Power Issues in Psychotherapy:

Reflections on psychoanalytic theory and clinical cases

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With love and gratitude to

Erica Fors
Nancy McWilliams
Hanne Haavind

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Preface

My investigation of power issues in psychotherapy grew organically out of my long-time interest for trying to understand power issues generally and out of my concerns to speak up on issues of diversity, social justice, and human rights. It intertwines with my experience as a clinical psychologist, supervisor, and teacher and also with my personal experiences. My overarching aim is to explore and integrate diverse theoretical, clinical, and empirical literatures in order to achieve a theoretical integration with practical applicability to power issues in psychotherapy. The work is in the tradition of hypothesis-generation and draws on literature studies and case studies as well as empirical scholarship. The process of reflecting upon these topics started a long time ago, through conversations with students, patients and colleagues, and also through my lived experience in an Arctic rural community. I felt that existing contributions on power issues in psychotherapy were limited and were not answering the range of questions involving power that arise in clinical work.

In addressing clinical applications in areas as diverse as medical record-keeping, urban biases in the mental health field, minority issues in diagnosis, bureaucratic challenges, and the dynamics of social privilege between therapist and patient, I have sought not only to make theory about power, as it influences psychotherapy, but also to make a power analysis more accessible to clinicians.

The inspiration for the first paper came from my clinical work. The idea of writing about collaborative reading of medical records with patients came out of a practice that I found was not described in the clinical literature. I took the initiative to make a contribution to the topic. Prof. Nancy McWilliams, who was consulting on my clinical work at the time, became interested in the question, and we decided to write about it together.

The second paper in this thesis developed from my practice. Finding myself

working in a colonized area (the rural Arctic), where I have noted symptoms of colonization in my patients and found very little written on psychological effects of urban colonizing behavior towards rural people, I began to try to formulate a language addressing the "countermapping" (Wood, 2010) of urban assumptions and biases in the field of psychotherapy and psychoanalysis.

The third text developed in response to a conference invitation. When the second edition of the *Psychodynamic Diagnostic Manual* (Lingiardi & McWilliams, 2017) was released at a conference in New York in June, 2017, I was asked to be a discussant on a panel addressing the new section in the manual on non-pathological issues that may require clinical attention (this section addressed minority stress). In the aftermath, my comments were developed into a paper co-written with Jack Drescher, which we were invited to publish in a special issue of *Psychoanalytic Psychology* dedicated to the PDM-2.

The fourth paper suggests that different sources of power affecting psychotherapy (which I construed as including professional power, transferential power, socio-political power, and bureaucratic power) operate simultaneously and synergistically. It addresses various interacting perspectives on power that apply to clinical challenges. I investigated several power themes through the detailed discussion of a case. I was invited by a patient´s general practitioner to discuss her case at an interdisciplinary meeting on obesity. The goal was to discuss one patient from three perspectives: those respectively of the doctor, the obesity expert, and the therapist. After the conference, I became interested in writing about the confluence of perspectives on power themes and dynamics that emerged in discussions of the case. Interestingly, all three presenters, including me, were feeling quite powerless to help the patient, and were projecting the power to do so elsewhere.

While working on this project, I received an invitation from *Contemporary Psychoanalysis* to contribute to a special issue on intersectional psychoanalyses of race,

social class, gender, and sexuality. I decided that this paper might fit that purpose. In all my writing, bridging theory development and applied psychological services has been a main goal.

The fifth text emerged from my teaching: For more than thirteen years I have been a guest lecturer at Gothenburg University in Sweden, teaching students in clinical psychology about how issues of power, privilege, and gender create biases in the assessment and treatment of psychopathology. I usually give them an exercise and ask about their personal social positions (gender, skin color, religion, sexuality, able-bodiedness, etc.). Then I ask them what kind of (imagined) patient would be hardest for them to meet, and why. What might be difficult and what could they do about it? What norms did they assume and what kinds of blindness might leak into their work? Whom were they afraid not to understand? From whom did they fear devaluation? Pondering these questions over many years, I felt I had to try to answer them myself. Originally, I articulated some ideas in a long paper, which I submitted to a major psychoanalytic journal but which was rejected on grounds of length. I then re-wrote them as a proposal for a full-length book, which earned a prize and a commitment to publication from APA Books and the APA Division of Psychoanalysis (39) (Fors, 2018a). For the purpose of this dissertation, I have reworked the theoretical contributions from this work into a condensed format.

Three of the texts have been published in *Psychoanalytic Psychology*. All have passed strict peer review. The fourth text was invited for publication in a special issue of *Contemporary Psychoanalysis*, dedicated to intersections of race, gender, and sexuality in psychoanalysis and psychotherapy and will be fully peer-reviewed before publication in 2021[1]. The Norwegian Centre for Research Data confers points for publication in these

[1] The paper is now accepted and in press.

journals. The fifth text (Fors, 2020b) is the theoretical foundation for my previously published book (Fors, 2018a), extracted and developed for the purpose of this thesis. The reworked extract focuses on the central theoretical contributions of the book while omitting some of the pedagogical interventions and personal reflections more suitable for the textbook envisioned by the American Psychological Association.

Research Community

I am a clinical psychologist, specialist in dynamic psychotherapy and a psychoanalyst (IFPS). I have worked for DPS Hammerfest, Finnmark Hospital Trust, and in private practice since 2008 and 2009, respectively. I am a member of the Institute of Psychotherapy, Oslo, where I also serve as a supervisor for training analysts. I am a member of the International Association of Relational Psychoanalysis and Psychotherapy (IARPP) and an international affiliate for Division 39, Division 35, and Division 12 of the American Psychological Association. I am a censor for the Swedish Psychological Association´s specialist degree program, examining scientific theses of people pursuing a degree as a specialist psychologist.

I currently hold the position of Assistant Professor at the University of Tromsø, Arctic University of Norway, Department of Clinical Medicine (Institutt for Klinisk Medisin), where I educate medical students on perspectives on cultural sensitivity and privilege awareness in the clinic. I have been a guest teacher for Gothenburg University´s track in clinical Psychology for 13 years. I am a regular guest teacher of clinical psychology at UiT. In the spring of 2020, I held the position of Erikson Scholar at the Austen Riggs Center, in Stockbridge, MA, USA.

I am a part of the rich research environment of Finnmark Hospital Trust, led by Dr. Mette Kjær, the head of research. I serve on the board of the Research Foundation for Finnmark Hospital Trust. In addition, I am a part of the newly started “Interprofessional rural research team – Finnmark” (INTEREST) at UiT, the Arctic University of Norway, led by associate professor and gynecologist Ingrid Petrikke Olsen.

I am participating in a research project in which we have designed a PhD project on cultural competency for medical students and managed to get full funding from

Helse Nord («Cultural competence among doctors in a culturally diverse region – better care for minority patients»). I participated in developing the project and acted in an informal capacity as one of the co-supervisors for the PhD-students. (UiT could not formally validate my responsibility as a co-supervisor until my doctorate is finalized, but the other supervisors wanted me on the team, so for now I am participating in the work without the formal status). The supervisory group is headed by Kari Milch Agledahl, Associate Professor, medical ethicist, and oculist; the two co-supervisors are Cecile Javo, phd and psychiatrist, and Mette Bech Risør, professor of anthropology.

In addition to writings mentioned so far, the book I published with APA Press has been translated into Swedish and published by Studentlitteratur (Fors, 2020a). I produced a training DVD for APA Books (Fors, 2018c), and a book chapter for Natur & Kultur in an anthology of lgbtq-competency (Fors, 2017). My most recent project is a follow-up book for APA Books, now under contract. The Erikson Scholarship from the Austen Riggs Center was awarded to support my work on that project.

My academic background is broad and reflective of my interest in finding overlapping ideas, intersections, and interdisciplinary themes. My original education was a bachelor's degree in media- and communication science from Gothenburg University, Sweden. After terminating a career in the information industry, I decided to change careers and pursued a clinical master´s degree from Gothenburg University (psykologexamen). There, I took extra courses in gender studies, the history of ideas, and astronomy/physics.

