Clinical Manifestations of Prejudice in Psychotherapy: Toward a Strategy of Assessment and Treatment

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Social bias is an issue of concern to both practitioners and clinical researchers. This article considers race and ethnic prejudice as a prominent clinical feature in three psychotherapy cases. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) diagnoses, General Adaptive Functioning ratings, and Minnesota Multiphasic Personality Inventory scores are considered in terms of the level of patient disturbance and severity of outgroup prejudice. Two cases exemplify chronic adverse outgroup ideation, reflecting a constellation of traits of personality disturbance, disinhibition, and adverse behavioral response (e.g., panic, hostility, and/or aggression) to intergroup contact, while one case evidences prejudicial ideation as a transitory, conditioned response to traumatic victimization by a member of a racial outgroup. Prejudice is considered as a clinical syndrome, with treatment strategy considered in terms of the severity and chronicity of prejudicial ideation.

Key words:* prejudice, racism, psychopathology, diagnosis, psychotherapy. *[Clin Psychol Sci Prac 3:296–309, 1996]

Psychological researchers have long demonstrated an interest in the topic of prejudice (Allport, 1954). Prejudice has been conceptualized from a variety of perspectives. Duckitt (1992) proposed a framework of four processes that are suggested to "subsume and summarize most psychological thinking" (p. 1182) on the causes of prejudice. These four processes include (a) theories that assume an inherently human propensity for prejudice, (b) intergroup interactions that create socially shared patterns of prejudice, (c) individual learning of socially shared patterns of prejudice, and (d) individual differences that mediate susceptibility to ascribe to prejudicial beliefs.

In this article the role of individual differences is considered in terms of the clinical manifestations of outgroup bias. Of particular interest is whether patients who express particularly virulent outgroup bias can be best understood as experiencing a true clinical syndrome secondary to other recognized diagnostic categories and associated with characteristic symptoms, including rigid cognitive style and impulsivity in affective expression. We conceptualize prejudice as more than faulty or overgeneralized cognitions (Jones, 1972). Rather, we conceptualize prejudice as consisting of both negative cognitions and an intensely negative affective response (Frosh, 1989).

Research of prejudice as an individual difference variable has provided ripe ground for psychological study. Racism has been understood "as projection: the expulsion of disturbing or painful feelings from inside oneself on to the socially legitimized target of another" (Frosh, 1989, p. 234). Pinderhughes (1989) has additionally considered outgroup prejudice as "societal projection" in which the majority group members feel dominant, competent, and part of a larger social context that is in opposition to persons viewed as "different." Prejudice as a form of projection is exemplified in the classic study of Dollard, Doob, Miller, Mowrer, and Sears (1939), in which the rise of anti-Semitism in Germany is attributed to the displacement of hostility associated with post–World War I political and economic hardship onto the Jewish minority group. In their seminal study on authoritarian-

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ism, Adorno, Frenkel-Brunswik, Levinson, and Sanford (1950) characterized anti-Semitism in terms of characterological rigidity, hyperconventionality, and sadism (Christie, 1991). More recently, Rokeach, Smith, and Evans (1960) studied dogmatism and cognitive inflexibility in association with prejudice. The efforts of these and other theorists describe the psychological experience of the prejudiced individual in terms of personality disturbance, which increases susceptibility to prejudicial beliefs and affects.

PSYCHOMETRIC ASSESSMENT OF PREJUDICE

The efforts of researchers in the decades immediately following World War II hold implications for contemporary psychological assessment. There have been a proliferation of social attitude scales on topics such as anti-Semitism (Selznick & Steinberg, 1969), homosexual bias (Smith, 1971), and anti-Black racism (McConahay, 1986). However, these measures are more typically used in social science research, as opposed to clinical practice. Furthermore, as such measures characteristically manifest strong face validity, they are vulnerable to favorable self-presentation bias. By comparison, a more clinically useful and unobtrusive assessment of outgroup prejudice is available from use of the Minnesota Multiphasic Personality Inventory (MMPI), thus minimizing face validity and self-presentation bias concerns. This approach is exemplified in the work of Harrison Gough.

Gough's studies of prejudice—or, as he has come to refer to it, "social intolerance"—have resulted in the introduction of two distinct assessment methods based on MMPI data. These include the measurement of outgroup bias via the Prejudice (Pr) scale (Gough, 1951b), and measurement of patient impulsivity, using the F and K scales of the MMPI (Gough, 1951c). In his development of the Pr scale, Gough employed a criterion reference keying strategy to select scale items, using the Sanford anti-Semitism scale as the criterion measure. This procedure resulted in the identification of 32 MMPI items for inclusion on the scale. The Pr scale was subsequently incorporated into the California Psychological Inventory as the Tolerance (To) Scale (Gough, 1987). Gough described the content of Pr scale items as reflecting anti-intellectuality; pessimism; feelings of cynicism, distrust, and suspicion; misanthropy; discontent with current status; a rigid, dogmatic thinking style; and feelings of estrangement. As he observed in 1951, "The overall picture which emerges . . . is one of a harassed, tormented, resentful, peevish, querulous, constricted, disillusioned, embittered, distrustful, rancorous, apprehensive and somewhat bewildered person" (1951b, p. 253). The portrait drawn by Gough is of such vividness that one could infer such individuals might suffer from a variety of diagnosable conditions, such as the personality disorders represented in the *Diagnostic and Statistical Manual for Mental Disorders* (4th ed.; hereinafter DSM-IV).

