Caldwell & Vera, 2010). Research has also examined the experience, and professional and personal impacts, of such trainings—for trainees of both marginalised and privileged identities (e.g., Crumb et al., 2019; Dunn et al., 2022; Paone et al., 2015). There is also research on the actual content of multicultural and diversity-related courses (e.g., Pieterse et al., 2009).

A more specific focus for such research has been the experiences of trainees from marginalised groups in therapy programmes more generally including, for instance, experiences of burnout, discrimination, and identity development (e.g., Basma et al., 2021; Locke, 2022).

A recent review of the research literature on supervision from a multicultural perspective identified 58 articles across 13 journals (Kemer et al., 2021). The scope and forms of research were relatively similar to research on social justice-informed training: focusing primarily on either particular models of multicultural supervision (such as multicultural competence–focused peer supervision, Somerville et al., 2019), or else with respect to particular cultural identities and intersectionalities. Some research has also focused on multicultural supervision interventions that aimed to enhance supervision and therapy, and supervisor and supervisee multicultural competences (e.g., Tran, 2022).

Another area of research is the extent to which therapists, generally, have multicultural and social justice competences (e.g., Aga Mohd Jaladin, 2017). Hemmings and Evans (2018), for instance, looked at whether therapists had training in identifying and working with race-based trauma. Related to this is research on factors that predict the extent to which therapists will practice in a socially just way, or advocate for it. For instance, Dictado and Torres-Harding (2022) examined predictors of trainees' pathologizing and invalidating microaggressions with sexual and racial minority clients. As here, the focus may be on practices and competences with particular groups of clients (e.g., Soheilian & Inman, 2015), but it may also be on the competences of particular groups of therapists (e.g., play therapists, Parikh et al., 2013).

Research (both qualitative and quantitative) has also looked at trainees' and therapists' understandings of the relationship between therapy and politics; their experiences of—and feelings and commitments towards—engaging with issues of social justice (e.g., Beer et al., 2012; Kennedy, 2014; Miller & Sendrowitz, 2011; Winter, 2021; Winter & Hanley, 2015) and power (e.g., Morrill, 2022); their views on the key social justice competences (Brown et al., 2019) and practices (such as broaching, Day-Vines et al., 2022); or their views on politics and social justice more

broadly (e.g., Steele et al., 2014). There is also research on how therapists see social discourses, such as on asylum-seekers, as influencing their work (Apostolidou, 2018).

Research into the experiences of people from marginalised groups

Within the therapy field, another large body of research is on the experiences and psychological needs of people (including clients) from marginalised groups, per se. Öksüz (2021), for instance, looked at the experience of postpartum depression in women with disabilities. A more specific body of research also exists on such people's experiences of, or attitudes towards, therapy. Here, the focus may be on specific social justice-related issues, such as barriers to accessing counselling (Lin et al., 2021) or experiences of microaggressions in therapy (Trusty et al., 2022; Yeo & Torres-Harding, 2021). It may also be on more general therapeutic processes, such as female substance users' perceptions of helpful and unhelpful factors in therapy (Halsall & Cooper, 2023). Much of this research is qualitative in nature, and has the aim of informing, sensitising, and enhancing therapeutic practices with people from these communities.

Measures

As in all areas of therapy research, a substantial proportion of research activity informed by a progressive social change perspective has focused on the development and testing of measures. Several of the most common ones are self-report instruments in which respondents are directly asked to evaluate their confidence in, and/or knowledge of, multicultural and social justice competences. Examples are the Multicultural Counseling Inventory (Sodowsky et al., 1994), the Multicultural Counseling Knowledge and Awareness Scale (Ponterotto & Potere, 2003), and the Social Justice Self-Efficacy (SJSE) Scale (Miller et al., 2009). Version of these scales have been developed for therapists from particular backgrounds, such as Malaysian counsellors (Jaladin et al., 2023); and with a focus on particular forms of marginalisation, such as social class and classism (Pietrantoni & Glance, 2019). Focusing on the other side of this coin, a measure has also been developed to assess reactance to multicultural training, with items like, 'Racism only exists in the perception of the individual' (Lowery et al., 2020).