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I am grateful to many people. Thanks to my employer, the Finnmark Hospital Trust of Norway, for supporting this project from its inception—not only morally but also financially. A special thanks to Mette Kjær, Head of Research at Finnmark Hospital Trust, and to Torben Wisborg, Head of the Research Board there, for helping me navigate Norwegian health law, Regional Ethical Committee requirements, and other practical issues. Much gratitude to the people I work under, Bryndis Rogde, Robert Kechter, Ragnhild Hanne Nilsen and Inger Lise Balandin, for supporting my work in the most generous ways. Thanks to my lovely colleagues for always backing my intellectual ambitions and enduring my absence from the clinic. Thanks to professor emerita Hanne Haavind for very valuable comments in the process of editing. Thanks to Joyce Slochower, Joel Weinberger, and Simone Drichel for theoretical discussions. I owe my deepest gratitude to my mentor and friend, Nancy McWilliams. My most poetic efforts cannot really express how important you have been, not just for this project but also for my professional and personal growth. "Thanks" feels like a platitude. Finally, heartful appreciation to my beloved wife, Erica, not just for reliably supporting my career in the most unselfish and generous ways but also for enduring my endless, preoccupied self-absorption in this writing. Your vital ideas, generous heart, sharp mind, and critical reflections are deeply important to me. Thanks for love and wisdom. Finally, and centrally, I want to honor the people I cannot name: my patients, supervisees, and students. A special thanks to the brave Isabel and the thoughtful Sonja. Thank you all. Any mistakes in my work are my own.

Abstract

The dissertation examines power issues in psychotherapy from different angles of vision and integrates diverse perspectives on power; for example, professional power, transferential power, sociopolitical power, and bureaucratic power. Through topics of the medical record, the patient-therapist relationship, geographical space, minority issues in diagnosis, and clinical challenges involving third parties, I explore unconscious and preconscious power dynamics. The work aims to integrate, and make clinically accessible, some diverse and relatively abstruse writing on power as it may affect the treatment situation.

In accordance with what philosophers of science have called the context of discovery (Reichenbach, 1938/2006) and scholarships of discovery, integration and application (Boyer, 1990), I contextualize science as an ongoing conversation. While emphasizing continuity and conversation in science, I acknowledge the discourse of narrative therapy and narrative knowledge (e.g., Bernhardt, 2019; McLeod, 2011; White, 2007) and the contemporary psychoanalytic emphasis on dialogue and conversation (e.g., K. Gentile, 2013, 2017; Orange, 2003; Suchet, 2004). In illustrating how power affects therapy relationships in indirect ways, the work is consistent with feminist ethics, intersubjectivity theory, social localization theory, autotheory, and the assumption that one can never be completely above or outside a social or scientific system (K. Gentile, 2013, 2017; Gergen, 2015; Harding, 2004, 2009; hooks, 2000; Smith & Watson, 1998; Young, 1997). It fits also in the tradition of pragmatic psychology (Fishman, 2017; Fishman & Messer, 2013).

The work is based in traditional literature studies (Jesson, Matheson & Lacey, 2011) and the case study method (Fishman & Messer, 2013; McLeod, 2011; Yin, 2012), in which the focus is on finding analytical and theoretical generalizations (Yin, 2012). In an attempt to make the work clinically relevant, I emphasize that even the most morally and cognitively

sophisticated therapist (and patient) inevitably will have internalized elements of societal norms and prejudices, consciously or unconsciously (e.g., Davids, 2003; Layton, 2006b; Yancy, 2015).

In the first study (Fors & McWilliams, 2016), my co-author and I explore the undertheorized question of sharing patients' medical records as part of the therapeutic process in mental health treatment. We argue that, especially with more seriously disturbed patients and those with significant personality disorders, if well timed, collaborative inspection of medical records can strengthen the therapeutic alliance, increase mutual understanding of the patient's problems, support the patient's self-respect, and contribute to a sense of emancipation and personal empowerment. The intervention of collaborative reading of medical records is hence put in a therapeutic context and integrated with the goals and language of psychotherapy.

The second study (Fors, 2018b) is a theoretical paper, formulating urbanity as a seldom-addressed privilege and exploring implications of the misrepresentation or absence of the rural world on the "map" of psychotherapy. I "countermap" urban biases with respect to power, space, and time, and I explore some implications for therapeutic ethics, the frame, self-disclosure, and potential interpretation as I investigate the urban valuing of specialized expertise over wisdom, urban disconnection from weather and distance, urban colonizing behavior, the dumping of incompetent professionals into rural areas, and the urban sense of entitlement to anonymity.

The third study is a theoretical paper (Drescher & Fors, 2018) analyzing how minority issues are framed in the *Psychodynamic Diagnostic Manual, 2nd ed.* (PDM-2) (Lingiardi & McWilliams, 2017). I use my co-author's case material to analyze some benefits and limits of the PDM-2's attention to "non-pathological conditions that may need clinical attention (minority stress)." I comment on the manual's implicit assumptions and potential

consequences with reference to the dyad of *similarity of nonprivilege* (Fors, 2020b/2018a). With reference to the case, in which a minority therapist treated a minority patient, I address historic milestones in the direction of social justice for gay and lesbian people, emphasizing that clinicians need to go beyond simply considering homosexual individuals as *healthy* to acknowledging the *cumulative trauma* of gay people's lives in a world in which heteronormativity continues and heterosexuality is generally seen as a preferable sexual orientation. I conclude that the PDM-2, despite giving greater attention to minority issues than other classification systems, gives no clinical guidance for issues that arise when a minority therapist treats a minority patient. I posit that distortions of envy, internalized subordination in both parties, countertransference, idealization, disappointment, and unspoken wishes to be understood by someone on whom sameness can be projected are characteristic of such dyads.

The fourth study (Fors, in press) is a theoretical paper in which four domains of power are highlighted through the lens of one case. These areas include professional power, transferential power, socio-political power, and bureaucratic power, all of which are explored through the case of "Sonja." The paper has the overall aim of illuminating power issues in psychotherapy and illustrating how they may operate simultaneously and synergistically through different persons involved in the patient´s care; in this case, a general medical practitioner, a dental nurse, an obesity specialist, the patient, and me.

The fifth study (Fors, 2020b) is a theoretical contribution suggesting a conceptual model of how relative power in psychotherapy might be framed. Here I explore the possibilities of examining these different kinds of power across varying diversities (race, class, sexual orientation, etc.), without equating those categories, without disowning the tension between essentialism and social construction, and without minimizing differences of traumatic history, degree of discrimination or violence, or psychodynamics involved in the

prejudice. I offer an integrative model, *the matrix of relative privilege*, as a useful tool for exploring how social power is ongoingly negotiated in clinical dyads. The matrix includes four core therapeutic patient-therapist-dyads: *similarity of privilege*; *similarity of nonprivilege*; *privilege favoring the patient,* and *privilege favoring the therapist*. It potentially brings social justice concerns into the technical sphere, not simply the ethical sensibility, of the consulting room.

The overarching conclusion of the dissertation is that addressing power in psychotherapy is a subtle, complex, and important ongoing process that has not been fully theorized. It is not a question that can be clarified once and for all. Nor is it a question that is fully separable from the therapist's own subjectivity, internalized norms, or social experiences with privileges and/or experiences of discrimination

Sammendrag

Denne avhandlingen undersøker et mangfold maktdimensjoner i psykoterapi. Arbeidet integrerer ulike perspektiv på makt: profesjonell makt, overføringsmakt, sosiopolitisk makt og byråkratisk makt. Ubevisste og førbevisste maktdynamikker i psykoterapi utforskes blant annet i felleslesning av pasientjournalen i terapiforløpet; i forhandlinger av sosial makt i pasient-terapeutforholdet; i psykoterapifagets partiskhet til urbane forhold, og i minoritetsproblemer knyttet til diagnostisering og maktspørsmål i samhandling med tredjeparter. I arbeidet konseptualiseres vitenskap som en pågående samtale, i samsvar med det som vitenskapsfilosofer har kalt konteksten av oppdagelse (Reichenbach, 1938/2006) og vitenskapsarbeidet av oppdagelse, vitenskapsarbeidet av integrering og vitenskapsarbeidet av applisering (Boyer, 1990). I tråd med tradisjonen pragmatisk psykologi (e.g. Fishman, 1999, 2017) er fokuset på en klinikknær tilnærming, hvor det undersøkes hvordan makt påvirker terapirommet i praksis, både ubevisst, bevisst og forbevisst.