Recent research supports the construct and criterion validity of the Pr scale (Dunbar, 1995). For example, in a community study of marital relationships Gough and Bradley (1993) observed that the To scale was significantly correlated with spousal ratings of intolerant behavior, as measured on an adjective checklist. Parents who ranked "high [on] the intolerance criterion saw their children as being difficult to manage, as resentful of parental discipline, and as vociferous in their resistance when wishes were denied" (p. 72). Earlier research had suggested that child-rearing practices may contribute to the formation of rigid social judgments, prejudice, and authoritarianism (Frenkel-Brunswik, 1948; Harris, Gough, & Martin, 1950).

There is evidence that impulsivity and anxiety, as reflected in MMPI F and K scores, may also be associated with social bias. Gough found that the MMPI scores of persons who reported anti-Semitic beliefs were characterized by elevated F ($T > 70$) and lower K ($T < 50$) scale scores on the MMPI (Gough, 1951a). The relationship of these two scales, widely understood to represent the patient's self-presentation, is suggestive of a disinhibited and impulsive social style. As suggested by Friedman, Webb, and Lewak (1989) this F-K pattern "suggests low self-esteem, low ego strength, emotional discomfort, difficulty coping, and an openness and willingness to admit to the numerous problems he is experiencing" (p. 147). Dunbar (1996a) found this high-F/low-K relationship was associated with negative outgroup beliefs and Pr scale score elevations in a clinical population. He also found a significant relationship between psychotherapy patients' Pr scale scores and clinician ratings of outgroup bias.

PSYCHOPATHOLOGY AND PREJUDICE

Contemporary clinical researchers have paid little attention to the associations between psychopathology and prejudice, and the treatment implications for the preju-

diced individual. A review of the contemporary clinical literature underscores the limited attention paid to the role of psychopathology in the endorsement of socially intolerant beliefs. Maciejewski (1994), writing in a German psychoanalytic journal, examined the xenophobia directed by Germans at Gypsies. Maciejewski proposes that this phenomenon is comparable to anti-Semitism and that both have their origins in the projection of unacceptable aspects of the self onto outgroup members. Heim (1992) conceptualized xenophobia and racism as consequences of narcissistic fantasies of the homogeneity of the body politic, in which the externalization of instinctual urges and unpleasurable experiences is projected onto foreigners. Bell (1978, 1980) has suggested a relationship between racism and personality disorders, as represented in the DSM-III system, noting that racism is characteristic of narcissistic personality disorder. Dunbar (1994) recently reported a significant relationship between White racial identity, narcissistic traits, and negative attitudes toward African Americans in a nonclinical sample.

It is unfortunate that race and ethnic prejudice have received little attention in the clinical research literature, whether as phenomena encountered in psychotherapy, regarding the current DSM-IV diagnostic system (American Psychiatric Association, 1994), or as a focus of treatment. This is despite conceptual support for the relationship between prejudice and the personality disorders. Furthermore, while there are measures available to assess the psychological significance of adverse outgroup beliefs (such as the MMPI Pr scale), it is likely these are not utilized by the majority of practicing clinicians (H. G. Gough, personal communication, October 14, 1995).

We propose a reconsideration of the associations between prejudicial beliefs and associated, measurable traits, particularly in light of the current diagnostic system employed by researchers and practicing clinicians. Toward that end, a series of case histories are presented below to illustrate the utility of clinical and psychometric methods in the assessment of race/ethnic prejudice, and to illustrate the proposal that virulent prejudiced beliefs and behaviors may rightly be considered a clinical syndrome.

CLINICAL CASE MATERIAL

Procedure

Three case histories will be presented. These were selected to illustrate a range of severity in clinical manifestations of prejudice. All individuals were psychotherapy patients who voluntarily initiated treatment, and were seen in a private psychology group setting in the Greater Los Angeles area. The two treating psychologists were Euro-White: one female and one male. The practice group where these patients were treated services a wide range of clinical problems and includes a heterogeneous sociodemographic client base. In none of the cases was prejudice or outgroup relations an initial focus of treatment, or the reason for self-referral. Details about each case are altered to preserve confidentiality and anonymity. While demographic and other identifying details are altered to preserve confidentiality, all subjects are Euro-White.

Measures

All subjects were initially seen in an individual assessment interview. Demographic information (e.g., patient educational level, race/ethnicity) was recorded and a DSM-IV diagnosis and General Adaptive Functioning (GAF) score were assigned. In addition, as part of the patient assessment, subjects completed the MMPI (the 566 version in Cases 1 and 3 and or version 399 with Case 2). The computed Pr scale scores are reported below for the cases, along with the main clinical and validity scales. In a nonclinical sample, the Pr scale has been found to yield a mean *T* score of 54 (Dunbar, 1995). With a recent clinical sample the mean *T* score was 58 (Dunbar, 1996a).

Method of Analysis

As pointed out by Kazdin and Kagan (1994), "The intensive study of the individual permits a level of analysis that may be as useful to our understanding as the study of groups of individuals" (p. 46). In this article, subject case descriptions follow, where possible, the recommendations for psychotherapy research as outlined by Kazdin (1992). Empirical psychometric data, ideographic (e.g., patient-specific) material, and pre- and posttreatment case reviews have been integrated, across multiple cases. Cases were selected to illustrate the variations in the strength and manifestation of race/ethnic prejudice, to provide for comparison of the experiences of situationally based bias with more long-standing bias, and, most importantly, to suggest testable theoretical and research questions about prejudice.