There are also measures of multicultural competences which test, more indirectly, respondents' attitudes, sensitivities, and open-mindedness towards other cultures, and their ability to adapt accordingly. Examples here are the Cross-Cultural Sensitivity Scale (Pruegger & Rogers, 1994), the Intercultural Adjustment Potential Scale (ICAPS) (Matsumoto et al., 2001), and the Multicultural Personality Questionnaire (Van Der Zee & Van Oudenhoven, 2000) (see review by Matsumoto & Hwang, 2013). More 'objective' still, Gillem et al. (2016) have developed a standardised multiple choice multicultural competence test. There are also tools which assess therapists' willingness to deploy particular social justice-informed practices, such as broaching (Day-Vines et al., 2022) and advocacy (Dean, 2009)—both generally and for specific marginalised groups (e.g., the School Counselor Sexual Minority Advocacy Competence Scale, Simons, 2017).

In contrast to these therapist self-report measures are observer- or client-completed measures of therapists' cultural competence, such as the Cross-Cultural Counseling Inventory—Revised (LaFromboise et al., 1991). There are also assessments of specific competences, like the Cultural Humility Scale (Hook et al., 2013), with items like, 'my counselor…Is considerate' [about the core aspect(s) of my cultural background]; and the Racial Microaggressions in Counseling Scale,

which assesses the perceived frequency and impact of microaggressions from their therapist (Constantine, 2007).

METHODOLOGY

While the majority of research related to progressive social change perspectives, as reviewed in the subsection above, has adopted a quantitative approach, the numerous challenges to a traditional positivist research paradigm (so numerous they can only be briefly mentioned here) could also be considered grounded in a progressive social change perspective. These reject, from a 'human science' and pluralistic standpoint, the assumption that human experiencing can be best understood through the generalising and reductive media of numbers, in terms of cause-and-effect mechanisms, and/or from the vantage point of an independent 'objective' observer (e.g., McLeod, 2011; Rogers, 1990; Slife, 2004; K. Smith et al., 2021). Instead, there is an emphasis on the idiographic and non-reducible nature of human experiencing, as often best expressed through language. Such literature also often emphasises the researcher's own reflexive positioning and willingness to co-produce research with participants and other stakeholders, along with challenges to positivist assumption of causality (Oddli et al., 2022). Closely related is a de-colonising approach to therapy research: conducting studies, for instance, from non-Western, indigenous epistemological standpoints (e.g., Mikahere-Hall, 2017). Research from a progressive social change perspective has also questioned what is meant by 'outcomes': is it necessarily equivalent to a reduction in symptoms (Donald & Carey, 2017; Sales et al., 2023)? Indeed, from this standpoint, the very prioritisation of research over other forms of knowledge in the commissioning and funding of therapy interventions (as 'empirically supported therapies') has been fundamentally challenged (Cooper, 2008).

ACCESS

Who gets access to therapy interventions? As with therapy training, a range of concerns have been raised regarding the ability of marginalised groups to engage with therapeutic services, with various attempts to overcome these barriers.

Most obvious, perhaps, are financial barriers. Fees for private therapeutic services can put them beyond the research of economically disadvantaged (and even economically non-privileged) individuals. As a result, wide swathes of therapists and therapeutic services—with either an implicit or explicit social justice awareness—have focused on providing low- or no-cost interventions to those struggling to access therapy: from Reich's freely-available sexual counselling services (Totton, 2000) to contemporary YIACS (Youth Information, Advice and Counselling Services, www.youthaccess.org.uk).

There may also be physical barriers to accessing therapeutic services, limiting access to those with disabilities. Stairs to a consulting room, for instance, may make it inaccessible to those in a wheelchair, a reliance on verbal communication may make it inaccessible to people with hearing impairments. Again, a wide range of more inclusive and affirmative practices have been proposed (see, for instance, Halacre, 2020).