Arbeidet består av litteraturgjennomganger (Jesson, Matheson & Lacey, 2011) og kasusstudier (Fishman & Messer, 2013; McLeod, 2011; Yin, 2012) der fokus er å finne analytisk og teoretisk generalisering (Yin, 2012). Avhandlingen bygger også på en feministiske etikk omkring sosial lokalisering, autoteori, subjektivitet og en betoning av at man selv aldri kan stå helt utenfor et sosialt eller vitenskapelig system (e.g., K. Gentile, 2013, 2017; Gergen, 2015; Harding, 2004, 2009; hooks, 2000; Smith & Watson, 1998; Young, 1997). Denne antakelse har som utgangspunkt at alle terapeuter og pasienter uunngåelig har internalisert normer fra samfunnet (e.g. Davids, 2003; Layton, 2006b; Yancy, 2015) og at ingen er fri fra kontekst. Arbeidet vektlegger den psykoanalytiske tradisjonen av kunnskap som dialog i utvikling (K. Gentile, 2013, 2017; Orange, 2003; Suchet, 2004), men også den

vitenskapelig tradisjon som tilhører diskursen om narrativ kunnskap (f.eks. Bernhardt, 2019; McLeod, 2011; White, 2007).

I den første studien (Fors & McWilliams, 2016) utforskes det å lese pasientens journal sammen med pasienten, som en del av den terapeutiske prosessen. Gjennom en litteraturgjennomgang av empiriske studier på pasienttilgang av medisinske journaler, (primært i somatikken), i kombinasjon med kasuseksempel fra terapier, genererer artikkelen teori ved å foreslå felleslesning av journal som et psykoterapeutisk verktøy. Særlig hos pasienter med alvorlig psykopatologi, som betydelig personlighetsproblematikk, argumenteres det for at felles journallesning kan styrke alliansen, øke den gjensidige forståelsen av pasientens utfordringer, støtte pasientens selvrespekt og bidra til en følelse av frigjøring og agens. Intervensjonen settes i en terapeutisk sammenheng, og er også integrert både i målene for psykoterapi samt i det teoretiske psykoterapispråket.

I den andre studien (Fors, 2018b), som er en teoretisk artikkel, utforskes urbanitet som et uuttalt privilegium. Implikasjonene av uriktige fremstillinger eller totalt fravær av mer rurale perspektiv for psykoterapi, diskuteres. Målet er å synliggjøre den urbane forforståelsen i psykoterapifeltet. Konsekvenser av teoretiske begrep som ’rammer’, ’selvavsløring’, ’anonyme idealer’, ’etikk’ og ’urban kolonialisme’ avdekkes og problematiseres.

I den tredje studien (Drescher & Fors, 2018) undersøker vi hvordan minoritetsstress blir adressert i diagnosemanualen PDM-2 (Lingiardi & McWilliams, 2017). Her anvendes kasusmateriale samt diagnosemanualen for å analysere fordeler og begrensninger ved manualens oppmerksomhet på ”ikke-patologiske forhold som kan trenge klinisk oppmerksomhet (minoritetsstress)”. Artikkelen belyser historiske milepæler i bevegelsen mot sosial rettferdighet for homofile og lesbiske. Dette illustreres i kasuset ”Frank”, hvor en minoritetsterapeut behandler en minoritetspasient. I gjennomgangen av

kasuset avdekkes det hvordan PDM-2, på tross av økt oppmerksomhet rundt minoritetssensitivitet sammenlignet med andre klassifikasjonssystemer, ikke nødvendigvis avhjelper utfordringer som oppstår når både terapeut og pasient tilhører en minoritet: likhet i underordning (Fors, 2020b/2018a). Fenomener som utforskes er misunnelse, internalisert underordning hos både pasient og terapeut, skuffelse og uuttalte ønsker om å bli forstått av noen som det kan projiseres sosial likhet på.

Den fjerde studien (Fors, in press) er en teoretisk studie der fire maktområder relevante for psykoterapi fremheves gjennom en kasustikkbeskrivelse: profesjonell makt, overføringsmakt, sosiopolitisk makt og byråkratisk makt. Disse maktdynamikkene blir utforsket i kasuset "Sonja". Det overordnede målet er å illustrere hvordan flere perspektiv kan vare valide samtidig og hvordan makt utspiller seg synergistisk gjennom flere aktører: en fastlege, en tannpleier, en overvekts-spesialist, pasienten og terapeuten.

Den femte studien (Fors, 2020b) er et teoretisk bidrag som presenterer en overordnet interseksjonell modell for hvordan sosial relativ makt i psykoterapi kan forståes. Jeg drøfter en integrerende modell, kaldt ”relativa privilegiers matrise”, for å analysere privilegier i den kliniske dyaden. Modellen er tenkt som et verktøy for å utforske hvordan sosial makt kontinuerlig forhandles frem i terapiforløpet gjennom fire kjernetyper av pasient-terapeut-dyader: Likhet i privilegier; likhet i ikke-privilegier; privilegier i pasientens fordel og privilegier i terapeutens fordel. I modellen utvides spørsmålet om sosial rettferdighet til å også innbefatte terapeutisk teknikk, ikke kun en terapeutisk etikk om alles like verdi. Relative privilegiers matrise tar for seg ulike kategorier av sosial ulikhet slik som eksempelvis hudfarge, klasse, etnisitet, alder, kjønn og seksuell orientering.

Avhandlingens overordnede konklusjon er at å adressere makt i psykoterapi må være en stadig pågående prosess og inkluderes i den terapeutiske samtalen. Det er ikke et spørsmål som kan bli avklart en gang for alle. Ikke heller er det et spørsmål som kan stå

utenfor terapeutens egen subjektivitet, internaliserende normer eller sosiale erfaringer med privilegier eller diskriminering.

List of Publications

Paper I

Fors, M., & McWilliams, N. (2016). Collaborative reading of medical records in psychotherapy: A feminist psychoanalytic proposal about narrative and empowerment. *Psychoanalytic Psychology, 33*, 35-57. http://dx.doi.org/10.1037/pap0000019

Paper II

Fors, M. (2018b). Geographical narcissism in psychotherapy. Countermapping urban assumptions about power, space and time. *Psychoanalytic Psychology, 35*, 446–453. http://dx.doi.org/10.1037/pap0000179

Paper III

Drescher, J., & Fors, M. (2018). A dialogue on cultural and minority issues in PDM-2 through the case of Frank. *Psychoanalytic Psychology*, 35, 357-362. http://dx.doi.org/10.1037/pap0000199

Paper IV

Fors, M. (in press). Power dynamics in the clinical situation: A confluence of perspectives. *Contemporary Psychoanalysis.*

Paper V

Fors. M. (2020b) *Relative Privilege in Psychotherapy.* Unpublished paper. (Theoretical foundation for Fors, M. (2018a). *A grammar of power in psychotherapy. Exploring the dynamics of privilege*. Washington, DC: American Psychological Association.)

1. Introduction

There are multiple perspectives from which one can examine power in psychotherapy (e.g., Aron, 1990, 1996; Brown, 2004; Hays, 2016; Herman, 1992; Layton, 2002, 2006a, 2006b, 2016a, 2016b; Orange, Atwood, & Stolorow, 2001; Suchet, 2007; Tummala-Narra, 2015, 2016; Worell & Remer, 2003.) Although most clinical literature has not used the language of "empowerment" to describe therapeutic aims, a core value of psychotherapy, regardless of tradition, involves empowering the patient. I would argue that all psychotherapy traditions share the goal of increasing patients' personal power and freedom from being controlled by the power of unwanted influences (the past, symptoms, trauma, irrational self-hating thoughts, overwhelming feelings, and so on).