Clinical diagnosis, rating of degree of impairment (GAF ratings), MMPI F and K scores, and MMPI Pr scale

Table 1. Summary of clinical material and diagnostic information concerning outgroup prejudice

	Clinician Material		DSM-IV Data		MMPI Data			
Case no.	Outgroup Target of Prejudice	Manifestations	Diagnosis	GAF[a] Score	Pr Scale *T* Score	F Scale *T* Score	K Scale *T* Score	Code Type[b]
1	Hispanic men	Anxiety	PTSD-acute	70	39	62	61	5"48'
2	Minority groups, especially African Americans	Avoidance Anxiety	PTSD-acute	51	59	80	42	96' '724'
		Casual use of ethnic slurs	Borderline traits					
3	African Americans, Asian Pacifics	Panic attacks, social avoidance, and occupational dystunction	a. Bipolar disorder	40	73	80	40	87*241' '[c]
			b. Narcissistic personality disorder		68	76	46	827*93' '41'[d]

[a]GAF scores at the initiation of treatment.
[b]Welsh code format employed for MMPI clinical scales.
[c]Initial MMPI scores.
[d]Subsequent (3 year) MMPI scores.

scores will be presented. The case information presented includes (a) presenting problem and DSM-IV diagnoses at treatment initiation, (b) outgroup attitudes as they emerged in therapy, (c) reported family of origin racial/ethnic attitudes, (d) MMPI data, (e) behavioral manifestation (if any) and degree of impairment related to the beliefs, and (f) course of psychotherapy treatment. This is summarized in Table 1.

Case Summaries

Case 1: Classically Conditioned Fear. This 28-year-old Caucasian woman was "carjacked" while she was getting into her car after leaving a convenience store, in broad daylight, in front of other store customers. Two young Hispanic men entered her car; one pointed a gun at her abdomen, ordered her to drive, and directed her to a deserted area of the county. She was told to open the trunk; she released the trunk latch from inside the car. As the two men hopped out of the car to examine the contents of the trunk, she put the car in gear and sped away. She heard gunshots but she was not hit. She called the police, and sought treatment a few weeks later due to intrusive memories, nightmares, and physiological reactivity to and avoidance of cues representing the event. The initial DSM-IV diagnosis was posttraumatic stress reaction–acute, and her initial GAF rating was 70. Her premorbid functioning was quite good, and even after experiencing the crime described, she still managed to function at work and in her personal relationships. Her pretrauma GAF was estimated at 85.

Early in the course of treatment the patient voluntarily disclosed that one of her symptoms was a newly developed fearful reaction to men she didn't know who were of the same age and ethnic group as the gunmen. Symptomatology included increased heart rate, cold sweat, physical tension, and fear. She denied the presence of these symptoms prior to the carjacking. In fact, this patient was extremely uncomfortable with, ashamed of, and embarrassed about these phobic reactions. She was bilingual in English and Spanish and prior to the crime had a high degree of comfort in multicultural settings. She completed the full MMPI. MMPI test data revealed a raw PR score of 6 (*T* score = 39). Her code type was 5"48', with *T* scores for F and K of 62 and 61, respectively.

Despite her phobic reactions, the patient attempted (successfully) to suppress overt behavioral manifestation of her fear. Treatment was brief (less than 3 months) and focused on amelioration of the posttraumatic stress disorder (PTSD) symptoms. As the trauma-related symptoms resolved, so did the anxiety and fear reaction to men of the same ethnicity as the gunmen. At the end of treatment, her GAF score returned to her premorbid score of 85.

Case 2: Prejudice Response Exacerbated by Traumatic Crime. This male patient entered therapy after witnessing a shooting that occurred within a few feet of where he stood. The female victim died on the scene; he was spattered with her blood. The perpetrator was an African American male. The initial PTSD symptoms resolved with treatment, but he stayed in therapy to address a variety of longer term interpersonal and occupational problems, including some sexual identity concerns. He had had few intimate relationships with women, and had never had a satisfactory romantic or sexual experience with a woman. His initial diagnosis included PTSD-acute, as well as borderline personality traits. Traits included impulsivity, affective instability, panic at perceived abandonment, and (quoting from the DSM-IV) "transient, stress related paranoid ideation or severe dissociative symptoms" (American Psychiatric Association, 1994, p. 424). His initial GAF score at the start of treatment was 51; with amelioration of the PTSD symptoms his GAF rose to 60.

Prior to the crime this patient had significant prejudicial beliefs about and reactions to (most predominantly) African Americans and Hispanics; however, prejudicial beliefs applied as well to Jews and Asians. These beliefs were shared by his family of origin; the family was also vehemently negative about homosexuals. After the crime, his hostility and prejudice against African Americans and Hispanics were heightened. Other reactions included panicky feelings and a desire to escape (sometimes acted upon) from any situation in which there was physical proximity to African American or Latino men. He expressed strongly held beliefs concerning the role of minorities and immigrants in violent crime, fantasies of serious danger if driving alongside a car with a member or members of the feared minority groups, various racist and anti-Semitic remarks, and so on. These beliefs predated the crime incident, and were supported and shared by his family; he expressed these beliefs and feelings without apology. The panicky responses seemed to have developed as a result of the crime. The outgroup attitudes described above were expressed early in treatment. His Pr *T* score was 59. His MMPI code type was 96″724′, with *T* scores of F = 80, and K = 42.

Initial treatment sessions focused on coping with the stress and anxiety associated with witnessing the shooting, and with managing the anxiety aroused by the presence of outgroup members. A variety of cognitive-behavioral techniques including systematic desensitization, cognition restructuring, and relaxation training curbed the physiological reactivity and escape behavior, but did not significantly change the belief system that predated the crime.

In the course of treatment a new theme emerged. He had concerns and confusion about his sexual orientation and was terrified that his family would discover his homosexual orientation, particularly as it violates his own family of origin's religious faith. In the course of treatment, he gained comfort with his sexual orientation and was able to enter a stable relationship with another man. Concurrently, the expression of racist beliefs and feelings lessened. At the end of treatment, he was able to rationally confront his own prejudicial beliefs and to discount them. However, under periods of stress, the racially charged, paranoid feelings and beliefs returned, as did impulsive attempts to escape the situation. His GAF at the end of treatment was 65. Treatment duration occurred over a period of 5 years.