Marginalised groups may experience particular barriers to accessing therapeutic services, and there is evidence that they are, 'less likely to seek out therapy and often terminate prematurely' (Oulanova et al., 2023, p. 11). This may be for physical reasons (e.g., the services are not physically located in their community), intra-

community reasons (e.g., there is a particular stigma towards therapy within the community), or extra-community reasons (e.g., the services are not well-promoted to that community, or the service does not provide therapists with an understanding of that community's issues or speak in their language). On this basis, a major focus for therapists with a commitment to progressive social change has been to develop services that provide focused therapeutic support for people from marginalised communities—often on a free or low-cost basis. Just some of the many examples are 'therapyforblackgirls.com', Londonfriend counselling services for LGBTQ+ people, and Woman's Trust counselling for female survivors of domestic abuse. There are also numerous examples of such services in the international development field, such as work with people experiencing PTSD in Uganda (Chung & Bemak, 2011), and the organisation 'Counselors without borders', which 'is committed to providing culturally responsive humanitarian counseling in post-disaster emergency situations' (https://www.counselorswithoutborders.org/).

THE THERAPY PROFESSION

In Totton's (2000) domain of the 'Politics of psychotherapy' and in Sanders's (2006) domain of 'The politics of the helping professions and their institutions', progressive social change perspectives are brought to bear on the structures and processes of the therapy profession itself.

Much of this focuses on hierarchical structures within the profession. This is particularly at a time when the 'SCoPEd' (The Scope of Practice and Education) Framework is being agreed by the professional bodies for counselling and psychotherapy (e.g., Stevens, 2019). At the root of this are concerns that SCoPEd is formalising a hierarchy in which 'psychotherapy' (or, in terms of the Framework, 'Column C') is ranked over basic ('Column A') and more advanced ('Column B') 'counselling'. Critics, like Counsellors Together UK and the Psychotherapy and Counselling Union, have argued that SCoPEd is a 'top–down' structured imposed by the professional bodies, and one that would penalise counsellors who choose not to undertake accreditation processes (Counsellors Together UK, 2019).

Overlapping with these concerns is a more general opposition to state regulation of the therapy profession (e.g., Postle, 2010; Tudor, 2011). Critiques, here, come from a broadly humanistic position, with the addition of more anarchistic elements. From this standpoint, regulation is seen as a means of controlling and homogenising the therapeutic profession; and, more insidiously, commodifying it such that it aligns with—and serves the purposes of—capitalism (Parker, 2014). Instead, from this standpoint, there is an emphasis on diversity of practice; and the possibility for therapists to autonomously, self-reflexively regulate. Consistent with this, for instance, the Independent Practitioner's Network (IPN) (https://ipnetwork.org.uk/) has been set up as an organisation of professionals offering self and peer-accreditations, with no hierarchy, limited bureaucracy, and no central administration.

There is also an issue of equitable status for therapists against other mental health professionals—as with, for instance, counsellors being supervised by psychologists in the NHS (Brennan & Hollanders, 2004)—and more generally the employment and working rights of therapists. This is the basis for the Psychotherapy and Counselling Union (https://www.psychotherapyand

counsellingunion.co.uk/) which campaigns against such practices as unpaid positions for early-career therapists.

PART 1: SUMMARY

This paper is the first part of a review which aims to create a systematic and comprehensive map of the interfaces between therapy and progressive social change perspectives. It suggests that progressive social change perspectives can contribute to therapy in seven principal domains: the existence of therapy-as-a-whole, therapeutic practice, supervision, training, research, access, and the therapy profession. Several of these domains can then be further divided into subdomains: in particular, therapeutic practice can be subdivided into understanding clients and formulation, therapists' self-understandings, the therapeutic relationship, methods and techniques, and therapeutic interventions.

This map covers each of the domains outlined in previous frameworks (e.g., Sanders, 2006; Totton, 2000), but adds three additional main domains: therapy-as-a-whole, supervision, and research. In addition, several new sub-domains have been added (Table 1). In these ways, it is hoped that this map will add clarity to the field, and provide stimulation to review, develop, build on, and further define each of the identified areas.

Most importantly, perhaps, this review brings together progressive perspectives from a range of different traditions, with the hope that this can enhance dialogue, learning, and practice around the globe. To date, pluralistic therapy has been primarily embedded in a UK-centric worldview. In this review, however, it is evident just how much work at the therapy and progressive social change interface is going on outside of this field. At the heart of a progressive worldview, as with pluralism, is a belief in cooperation across diversity. Through cooperation and mutual learning across different progressive traditions, the possibility for growth and development of social justice thought and practice in the therapeutic field may be maximised.

COMPETING INERESTS

The author has no competing interests to declare.

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