Every school of therapy has its own way to focus on psychological agency, though this focus is not always explicit. Common therapeutic questions involve investigating patients' (and therapists') conflicted or disowned agency and its paradoxes (its coexistence with surrender to relationship, to what is determined, to what transcends our control).[2] Therapeutic ethics foreground respect and support for patients' autonomy, self-determination, and sense of agency. Cognitive-behavioral language may construe treatment goals as obtaining power over one´s automatic negative thoughts, anxiety or voice-hearing (e.g., Beck, 2011; Garrett, 2019) or becoming empowered by finding ways to cope or manage somatic pain (Turk & Gatchel, 2018). In the psychodynamic tradition, empowerment has been depicted in terms of the achievement or repair of autonomy (Erikson, 1950), liberation from self-defeating unconscious dynamics, the conquest of disabling fears, reduction of pressures from internalized objects, overcoming the repetition compulsion (Freud, 1919;

[2] Thanks to Jill Gentile for helping me reflect on this matter. (Personal communication December 10, 2020).

Racker, 1966; Shedler, 2010), and working through transferences that interfere with agency (e.g., Abbass, 2016; Racker, 1966; Racker 2002).

Contemporary relational contributors have framed patient empowerment in terms of increasing clients' "sense of subjective self" (Stern, 1985), "interiority" (Slochower, 2004) or "subjectivity" (Benjamin, 1998), the latter an emphasis shared by the narrative tradition in psychotherapy. Behaviorally oriented psychologists might refer to the similar concept of "locus of control" (Rotter, 1966).

The ideal of respecting patient autonomy and helping people to gain autonomy goes far beyond psychotherapy. Interestingly, a similar question about when and when not to be in control of one's own life is an ongoing debate in the field of medical ethics. Concepts such as shared decision-making and patient consent run into the same dilemmas that psychoanalysis continues to try to answer; for example, about what kinds of decisions and choices patients can understand and make, when consent is truly "informed," and what is needed to be able to make truly agentic choices (Agledahl, Førde, & Wifstad 2011).

In recent decades, the field of psychotherapy has looked at power in additional ways, addressing how *issues of societal power* interact with clinical responsibilities. Attention has been given to the many ways in which social categories, sociopolitical realities, and some elements in psychotherapy practice itself embody elements of power. The level of cultural competency of the therapist, the role of medical records, the history of diagnosis, and the inevitable dependency and asymmetry in the doctor-patient relationships, for example, are currently being addressed in terms of power (e.g., Fors & McWilliams, 2016: Drescher, 2002, 2015; Johannisson, 1994; Tummala-Narra, 2015, 2016.) Power themes relevant to psychotherapy have been recently construed as involving more than liberating people from their personal history or helping them survive in an unfair world with as much individual autonomy as possible. Current writing addresses psychotherapy practice itself as a field in

which power is inevitably felt and addressed. In this vein, Walls (2006) writes that uncovering political aspects of psychotherapy itself is urgent:

> One way a dominant ideology works is to present an idealized value as representative of the society, while submerging any antisocial implications of the ideal in an unconscious element of the norm. . . .The question then becomes: do we want to practice a psychoanalysis that is itself a form of ideology, in that it enforces a norm to maintain the unlinking of the awareness of the individual from his or her social context, an unlinking that is manifestly operating in the service of obscuring relations of domination? Or do we want to practice a psychoanalysis that is committed to a process of making the unconscious conscious, including the political unconscious, when doing so ameliorates our patient's suffering? (Walls, 2006, p. 119)

1.1. Aims of study

In this project, I have examined interactive conscious, unconscious and preconscious power processes that operate between therapist and patient and also between the clinic and society, with the ultimate aim of developing more power-sensitive practice among clinicians. The original idea was to address issues of power in the clinical encounter in a variegated way, going from issues of the medical record to the therapeutic relationship to the health center context, and then towards diagnostic and geographical mapping of internal and external space. The more I investigated such questions, the more I realized how inextricably the domains intertwine.

My aim has been to develop a domain of knowledge that would foster increased clinical awareness. I have not attempted to draw conclusions about how power in psychotherapy works for good and/or ill. Instead, through case-by-case reflections, I hope to

contribute to the exploration of the complex effects of social power as it enters clinical practice, putting words to subtle dynamics and illustrating how power affects relationships in indirect ways. Consistent with what philosophers of science have called "context of discovery," "scholarships of discovery," "scholarship of integration," and "scholarship of application" (e.g., Boyers, 1990; Reichenbach, 1938/2006), I conceptualize science as an ongoing conversation. In so doing, I acknowledge the discourse of narrative knowledge (e.g., McLeod, 2011; White, 2007), a scholarly tradition that parallels the contemporary psychoanalytic emphasis on evolving dialogue.

By opening up a conversation about social power in therapy, I hope to offer clinicians more choices in how to understand or handle a clinical situation. I have not attempted to offer specific protocols for treatment under different conditions of power, or to provide definitive answers about how power works in therapy. My aim is to integrate and make clinically accessible some diverse and relatively abstruse writing on power as it may affect treatment. I address different sources of power relevant to the clinical situation and comment on ways that power plays out in relationships among patient, therapist, and society. Through clinically relevant topics such as medical records, the patient-therapist relationship, implicit urban norms in psychotherapy, and clinical challenges involving third parties, I ponder power themes relevant to the clinic. At the sociocultural and political level as well as that of the individual, I study sources of power and how they express themselves through the patient, therapist, and health system. The questions I address include:

- How can medical records be used in psychotherapy in ways that empower patients? What are advantages and disadvantages to the clinic of providing access and sharing information? How is the clinical relationship affected when the patient reads the

therapist's notes? Would therapists be unduly burdened by patients' access to their medical records? Would patients be harmed in any way?

- What implicit urban biases affect psychotherapy? Do prejudices favoring urbanity confer privilege on urban therapists or patients? How might a psychoanalytic perspective construe urban bias? How can urban exploitation and devaluation of the rural be reframed for clinicians and patients working in a colonized space?

- What does a mutual lack of privilege bring to the clinical situation? The underlying question here is whether women should ideally be treated by female therapists, blacks by black therapists, gays by gay therapists, Jewish people by Jewish therapists, and so on. Or can such matters be addressed therapeutically in a relationship characterized by difference as well as similarity?

- How do different kinds of power operate simultaneously and synergistically in psychotherapy? How do we understand the clinical impact of professional power, transferential power, social power, and bureaucratic power, respectively? How can power-relevant clinical challenges that involve third parties be comprehended and navigated? How is power projected, owned and negotiated?

- How might a conceptual model of power in psychotherapy be framed? Is it possible to talk about different kinds of power across varying categories of difference (race, class, sexual orientation, etc.) without equating those categories? Would an integrative model of relative privilege be a useful tool for analyzing how social power is ongoingly negotiated in clinical dyads?

These questions are explored with the help of cases that function as examples. The work is theory-generating, builds on traditional literature review and case study methods, and finds its home in the interface between postmodern feminist writing, sociological theory, philosophy, auto-theory, ego psychology, object relations theory, narrative theory, and diverse and relatively abstruse writing on power as it may affect the treatment situation. In the following, I describe a clinical perspective on power, pragmatism, and feminist ethics as a platform of departure. Feminist ethics emphasize going beyond obligations to follow existing rules, attending to the specific consequences of own one's conduct for dependent others, and assuming the responsibility to explore and not foreclose information. Pragmatic clinical perspectives share a feminist emphasis on accessibility and noticing the therapeutic self as a part of the clinical context.

1.2. Clinical perspective on power

This work belongs in the tradition of examining interactive unconscious processes between clinic and society, with the ultimate aim of developing more power-sensitive practice among clinicians. In conformity with contemporary feminist, anti-racist, and intersectionally oriented psychoanalysts, I bring theoretical perspectives on power into the realm of the clinic. I also do the converse, drawing on clinical data to formulate power theories. This approach fits a power-sensitive academic tradition in which the concrete, commonplace, and subtle become recognized as inherently political and thus as arenas for exploring power issues.