Case 3: Chronic Prejudicial Ideation, Behavioral Manifestation, and Severe Psychopathology. This college-aged male was referred by his internist for evaluation and consultation concerning difficulty with concentration, memory, and dissociation. Cognitive testing revealed a thoroughly normal neuropsychological profile. MMPI results yielded a significantly elevated 8–7 profile (87*241″; F scale *T* score = 80, K scale *T* score = 40). The computed Pr scale (*T* score) was 73. Initial GAF was 40, with impairment of reality testing and impairment of completion of daily tasks. Within the first 2 months of treatment, serious mood and sleep fluctuations resulted in a provisional diagnosis of bipolar disorder. Based on psychiatric consultation the patient was started on lithium; he has maintained good adherence to the medication and his mood has stabilized. However, during the past 6 years he has experienced two brief but debilitating episodes of disturbance of reality testing. This patient had an erratic employment history, due to the patient's reactions to African Americans encountered in his workplace. He reported severe anxiety, problems with concentration, and minimally controlled hostility while in the presence of African Americans. These reactions were so overt that it caused dismissal from two jobs because of his panic and agitation in having to interact with African American customers. His hostile ideation concerning African

Americans, whom he readily acknowledged disliking, was ego syntonic to him; however, he found the symptoms of panic, fear, and hostility to be highly undesirable.

Treatment shifted in emphasis from a supportive and cognitive approach to a more structured behavioral regimen, emphasizing imaginal and in vivo systematic desensitization, with an emphasis on symptom management in the presence of African Americans, both in pleasant environments (e.g., nature settings) and in the workplace. The patient (who was interested in business) was given materials to read concerning marketing to ethnic communities, and restructuring interventions focused on the reality that it "made sense" to master his panic response to persons of color. This treatment strategy proceeded over a 9-month period, with subsequent tapering off of psychotherapy sessions to twice a month. The patient reported a significantly reduced level of arousal in the presence of Black coworkers and customers and was able to work effectively. However, his feelings of dislike and his private denigration of African Americans were unabated.

After nearly 2 years the patient terminated psychotherapy treatment, remaining under medical supervision for pharmacotherapy. After a period of nearly 3 years, he reinitiated treatment, due to a recurrence of the original mania symptoms. These were diagnosed as a rapid-cycling bipolar disorder, with psychotic features. The patient resumed regular weekly psychotherapy, to address stressors at both home and work, which may have contributed to the relapse. At this time he was retested on the MMPI, with a clinically elevated (8–2–7) profile found (827*93"41'; F = 76, K = 46, Pr = 68). An additional diagnosis of narcissistic personality disorder was assigned. The patient's racial attitudes had evolved. He continued to express a dislike toward African Americans, yet acknowledged that one of his better friends was African American, and his panic and anxiety in exposure situations had not reoccurred. He expressed disapproval of family fears of persons of color. He now doubted the credibility of concerns about African Americans. However, he now expressed an aversion to Asian Pacifics, particularly men, with the old patterns of fear and panic recurring. This interfered with medical treatment; for example, he once left a physician's waiting room because there were employees of Asian descent working at the desk. He would not allow an Asian American male to move in as a roommate, because he "didn't like them on the street," or in his home.

While this patient demonstrated significant improvement in terms of reduction of severe anxiety and panic in the presence of African Americans, his general social attitudes toward persons of color remained largely intractable. Furthermore, expressed prejudice toward other ethnic/race groups had migrated to a second distinct social group (persons of Asian descent). In his behavioral response to both of these groups the patient evidenced an impairment to his overall level of functioning, which at varying times compromised his economic security, job performance, and domestic circumstances. Finally, the 3-year interval between MMPI administrations revealed a very stable Pr scale score and consistent relationship between the (elevated) F and (relatively lower) K scale scores.

Discussion

The case material illustrates a range of severity of clinical manifestations of prejudice and illustrates proposed assessment methods appropriate for clinical practice. It is hoped that this case material will provide ground for future systematic clinical research in the diagnosis and treatment of prejudice as a focus in psychotherapy.

In Case 1, prejudicial ideation served as one of the prominent symptoms of acute PTSD. Adverse response was reportedly limited to members of the perpetrator's ethnic group. This acute outgroup response was apparently developed through classical conditioning (Mowrer, 1960), and was experienced by the patient as uncomfortable and "ego dystonic." There were no overt behavioral manifestations of prejudice. Prejudicial ideation did not predate the traumatic event, and remitted with treatment of the PTSD. Her Pr score was quite low (*T* score = 39), and F and K scores were inconsistent with the high-F/low-K pattern noted by Gough's earlier research. Her GAF scores at the beginning and ending of treatment were relatively high. Case 2 is superficially similar to Case 1 insofar as prejudicial ideation initially presented in treatment as part of a PTSD symptom picture. However, for Case 2 the prejudicial beliefs existed prior to the traumatic event, extended to several outgroups, and were not experienced as ego dystonic. The Pr score was relatively high (*T* score = 59), and the GAF score was moderately low (51). Additionally, the impulse-disordered profile suggested by the high F (*T* score > 70) and low K (*T*

score < 50) was noted. Even after treatment, prejudicial beliefs remained.

A somewhat different clinical situation is reflected in Case 3. In this instance, significant psychopathology included the manifestation of hostile and aggressive behaviors toward outgroup persons; global level of functioning was low (GAF = 40). Pr scores were high at both MMPI administrations, 3 years apart (73 and 68), as were the elevated F and lowered K score patterns. For Case 3, fluctuations of mood and personality disturbance were related to the patient's behavioral and affective impairment in the presence of African Americans, initially, and subsequently in the presence of persons of Asian heritage.