Although many psychoanalytic theorists have written about socio-political issues in psychotherapy, much of that writing is highly theoretical and not very "hands on" (e.g., Benjamin, 1988, 1991, 1995, 1998, 2004, 2017; Butler, 1990; Chodorow, 1978, 1989, 2000; J. Gentile & Macrone, 2016; Kristeva, 2004; Silverman, 2003). Contributions on issues

of power have also come from psychoanalytic fields other than the mental health disciplines, such as cultural studies, gender studies, literature science, sociology, and philosophy. Writing in an advanced, abstract language about issues such as "racial melancholia" (Eng & Han, 2000), "gender melancholia" (Butler,1995), the "moral third" (Benjamin, 1988, 1991, 1995, 1998, 2004, 2017), "detachment from privilege or social context" (Layton, 2002, 2006a), the "normative unconscious" (Layton, 2002), privilege as a "social defense" (Young-Bruehl, 1996), and "internalized racism" (Davids 2003, 2011), or about the phenomenon of projection of badness onto minorities (Akhtar, 2007, 2014), numerous scholars have made important contributions. Yet I found that little work had been done to make these concepts applicable to practical clinical work. I suspect I am not the only clinician struggling with the effort to make a bridge from brilliant theory into real-world clinical practice.

When looking into the literature on how societal power issues enter the therapy dyad, I was struck by another kind of absence. Contributors to the domains of feminist psychotherapy (e.g., Brown, 2004; Worell & Remer, 2003), cultural competence (e.g., Tummala-Narra, 2015, 2016), empowerment for disabled people (Emanuel, 2016), critical psychology (Prilleltensky & Nelson, 2002), and micro-aggression theory (Pierce, 1970; Sue, 2010) have all provided clinically relevant writing. But such literature often inclines toward a different limitation, construing social power issues in terms of categories, groups, or specific minorities and not in terms of power itself. Sometimes the treatment of subordinated groups is described in terms of specific "competencies" (Fish & Evans, 2016; Kleinman & Benson, 2006; Truong, Paradies, & Priest, 2014), and often the therapist is assumed to be a majority person (e.g., Lingiardi & McWilliams, 2017). Some more radical writers have even suggested that analyzing the politics of the heterosexist patriarchal society is the only reasonable approach to power issues in therapy and is in itself therapeutic (Kitzinger & Perkins, 1993). Unconscious dynamics are often overlooked in such analyses, and most often, as Young-

Bruehl (1996) has emphasized, one power dimension is addressed to the exclusion of others (e.g., Brown, 2004; Emanuel, 2016; Holmes, 1992, 1999).

I wanted to engage with interrelated writing from several human rights fields. I was interested in bringing complicated theory down to a practical level, without making ideas into a manual and without losing complexity. The aim was to make a clinically oriented contribution that embodied my debt to all the contributors I have mentioned. I tried to integrate abstract theory from different traditions with writing on its clinical applications; I have found inspiration in writers who have managed to do this kind of integration (Holmes, 2006, 2016; Layton, 2016b; McWilliams, 2011; Suchet 2007).

1.3. Feminist ethics

I view bridging from theory to practice as a part of feminist ethics, which emphasize the value of making complicated theories comprehensible and useful, and frame that activity as an act of empowerment. Eagly, Eaton, Rose, Riger and McHugh (2012), after investigating half a century of research on women and gender, concluded that feminism embraces more than gender. It includes intersectional contributions, addresses research questions and experiences that were not previously prioritized, and pays attention to power relations in general (see also Eagly & Riger, 2014). The trend is to address broader issues of power, as exemplified in the recent practice of feminist participatory action research (Brydon-Miller, 1997; Frisby, Maguire, & Reid, 2009), in which the research itself is seen as part of a political engagement. Quoting Reason and Rowan (1981, p. 489), Brydon-Miller writes that "All research is located within specific political, social, and economic contexts. 'Research can never be neutral. It is always supporting or questioning social forces, both by its content and by its methods.'" (Brydon-Miller, 1997, p. 83).

Other examples of naming power-sensitive practice as feminist include

attention to class issues, racial issues, and power dynamics between therapist and patient (Worell & Remer, 2003). All share the assumption that the personal is political and the reverse: the political is personal. Contemporary psychoanalytic feminists (e.g., K. Gentile, 2013, 2017; hooks, 2000) also emphasize that one cannot stand outside one's theories, research, or clinical work. Harding (2004, 2009) has suggested that acknowledging one's social location (or standpoint) is crucial since it affects how we view the world and what research questions we would ask or acknowledge. She stresses that this perspective inevitably extends the logic of research itself and aims at the starting point of the scientific process: the context of discovery (Reichenbach, 1938/2006). Harding even suggests that knowledge is local, and that people from a marginalized group, who see the world from lower in the societal hierarchy, might be more objective than those with more privilege, a notion that has been called "strong versus weak objectivity." Her theories have been critiqued for being essentialist, assuming all members of a group are alike. Yet despite such criticisms, her ideas have survived over 40 years and spread to different fields (Harding, 2004, 2009), a phenomenon that I interpret as meaning that despite some dogmatism, something in her perspective strikes others as valuable.

I see the work as feminist in two respects. First, addressing power issues in itself is a feminist project. Second, I believe the method is consistent with feminist logic: I use the personal as a tool of investigation and use self-disclosure purposefully with respect to patients, science, and myself. My attempt to apply theory to concrete clinical challenges is a choice. It includes an effort to avoid jargon, given that psychoanalytic and scientific language has sometimes been criticized as alienating, narcissistic, class-biased, and disdainful of ordinary readers (cf. Gabbard, McWilliams, & Shedler, 2020).

I consider the work also to be LGBTQ+ affirmative, anti-racist, and anti-colonial. Given the intersectional purpose, I embrace a synthetic understanding of power

issues (cf. Crenshaw,1989; Lugones, 2010) and write from a feminist tradition that theorizes beyond matters of gender (Eagly & Riger, 2014; K. Gentile, 2013, 2017; hooks, 1990, 2000). That tradition includes attention to issues of post-colonialism (Fanon, 1952/2008; Spivak, 1987), able-bodiedness (McRuer, 2006), sexuality (Butler, 1990, 1995), race (hooks, 1990), and others. As feminist theory has been a main contributor to power-sensitive literature, the work fits into a feminist framework even though it is far from narrowly gender-based.

The writing – and its overall tone of personal, practical translation from more abstract language into clinical encounters – is consistent with a growing strain in psychoanalysis that emphasizes accountability and critiques some academic writing for implicit white privilege. From this perspective, the elite classes, via intellectualization and the narcissistic attractions of being seen as brilliantly inscrutable, often unwittingly dissociate themselves from the damaging effects of exploitation, oppression, and discrimination. In the judgment of Melanie Suchet, for example, (personal communication, May 9, 2019), our vulnerability to idealization, to being impressed by abstractions, sometimes functions as an unconscious enactment of white supremacy. From a philosophical perspective, Monmonier (1996) and the philosopher of science Winther (2020) made similar remarks about geographical maps, pointing out how they may exemplify processes of distorting, narrowing, universalizing, ontologizing, and even lying. They evade questions about who owns a land, about what is to be included and omitted, and about what names should appear (e.g., should a city name be that of the indigenous people or the colonizers?). Winther (2020) argues that this process is true not only for maps but for all scientific constructs and theories.

The project was thus double-edged: As I addressed power issues from different perspectives and considered different aspects of clinical work, I wanted to formulate and synthesize unformulated clinical experiences on power issues and connect them to theory. But equally, I wanted to translate abstract language that embodies power issues into

practical clinical interventions (such as reading the medical record together with the patient, (Fors & McWilliams, 2016). This approach is also consistent with the philosophy of pragmatism (Fishman, 1999; Goldberg, 2002) as well as with what has been called the ethics of ordinary life (Das, 2012).