There are undoubtably patient-specific characteristics of the cases presented here that have shaped our findings. The interested practitioner and clinical researcher should consider, for example, that these patients all voluntarily sought psychological services. It is therefore difficult to know what diagnostic impressions and treatment courses will be characteristic of those individuals who are mandated for treatment, as is increasingly being required with convicted hate crime perpetrators. The absence of an a priori treatment model also limits the ability to replicate the efficacy of our interventions. In the absence of a method of treatment thoroughly grounded in clinical research, the practitioner's response to outgroup hostility is likely to remain in context of other related clinical problems (e.g., trauma symptoms, anger management). Additionally, the societal context of these cases should not be overlooked. The community in which these individuals lived (Los Angeles) has been impacted by the 1992 riots as well as concerns about immigration (as reflected in 1994's Proposition 187) and continued growth and presence of persons of color throughout Los Angeles County. Other community settings may not as such engender the same concerns for persons seeking psychological services.

Implications for Clinical Research

The intent of this article is to propose a framework to understand outgroup prejudice in terms of clinical practice. Given the paucity of recent clinical research on this topic, case illustrations have been used to illustrate possible assessment strategies. Inherently there are limitations in this approach. Case studies are nonexperimental investigations of individuals using clinical impressions and archival material (e.g., clinician observations, psychometric test data, and the DSM categorical ratings). In contrast to single-case research designs (Kazdin, 1992), case studies do not utilize an experimental design (such as an ABAB design), are not typically replicable, and are subject to the biases inherent in patient self-report and clinician observation, record keeping, and memory. Nevertheless, we believe there is a role for case studies, particularly regarding seldom-explored topics. In Meehl's (1954) words,

> *It is the tremendous interest in the individual case that defines the clinician. . . . An improbable factor of a given type may occur with extreme rarity, but improbable factors as a class, each of which considered singly will not appear in a statistical analysis as significant, may contribute heavily to the misses [e.g., instances in which statistical prediction miss the mark]. (p. 25)*

There is essentially no available information on the frequency with which prejudice and outgroup hostility are significant focuses of clinical treatment. Research needs to determine whether outgroup prejudice is more likely to be encountered in multiethnic communities and social settings characterized by significant demographic change. Furthermore, the frequency of intergroup contact is an important factor to be considered in clinical research of prejudice. As illustrated by these cases, the behavioral manifestation of the prejudicial belief system was due to adverse intergroup/interpersonal experiences.

We anticipate that this clinical problem will most likely be further explored via more rigorous and systematic case study methods than provided in the present instances. It is unlikely that many researchers would be able to access a satisfactory number of participants to allow for an empirically driven analysis of this issue. This is all the more likely given the absence of an agreed upon methodology concerning the clinical study of prejudice. The establishment of a recognized model of clinical assessment is therefore needed, to guide future research. The proposed subtypes of outgroup prejudice, as suggested here, provide a first step toward formulating assessment and treatment strategies. It is hoped that this model may serve to guide both psychometric assessment and clinician-based diagnosis. We cannot emphasize too strongly the need to consider this serious social and clinical issue in terms of the contemporary diagnostic nomenclature. Clinical research must resume the study of

prejudice and outgroup hatred via a theory- and method-driven approach.

These case histories raise a number of implications for research concerning psychological assessment. These include whether psychometric measures (such as the MMPI) may yield a distinctive profile or pattern of symptom complaints that are related to outgroup bias or social group phobias. Additionally, our cases raise the question as to whether the Pr scale reflects a unique aspect of social cognition, one that predisposes psychotherapy patients to ascribe to intractable prejudicial belief. It has been suggested that high scores on the Pr scale (e.g., *T* scores > 65) reflect a rigid cognitive style. In terms of prognosis, we wonder whether patients scoring high on this measure are indeed particularly invulnerable to reduction in symptoms or beliefs related to race/ethnic prejudice, particularly when combined with the F-K pattern reflecting disinhibition and impulsivity. Put another way, is the Pr scale of predictive value concerning treatment outcome for outgroup bias? Finally, does the Pr scale reflect the degree to which outgroup prejudice may be an unquestioned component of the patient's world view?

PREJUDICE: COMORBID, SYNDROME, OR DIAGNOSTIC FELLOW TRAVELER?

As has been suggested in the case histories, clinical and psychometric assessment may help to inform our thinking about prejudice as a factor in psychotherapy treatment. At the same time, even with further clinical research on the topic, there is reason for extreme caution regarding how to best incorporate such an assessment process into the present diagnostic system. In context of current clinical debate, it seems fair to question whether prejudice should be considered a comorbid disorder, a syndrome, or if neither, then what sort of a diagnostic fellow traveler it might be.

While prejudice may share many symptoms with other Axis 2 disorders, it is incorrect to think of it in terms of comorbidity (defined as "the co-occurrence of two supposedly separate conditions at above chance levels" [Rutter, 1994, p. 100], and a "descriptive term that concerns the co-occurrence of two diagnostic entities" [Feinstein, 1970, as cited by Rutter, 1994]). Current thinking about the appropriateness of the concept "comorbidity" for psychopathology reflects a lack of consensus. Lilienfeld, Waldman, and Israel (1994), for example, question the applicability of the notion of comorbidity to various diagnostic conditions such as the personality disorders, particularly if the discrete Axis 2 diagnoses are not true, independent disorders. If in fact an individual with multiple Axis 2 diagnoses is more accurately described as experiencing "a single condition that is manifested in multiple domains that cut across several DSM-III-R [sic] personality disorder categories" (p. 78), can we consider chronic prejudice, which we propose does frequently imply personality disturbance, to be comorbid? As recent discussion in this publication has made clear (see Blashfield, McElroy, Pfohl, & Blum, 1994; Lilienfeld et al., 1994; Robins, 1994; Rutter, 1994; Spitzer, 1994; Widiger and Ford-Black, 1994), there are significantly different opinions found among scholars in the field of psychopathology research.