1.4. Pragmatism

Goldberg (2002) addresses the value of pragmatism in both psychoanalysis and the clinic setting in general:

> Pragmatism is seen as a theory of instrumentation or a collection of tools for accomplishing goals; it claims that many of our efforts to know and seek truth are based upon myths. Psychoanalysis, too, can be seen to pursue certain theoretical claims based on myths. The present climate of pluralism in psychoanalysis is not a phase, but an indication of our diverse ways of achieving in-depth understanding of another person. . .. Pragmatism advises us to focus on the possibility that we may be captured by one or another of the above-mentioned myths as we struggle to resolve the unresolvable. Knowledge must be seen as a tool for adaptation, rather than as a picture of reality. (pp. 235-248).

The value of addressing subtle dynamics in the concrete and ordinary has also been discussed in other fields. For example, the anthropologist Das (2012) has suggested that ordinary ethics or focusing on the subtle actions and discourses in ordinary life, is a core feminist ethical stance: “In this theory of ordinary ethics I have privileged the voices of women. I hope this gesture will appeal to those who are willing to think from the feminine regions of the self as a way of inhabiting the world with others” (p. 146). Similarly, in

studying “micro power,” the social psychologist Asplund (1987) addressed it in such commonplace practices as greeting rituals. The clinical bridging is not intended as a devaluation of the theoretical but as appreciating its applicability to the most ordinary human activities, including the craft of psychotherapy.

Voices of ordinary clinicians are rare in contemporary academic psychology. Giants such as Marsha Linehan (Dialectical Behavior Therapy), Peter Fonagy (Mentalization Based Therapy), Jeffrey Young (Schema Therapy), and Otto Kernberg (Transference Focused Psychotherapy) have developed their own methods on the basis of clinical experience, have turned to research to investigate the efficacy of their respective methods, and have then come back to the issue of clinical application. But such efforts and successes are rare. Much clinical wisdom resides in people of less genius, whose potentially important contributions are less commonly noted in the academic literature.

Most influential scientific writing on psychology and psychotherapy now seems to emanate from full-time researchers. Many distinguished writers have recently commented on a widening split between clinicians and researchers, with each group having increasingly different incentives and cultures (see, e.g., Boswell, Kraus, Miller, & Lambert, 2014; Shedler, 2006). Each group may consequently find it difficult to mentalize the assumptions and exigencies of the other (e.g., Halvorsen, Benum, Oddli, Stänicke, & McLeod, 2017; McWilliams, 2017). In the current research literature, some scholars have bemoaned “empirical imperialism” (Castonguay et al., 2015), in which academic researchers expect deference from clinicians but fail themselves to listen to their clinical colleagues.

In this vein, both Wachtel (2016) and Orange (2003) emphasize the limitations of randomized-controlled studies, suggesting that the assumptions of their authors about the real-world clinical implementation of RCTs can be naïvely narrow; specifically, these investigators fail to appreciate the struggles and efforts of ordinary therapists with naturalistic

samples of complex patients (see Shedler, 2018, for an even harsher critique). Halvorsen, et al. (2017) note that "Several studies have suggested that research participation increased therapist interest in research and willingness to use research findings to inform their practice" (p. 4). Attention to research by clinicians is assumed to be valuable for practice. Here I emphasize the equal value of the opposite, that researchers may learn from clinicians, that they might do better research if they were to listen to those who spend time with real patients who have not been cherry-picked to lack comorbidities. In an interview Shedler states:

> There is bifurcation in psychology between clinical practitioners and academic researchers who claim to speak on behalf of psychology. We rarely hear the voices of clinical practitioners in public discourse. The voices of academic researchers dominate and take up all the oxygen—and they are the voices of people with no meaningful clinical experience. (Aftab, 2020).

In this intellectual climate, the overall aim has been to make a contribution from a clinical voice that can amplify, from varying perspectives, power issues in psychotherapy. In this context; I frame science not only as randomized controlled trials of specific techniques developed for reducing symptoms of specific disorder categories, but also as scholarship that includes an ongoing conversation that, in a methodological sense, is a part of what philosophers of science have called justification of science, scholarships of discovery, scholarship of integration, and scholarship of application (e.g., Reichenbach, 1938/2006; Boyers, 1990). It also includes and acknowledges the researcher as not detached from the research itself. This is not an entirely new concern: Polanyi (1958) emphasized tacit knowledge and personal knowledge, stressing that they cannot be disconnected from science; they are not separable and are vital to the creation of new knowledge.

In the context in exploring how a therapist´s personal presence and way of being influenced the work with a patient, Bernhardt (2019) argue that the personal is an active ingredient in professional knowledge:

> In his seminal work “The Reflective Practitioner,” Donald Schön (1983) explored how our personal knowledge not only integrates and affects how we learn, but also is an irreplaceable source of understanding that, to a large degree, has been both ignored and disparaged as "armchair science" by the mainstream positivistic philosophy of science (Danziger, 1990; Fishman, 2017). Schön introduced the concept reflective practice to explain how we, as human beings, process and make use of different sources of knowledge: "Just as reflective practice takes the form of a reflective conversation with the situation, so the reflective practitioner’s relation to the client takes the form of a literally reflective conversation" (Schön, 1983, p. 295). Even though Schön addresses the use and learning of various kinds of professional knowledge in his writings …, his argument resonates closely with the reflective mentalizing and the authentic stance that many psychotherapists strive to maintain in their clinical work. Within the context of psychotherapy, he emphasizes that such reflective practice means that the therapist is involved in an ongoing internal "dialogue about the dialogue" between acquired professional knowledge and continuous internal meaning-making through personal interaction with the patient. This inner dialogue is assumed to be vital for how learning processes and the development of expertise take place. (Schön, 1983). (pp. 153-154).

In scientific scholarship, however, personal knowledge is never enough and will always interact with more traditional approaches to understanding. In the upcoming sections I situate the work within several different theoretical frameworks.

2. Theoretical Framework

In the following sections I address the heterogeneity of psychoanalysis, connections between the clinic and issues of social justice, specific psychoanalytic traditions that bridge social justice with psychoanalysis, and different theories on how prejudice and privilege affect clinicians and patients. In this section I talk also about different ways to understand unconscious processes.

2.1. Theoretical Framework: Heterogeneity of Psychoanalysis

To investigate subtle power issues in the clinical setting, I use models that address unconscious dynamics of how social structure is internalized in all of us. I go beyond formulations of prejudice as simply a matter of mislearning, or as a problem that can be solved by education. I see the situation as much more complicated. The project was to address interactions of both conscious and unconscious parts of the patient and the therapist.

Thus, this work emerges from the psychoanalytic tradition. I understand "psychoanalysis" as Freud did; namely, as the investigation and illumination of unconscious processes. I address unconscious and preconscious dynamics and motives, inferable from such phenomena as transference and countertransference, psychological defenses, and behaviors suggesting resistance and counterresistance. I subscribe to a psychoanalysis that respects contemporary psychoanalytic pluralism (Wallerstein, 1995) and has been particularly influenced by the "relational turn" (Aron,1996). I am indebted to Freud himself,

to the American ego psychologists, interpersonalists, and self psychologists, and to the British object relations tradition. I am less well versed in Lacan and French psychoanalysis generally. Such integration is not unusual, especially in clinicians. According to Fonagy:

> It could be argued that the so-called major psychoanalytic schools which have emerged to organize our discipline over the last half of the 20th century are breaking down. Ego psychologists are no longer ego-psychologists, Winnicottians are no longer just Winnicottian, self-psychologists have fragmented, Kleinian-Bionians have less and less in common beyond these two giants of the field, Anna Freudians were probably an improbable grouping even during her lifetime, and interpersonalists never had a coherent theme beyond the citation of Harry Stack-Sullivan. (Fonagy, 2015, p. 43).

I use the terms "psychoanalytic" and "psychodynamic" equivalently, even though for some purposes, a distinction between those labels is useful. (Many writers have reserved the term "psychoanalytic" to apply to the clinical procedure of working multiple times a week with patients seen on the couch, while using "psychodynamic" to describe therapies that are centrally influenced by psychoanalytic theories but in which patients are treated at lower frequency and face to face.)

"Classical psychoanalysis" is indeed one version of putting psychoanalytic ideas into practice. But my use of the term "psychoanalysis" assumes a broader definition of the psychoanalytic tradition, and of psychoanalysis as a treatment, than the multiple-days-a-week-on-the-couch model. It refers to the *body of knowledge* embraced by psychoanalysis as a discipline rather than to a technical treatment approach; it also includes a heterogeneity of psychoanalytic approaches. Making a sharp division between what is "psychoanalytic" and

what is simply “psychodynamic,” rather than appreciating the continuities between classical psychoanalysis as a treatment and other applications of psychoanalytic theories, seems to me to have sometimes had the effect of failing to acknowledge the psychoanalytic origins of core concepts and phenomena now used outside psychoanalytic circles (see Bornstein, 2005; Shedler, 2010). I appreciate how psychoanalysis has been used in other fields such as literature studies, arts, genders studies, film studies, cultural studies, and philosophy. McWilliams (2020) observes that there are three common meanings of “psychoanalysis”: a treatment, a knowledge base, and an ethos. Shedler (2002) writes:

> The term psychoanalysis refers to a great many things: a diverse collection of therapeutic techniques, a wide range of theories and models, a rich collection of diagnostic constructs, and a certain attitude toward mental life that is not wedded to any specific technique or model (Gabbard 2000; Schafer 1983) (p. 431).

Contemporary psychodynamic and psychoanalytic *clinical practices* embrace a wide range of formats. They include variations involving frequency of sessions, length of treatment, using the couch or sitting (or, recently, working remotely), depending on realistic exigences and the need to adapt to different kinds of psychopathology. Some psychoanalytic approaches (e.g., Transference Focused Psychotherapy and Mentalization Based Therapy) are designed for work with a special patient population, such as people with borderline-level pathology. Among the best-known psychoanalytic traditions are Freudian drive theory, ego psychology, interpersonal psychoanalysis, object relations theory, self psychology, relational analysis, and group psychoanalysis (e.g., the Tavistock model). Additional psychodynamic approaches are captured in acronyms used for research, such as ISTDP (Intensive Short-Term Dynamic Psychotherapy), AEDP (Accelerated Experiential Dynamic Psychotherapy), IPT

(Interpersonal Psychotherapy) and DDP (Dynamic Deconstructive Psychotherapy). The *Psychodynamic Diagnostic Manual (PDM-2)* (Lingiardi & McWilliams, 2017) is a good example of an integration of all these approaches, which share certain basic assumptions about unconscious dimensions of the human mind. Identification with different orientations within psychoanalysis did not prevent contributors to the PDM from collaborating collegially on this project or on the first edition of the PDM (PDM Task force, 2006).

Psychoanalytic approaches vary in their focus: conflict, developmental issues, defenses, trauma, self-experience, and so on. They differ technically as well, expressing divergent understandings of some concepts (e.g., neutrality) and differing conceptualizations of issues in the general territory of countertransference, enactment, role responsiveness, and projective identification. ISTDP focuses on body language and levels of anxiety in the room, IPT focuses on relationships in the present; TFP addresses internal objects, primitive defenses, and transference; MBT emphasizes expanding the patient's capacity to imagine the separate subjectivities of others; and contemporary relational psychoanalysts look at binary enactments and strive to expand thirdness. All these clinical perspectives belong to the psychoanalytic family tree, and the work derives from and integrates many of them. It is integrative in another sense as well. I try to synthesize empirical research with contemporary psychoanalytic, philosophical, feminist, postcolonial, and intersectional writing.

Because of its emphasis on unconscious processes, my writing has consistently been considered psychoanalytic by its publishers. I have, however, tried to use words that communicate beyond the psychoanalytic community and beyond my preferred parts of that community. Because of my interest in connecting theory and research with practice, I have attempted to use language that is understandable and usable by people of all theoretical orientations. For example, even though the paper about collaborative reading of medical records addresses certain specific psychoanalytic considerations, such as whether or not this

practice might harm the transference, I hoped that the article would be useful to therapists trained mainly in cognitive and behavioral therapies. And I am pleased that it has indeed been picked up by a wide range of researchers interested in the effects of patient access to medical records and has been cited beyond the psychoanalytic community (Grenfeldt & Parkdahl, 2018; Kroon, 2016; Peck, Torous, Shanahan, Fossa, & Greenberg, 2017). Similarly, my paper on geographical narcissism addresses ramifications of the exploitation of the rural that may be meaningful outside a psychoanalytic or even psychotherapeutic frame (for example, in a general health context and in the context of training medical students in Australia). This paper has also been read and cited beyond the psychotherapeutic community, including by academic scholars in philosophy and planetary health ecology in Australia and Canada (Horwitz & Parkes 2019; Malatzky Cosgrave, & Gillespie, 2020), in rural health in Australia, Norway, Scotland, Iceland Canada and Sweden (Abelsen, et al. 2020; Couch, O'Sullivan, Russell, & McGrail, 2019; McGrail, O´Sullivan, Russell, & Rahman, 2020; O´Sullivan, Cairns, & Gurney, 2020; Reeve, Johnston, & Young, 2020) and in and in mental health in South Africa (Reid, 2019). It seems to have been effective in naming a pattern, theorizing about it, making implicit dynamics more conscious, and opening up professional and nonprofessional conversations on power dynamics. I hope that the concept of relative privilege will be similarly useful outside psychoanalytically oriented psychotherapy.

Psychoanalytic language, especially if made accessible, can be relevant to all kinds of therapeutic relationships, including non-psychoanalytically defined therapies. All human relationships may be seen as having unconscious aspects, whether or not those are acknowledged (Weinberger & Stoycheva, 2020). Shedler (2010) even argued that the effectiveness of non-psychoanalytic treatments comes from their unnamed psychodynamic elements, such as the therapeutic relationship (Safran & Muran, 2003) and the psychological centrality of attachment, a core psychoanalytic concept (Bowlby, 1969). Bornstein (2005)

argued that traditional psychoanalytic concepts have often been renamed and used by mainstream psychology.

In such an integrative project, I am aware of the need to be sensitive to dangers like unreflective eclecticism, superficiality, cherry-picking ideas, and not being theoretically stringent. But there is also some danger in excessive theoretical or methodological purity, in seeing all phenomena through one preferred lens. In trying to find shared patterns, in going beyond narrow competing labels, in avoiding contemporary temptations to rename phenomena with the aim of claiming originality, I hope that my approach embodies intellectual integrity. I hope it can be enriching to clinicians, who care less about technical orthodoxy than about practical treatment goals. Ideally, an integrative approach can illuminate deeper patterns that are have been described in different nomenclatures.

2.1.1. Theoretical Framework - Interaction between Clinic and Society

Concern with social power in the clinical situation led to my looking at psychoanalytic perspectives on the relationship between society and psychoanalysis. There is a long intellectual tradition of applying psychoanalytic understanding outside the clinic; analyzing, for example, politics, colonialism, and issues of history and social discrimination (e.g., Auestad, 2015; 2019; Coles, 1977; Fanon, 1952/2008; Frankel, 2019; Frosh, 2010; Hollway, 2006; Layton, 2016a; Maher, 2019; Mulinari, 2019; Sinclair, 2019; Young-Bruehl, 2013). Layton (2016a) wrote about psychoanalytic norms that affect group-level unconscious processes. Young-Bruehl (2007) addressed prejudice as a social defense. Auestad (2015) tried to understand the colonialist and racist unconscious through film and philosophy. Urwin, Hauge, Hollway, and Haavind, (2013) used object relations theory to explore the effects of culture on internalization processes in motherhood. Psychoanalytic perspectives have played a major role in literature studies, film studies, gender studies, anthropology, and

post-colonial and cultural studies (e.g., Auestad, 2019; Butler, 1990; Greedharry, 2008; Kristeva, 2004, as well as in applied psychoanalysis (Esman, 1998).