In considering the conceptualization of chronic prejudice as a clinical condition, we tend to agree with Rutter (1994) that further attention to whether a clinical problem (such as chronic prejudice) is comorbid when it co-occurs with a recognized diagnostic category is warranted. However, we also agree with Lilienfield et al. (1994) that there is certainly no available evidence that a clinical problem such as prejudice is a condition independent from other recognized psychological disorders. Equally, our case illustrations support the notion that chronic prejudice is not related to a specific diagnostic category, although it seems to most frequently co-occur with Axis 2 disorders.

We do not propose that all bias is the product of personality type or psychopathology. To assume that all instances of outgroup bias meet some still-to-be-established criteria for a diagnostic category or co-occurring condition is on its face simple minded. There is certainly evidence that outgroup bias is a frequently held belief in the general population (Hoffman, 1993). In addition, the wealth of experimental social psychological research has supported the notion that outgroup stereotyping and bias are frequent by-products of ingroup identity (Tajfel & Forgas, 1981; Tajfel & Turner, 1979). Finally, there is evidence that outgroup stereotyping may be a normative cognitive process and is not per se reflective of a disorder (Mackie & Hamilton, 1993). What we hope to make clear from the clinical case material, however, is that outgroup bias and prejudice may co-occur with other psychological disorders in such a manner as to be both clinically significant and disabling to the patient. To suggest less would err in the direction of treating all

adverse responses to race and ethnicity as being normative when in fact they are not. As a final consideration in this regard, psychopathology research clearly needs to determine the base rates of significant and disabling outgroup prejudice with patients receiving psychological services. Implicit to this argument is also the very real need to reestablish investigation of race and ethnic bias as an area of concern to clinical researchers. This means that the problem of prejudice needs to be reconsidered in terms of our contemporary diagnostic system, rather than in terms of psychodynamic principles that are not derived from community or epidemiological studies.

As observed in Cases 2 and 3, the clinical features associated with chronic prejudice are characterized by a rigid belief system concerning a designated social outgroup; this is accompanied by an intense and ineffectual affective response to contact with outgroup persons, difficulties with impulse management in this arena, and, consequently, interpersonal difficulties that may lead to significant impairment in undertaking daily life tasks. We have attempted to illustrate chronic, rigid prejudice, and to contrast it with transient, situationally mediated prejudicial reactions. The relevant clinical features are summarized in Table 2.

The clinical features of chronic prejudice presented are largely consistent with the general criteria used to diagnose a personality disorder as described in the DSM-IV, in which an enduring pattern of inner experience and behavior results in clinical symptomatology and functional impairment. However, we do not imply that prejudice is a distinct clinical disorder. Rather, clinical features of prejudice seem to be characteristic of Kazdin's (1983) description of a syndrome, that is, a constellation of distinct signs and symptoms that covary across individuals, of unknown etiology. Perhaps prejudice is best thought of as an indicator of the "extensive" or "diverse" personality disorder described by Oldham et al. (1992) and O'Boyle & Holzer (1992).

Table 2. Proposed dimensions related to outgroup prejudice

1. Common characteristics of prejudicial ideation
   - Patient's identification with distinct social ingroup
   - Adverse affective, ideational, and/or behavioral response to members of defined social outgroups
2. Characteristics of transitory prejudicial ideation
   - Adverse intergroup contact experience or traumatic event associated with outgroup members
   - Absence of chronic personality disturbance or disorder
   - Severity of psychopathology evidences mild to moderate disturbance (e.g., as represented by GAF ratings)
   - Adverse behavioral response to intergroup contact compromises functioning in few or no basic life domains or tasks
   - Adverse cognitive ideation or affective arousal is localized to a distinct social outgroup
3. Characteristics of chronic prejudicial ideation
   - Presence of significant personality disturbance or disorder
   - Impulsivity or disinhibition regarding self-presentation and interpersonal relationships
   - Psychopathology evidences moderate to severe disturbance (e.g., as represented by GAF ratings)
   - Generalized adverse response associated with outgroup members in the absence of traumatic event
   - Prominent behavioral features of aggressiveness, hostility, and/or panic are noted secondary to intergroup contact
   - Manifested behavioral response to intergroup contact compromises functioning in a variety of life domains/tasks
   - Adverse cognitive ideation or affective arousal may be generalized to more than one distinct social outgroup

Proposed Subtypes of Prejudice as a Clinical Phenomena

Based on prior research and the authors' clinical experiences, five clinical subtypes of prejudice are proposed. These are (a) critical incident prejudice response, (b) avoidant outgroup disorder, (c) antisocial prejudice disorder, (d) narcissistic/labile prejudice disorder, and (e) paranoid/delusional prejudice disorder. A brief summary of each hypothesized subtype is presented below and considered in terms of future research concerning treatment.

Critical Incident Prejudice Response. This subtype is characteristic of the formation of classically conditioned adverse outgroup beliefs and affects secondary to trauma (e.g., assault). The unique role of aversive association and intrusion concerning outgroup persons following the traumatic event is the primary signifier of the condition.

We propose that in comparison to the other subtypes, this form of outgroup prejudice holds the greatest potential to benefit from psychotherapy. This is because the prejudicial response is stimulus specific and frequently is of short duration. In instances of social or environmental stressors, the prejudicial ideation may remit with cessation of the critical event or via brief psychotherapy intervention. In instances of trauma-induced prejudicial response, however—as reflected in Case 1—treatment of arousal and intrusions will require the employment of cognitive-behavioral techniques found to work with crime and critical incident victims.

Avoidant Outgroup Disorder. This subtype is characterized by personality traits of introversion and avoidance. Alienation, anomie, and estrangement are typical (Ehrlich, 1973). Patients characterized by this subtype may be less likely (as with the paranoid subtype) to voluntarily discuss outgroup prejudicial beliefs. As a consequence, attention to this clinical problem is likely to be minimal

in psychotherapy treatment. It is not unlikely, however, to encounter outgroup denigration with this subtype, which is independent of actual intergroup contact experiences. Likewise, the rigidity of the belief system in terms of outgroup intolerance is notable.

The functional impairment related to this subtype is hypothesized to be the same as that found in other instances of avoidant personality disorder and social phobia. By the nature of the personality traits associated with this subtype, behavioral manifestation of outgroup prejudice is more likely to be evidenced in terms of withdrawal and disengagement, rather than aggression or confrontation. It is proposed that treatment would typically concern alleviation of the patient's social estrangement and isolation, rather than to address specific outgroup relations. Proposed treatment models that address clinical problems of anxiety and social phobia are likely efficacious with this subtype.

Narcissistic/Labile Prejudice Disorder. This proposed subtype reflects the DSM-IV Cluster B personality disorders in which there is no demonstrable sociopathy. This subtype of clinical prejudice is marked by affective lability and hostility, as suggested by Bell (1980). The role of traits of personality disturbance (e.g., narcissism) should also be considered in determining the subjective impact of intergroup conflict. As Dunbar (1996b) has noted, nonclinical participants with higher Pr scale scores evidenced greater trauma symptoms of stimulus avoidance and intrusion, as well as greater affective arousal, following adverse intergroup contact experiences. While this may not be an intractable condition (as suggested by Case 3), it is hypothesized that long-term adjustment and intergroup relationships will likely remain problematic.

Paranoid/Delusional Prejudice Disorder. This subtype of outgroup prejudice is characterized by fear reactions, rigid beliefs of the potential for harm from outgroup persons, and utilization of projection as a defense against intergroup contact experiences. The self-perception is one of having been wronged by members of a given (or multiple) social outgroup. Suspiciousness and cognitive inflexibility are prominent clinical features. In more extreme instances, outgroup ideation may manifest as a fully wrought delusional system. These features may or may not serve to meet the criteria for paranoid personality disorder. Of interest is the relationship that has been drawn in criminal law between the delusional disorders and aggressive racist behavior. Referred to as racial paranoia-induced delusional disorder, this nonclinical formulation has been proposed as a defense with hate crime perpetrators tried on charges of assault and attempted murder (Third World Law Journal, 1991).

It is proposed that the treatment of paranoid outgroup ideation will prove to be prognostically poor. Interventions that fail to address the patient's underlying guardedness and inflexibility are unlikely to prove effective. As has been suggested elsewhere, a primary therapeutic goal with guarded and suspicious patients is the development of a level of trust and openness to facilitate modification of the basic belief system (Beck & Freeman, 1990). This is not likely to be accomplished by psychotherapy that initially focuses on issues of outgroup prejudice. As with other forms of paranoid and delusional disorders, the patient's voluntary discussion of outgroup prejudice is not easily accomplished and in this sense poses a therapeutic challenge similar to that of the avoidant prejudice subtype discussed previously.

Antisocial Prejudice Disorder. This proposed subtype includes the variants of antisocial personality as suggested by Lykken (1995) and is closely aligned with Hare's (1991) definition of sociopathy, as exemplified by his second factor-derived dimension from the Psychopathy Checklist, which reflects low frustration tolerance, impulsivity, and conduct disturbance. We feel that it is important to distinguish between the impulsive antisocial individual, who is apt to demonstrate a variety of criminal and aggressive behaviors, and the ideologically motivated person, who demonstrates a particular preoccupation with opposition to outgroups such as ethnic minorities and gay/lesbian persons. Accordingly, we have defined two categories that are most characteristic of this subtype. In the first of these, outgroup prejudice is secondary to an undersocialized and antisocial personality type. In the second category outgroup prejudice is based on an ideologically driven antisocial world view.

The first category is characterized by outgroup hostility that is manifested by an impulsive and thrill-seeking personality disorder. These individuals are frequently hate crime perpetrators, as defined by various municipal civil codes. These individuals evidence a low recurrence of criminal activity toward outgroup persons (Levin & McDevitt, 1993). The psychopathology is principally antisocial and is only secondarily characterized by hostility toward specific social outgroups. The second category

includes individuals who evidence strongly held beliefs that place them at odds with mainstream cultural conventions and practices. Such groups include members of fascist and violent antigovernment groups. This includes persons who meet the criteria of ideologically based criminal assault, as found in the FBI crime classification system (Douglas, Burgess, Burgess, & Ressler, 1992). This subtype also includes persons characterized by hyper-authoritarianism, that is, persons who fail to conform to community standards of the democratic and egalitarian social compact, as originally described by Adorno and his colleagues in 1950.

We hypothesize that efficacy of treatment with this subtype is poor. This is due to the role of characterological disturbance in this form of outgroup hostility. Policy experts in the area of remediation and rehabilitation of hate crime perpetrators have noted the failure of psychoeducational and group interventions with this population (Persily, 1996). In many instances psychological treatment of choice is comparable to that found in other antisocial and criminal offender models (Bourdain, 1994).

These clinical subtypes can be of assistance to the practitioner in considering co-occurring diagnostic features as well as treatment approaches. Likewise, these subtypes imply distinctly different clinical profiles, with respect to psychometric assessment. It is anticipated that, if these subtypes prove of clinical utility, clinical researchers may be able to identify differences in symptom cluster and/or scale elevations on psychometric measures such as the MMPI, Millon scales, and the California Personality Inventory.

Implications for Clinical Practice

As suggested by Case 1, there is some evidence that a conditioned learning model may explain the development of prejudiced ideation or behavioral response for some psychotherapy patients. If conditioned learning is explanatory for some patients who evidence outgroup bias, particularly secondary to a traumatic event, then it could be expected that cognitive and behavioral conditioning techniques might be a treatment of choice. One example of the employment of a cognitive-behavioral response to negative outgroup response is provided in two studies of systematic desensitization in the treatment of anxiety related to racism toward African Americans (Cotharin, 1978; Cotharin & Milkulas, 1975). Cotharin attempted to determine the effectiveness of systematic desensitization to reduce the negative emotional arousal accompanying racial prejudice in Whites toward African Americans. Therapeutic gain is reported this study. However, in Cases 2 and 3 remission of negative affects, arousal, and behavior was not accompanied by reduction of negative outgroup beliefs and attitudes. Furthermore, in one patient (Case 3), reduction in overt hostility toward one racial outgroup migrated over time to a second ethnic/racial group. It therefore remains to be determined as to whether some individuals are more likely than others to generalize conditioned negative responses from one racial/ethnic outgroup to other racial/ethnic outgroups. Conversely, if outgroup prejudice is clinically prominent in the absence of a specific traumatic event, or if there is evidence of the prejudiced belief system being long-standing, plausible treatment options might include uncovering/insight-type treatment modalities as well as interpersonal process approaches. In either case, however, we feel that the treating practitioner will need to integrate themes concerning interracial/ethnic contact (Tzeng & Jackson, 1994) and patient racial identity (Carter, 1995) if there is to be significant therapeutic gain in this regard.

It should also be considered that while others have argued for the efficacy of a group therapy model for prejudice reduction (Penterotto & Pedersen, 1993), the availability of such a treatment option is quite limited in terms of referral for patients who are seen in outpatient settings. Furthermore, the very real question of achieving patient compliance to participate in such a treatment modality (e.g., treatment specifically addressing prejudice reduction) must be questioned. None of the patients described here initiated treatment because of his/her feelings about racially and ethnically different persons. Rather, treatment was initially sought to ameliorate adverse symptomatology *as experienced by the patient.* It is therefore important to consider that the readiness of the patient to freely participate in targeted prejudice-reduction treatment should be seriously questioned, particularly for persons who may *most* be in need of psychological services. Therefore, it appears that the focus of treatment related to prejudice will in most cases remain with the treating psychologist with whom the patient has initially initiated psychotherapy. We believe that there are several opportunities, in context of the therapeutic relationship, to create a corrective therapeutic response to the patient's negative outgroup belief system. Issues that may be addressed

include the clarification of how the adherence to prejudicial beliefs is self-defeating or "costs" the patient. For example, focusing on how a panic response to contact with African Americans may compromise job security or how negative beliefs about culturally different persons may create conflict with coworkers may help to clarify the need for the patient to develop effective behavioral responses to interrace and ethnic group contact, which is consequent to leading a more adaptive lifestyle.

We would like to point out the critical role that race and ethnicity played in the therapeutic dyads discussed in the present study. As Comas-Diaz and Jacobsen (1991) have suggested, same race/ethnic therapy dyads may facilitate mirroring of greater patient self-esteem and self-regard. We feel that this is particularly true in terms of White therapists demonstrating comfort in exploring and clarifying the impact of interracial/ethnic contact for their White patients. Equally, of course, the failure of the White treating psychologists to address their patients' adverse racial/ethnic beliefs may help to reinforce a prejudiced and culturally avoidant world view. In the present study the three White patients were working with a same-race practitioner. As Helms (1990) has made clear, the impact of the practitioners race *and* racial identity is a critical factor for psychotherapy outcome. Our impression is that these three patients not only would have avoided issues of outgroup prejudice with a therapist of a different race/ethnic background but would not have remained in treatment.

These patients sought psychological services to address problems they experienced as aversive and that compromised their life functioning. As treatment progressed, it became apparent that issues concerning outgroup prejudice were a clinically salient aspect of the symptomatology. In terms of the therapeutic alliance, these individuals were not initially seen as persons who endorsed social beliefs that were undesirable, if not repugnant. Rather, through treatment the patients' fears and hostilities toward outgroup persons were encountered as part of the clinical problem.

We have sought to illustrate how these cases reflect meaningful clinical information that is related to outgroup prejudice. However, the presenting clinical problems of these patients are not adequately explained in terms of outgroup prejudice solely. Equally, the issues raised are most salient to psychological service delivery in multicultural settings and may be of less immediate relevance to persons in more homogeneous settings. It is unclear whether these aversive outgroup beliefs would have been clinically manifested in a social milieu that would yield infrequent interethnic/race contact experiences. At the same time, the clinical appraisal and treatment of prejudice are likely to be of increasing importance nationally, given the continuing racial/ethnic diversification found throughout the United States.

As we have noted, prejudice, as suggested by Duckitt (1992), may be understood in terms of individual differences that may pose significant barriers to the successful treatment of persons receiving psychological services. One of the most critical points raised in these case histories concerns the need for practicing psychologists to be competent to therapeutically respond to persons who experience disabling prejudicial outgroup beliefs. An informed and effective therapeutic response is required with persons such as those presented in this article, if practitioners are to be in the service of their patients.

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