Freud (e.g., 1901, 1905, 1913, 1921, 1930, 1936, 1939) applied psychoanalytic ideas to religion, civilization, war, and other topics. He theorized about culture, group psychology, the darker sides of humanity (as in his eventual emphasis on aggression), and the lighter sides (as in his longstanding interest in jokes and unconscious puns). But he also did the converse, using his theorizing on culture to make sense of clinical material. In the next pages I discuss ways psychoanalysis may engage with issues of society and power. Then I return to the clinic.

2.1.2. Psychosocial perspectives

One connection between psychoanalysis and societal perspectives is the psychosocial tradition. Drawing from Lacanian, Kleinian, and Winnicottian theory (e.g., Bowker & Buzby, 2017; Frosh, 2010, 2015; Hollway, 2006), scholars in the United Kingdom have emphasized how psychology cannot be separated from its social context. This discourse has not been predominantly clinically oriented, but it offers a valuable perspective on how society and psychoanalysis are interlinked. For example, Hollway (2006) notes the usefulness of psychoanalysis to social psychological research: "Psychoanalysis can remind researchers of all the idiosyncratic ways in which unconsciously researchers will project their own issues onto participants, both in the face-to-face relationship and in data analysis." (p. 545).

The field of psychosocial studies applies psychoanalytic knowledge to a wide range of fields, including the arts, history, philosophy, social science, and politics (e.g., Auestad, 2015; Bar-Or & Bonwitt, 2019; Frankel, 2019; Frosh, 2010, 2015; Greedharry, 2008; Mulinari, 2019) An example of the creative use of psychoanalysis in this discourse is the work of Bar-Or and Bonwitt (2019), who through the improbable marriage of

psychoanalysis and architecture explored what they call “embarrassment zones” in Tel Aviv. Combining psychoanalytic ideas with the discipline of architecture, these authors explore how buildings and spaces affected by violence bear scars of trauma and shame. They theorize that the act of construction is also a reconstruction of the past that involves the repetition compulsion, denial, dissociation and discomfort.

Another example in this area is a contribution from Sinclair (2019). Inspired by Lacanian psychoanalysis and theories on de-colonization, she writes at the intersection of religion, history, de-colonization, and psychopathology. Her work de-pathologizes magical thinking and understands the devaluation of folk magic as a part of colonialism, asking why magical thinking and rituals in Christianity are somehow seen as more mature and less problematic than the “primitive and childlike folk magical practices” of the poor, the African, the outsider, the other, which are often seen as exemplifying primary process thinking.

Maher (2019) has theorized how colonialist racism colonized people´s minds such that many individuals from Zimbabwe began to lie about their heritage, saying they were South African. Auestad (2019) has looked into the social unconscious, connecting prejudices to the science of film and analyzing racist aspects of self-identified non-racist people through popular culture. This discourse is fascinating, and yet I have found it of limited value for conceptualizing concrete clinical interventions. While I also have theorized in some non-clinically applicable ways (e.g., Fors, 2019a – not included here) and in hybrid ways, addressing both clinical and societal phenomena (Fors, 2018b),[3] the focus of this dissertation is on clinical implications of social power relationships.

[3] I was interested to find this paper on a university syllabus under the heading of postcolonial writing.

Like the American relational scholars, contributors to the psychosocial studies discourse emphasize reciprocal influence; rather than framing issues as *individual versus social*, they acknowledge mutually interweaving aspects of influence. Frosh (2010) has written, "Psychology operates in a *social* field. It is not just a body of knowledge, but a branch of activity that has its own ideological and hence political investments – rather a different point of view from the one adopted by those who claim for it some kind of scientific 'neutrality'" (p. 191). He emphasizes, however, that psychosocial studies "is a fragile entity, perhaps reflecting the difficulty of maintaining the thinking-together of social and individual that are constantly pushed apart by fundamental ideological impulses of liberalism and late capitalism" (p. 193). From a perspective similar to my own, scholars in the psychosocial studies area see psychoanalysis as inherently embedded in a political and social context. But so far, they have articulated few implications for applied clinical work. While I have found some inspiration in this area, it is not the main theoretical engine of my own work.

2.1.3. The relational movement

Another psychoanalytic tradition that addresses power issues, society and politics is the relational movement that emerged in the United States in the 1980s (e.g., Aron, 1990, 1991, 1996; Benjamin, 1988, 1991, 1995, 1998, 2004, 2017; Layton, 2002, 2006a, 2006b, 2016a, 2016b; Mitchell & Aron, 1999, Samuels, 2006; Suchet, 2007; Slochower, 2013, 2017). Relational psychoanalysis arose from *within psychoanalysis*; one of its main concerns was to contextualize clinical psychoanalytic practice within questions of politics and society. The British psychosocial studies perspective and the American relational movement have much in common despite their differing intellectual origins.[4]

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[4] Thanks to Simone Drichel for helping me to reflect upon these topics.

Though the work is integrative, relational psychoanalysis is the psychoanalytic movement with which I feel the most intellectual kinship. Emerging in the United States via a seminal text by Greenberg and Mitchell (1983), the relational psychoanalytic tradition has been centrally concerned with issues of power and questions of ethics. It arose partly as a corrective to authoritarian models of psychoanalysis and versions that stressed interpretative accuracy (Slochower, 2017). Relational analysts see the therapeutic process as co-created by the subjectivities of both patient and analyst. Aron (1990) and others have called it a "two-person psychology" to emphasize the psychoanalyst´s subjective contribution to the process. They have questioned both the possibility and the value of neutrality (e.g., Aron, 1990, 1996; Benjamin, 1988, 1991, 1995, 1998, 2004, 2017; Layton, 2002, 2006a, 2006b, 2016a; Mitchell, 1984; Mitchell & Aron, 1999, Orange, Atwood, & Stolorow, 2001; Samuels, 2006; Suchet, 2007; Slochower, 2013, 2017).

Another relational concern has been with the "developmental tilt" of classical and object-relational analysis (Mitchell, 1984); relational analysts emphasize the patient's adulthood and question whether the patient has to regress to dependency in treatment. Patients are seen as equals in a "mutual but asymmetrical" relationship (Aron, 1991). The rejection of neutrality implied also the rejection of the ideal (or possibility) of the analyst's objectivity and thus opened discussion of how the therapeutic relationship is inevitably connected to the outer world and to sociopolitical matters. Issues involving politics, class, race, ethnicity, sexual orientation, and climate change have been in recurrent focus in the relational literature (e.g., Drichel, 2019; Fors, 2018b, 2019a; Layton, 2016b; Layton, Hollander, & Gutwill, 2006; Orange, 2017). Because of its attention to power issues and politics outside the clinic, some have even referred to the relational movement as "the ethical turn" in psychoanalysis (e.g., Drichel, 2018, 2019; Goodman & Severson, 2016; Orange, 2017).

> We reacted against the authoritarianism implicit in visions of interpretive accuracy; some also rejected the developmental tilt (Mitchell, 1984) embedded in ideas of parental (analytic) repair. Moderating our power and omniscience, we affirmed our patients' capacity to see us, to function as an adult in the analytic context. We rejected sharply tilted clinical models lodged in beliefs about the power of both interpretation and confrontation. Relational writers emphasized the mutative potential inherent in enactment. Unformulated experience, dissociation, and shifting self states shaped analytic process for both patient and analyst. Unpacking these dynamics required mutual exploration because we were implicated along with our patients. (Slochower, 2017, p. 283).

Similar critiques of orthodox versions of psychoanalysis for being homophobic, authoritarian, and dogmatic have come from other directions. The Norwegian psychologist and gender researcher Haavind (2003) wrote that being pro-feminist and *non-psychoanalytic* has been her way of attuning to ethics throughout her career. Her work addresses many of the issues with which relational analysts inside the psychoanalytic community have been preoccupied, but her solution to was to leave that community: "The non-psychoanalytic stance originated more than thirty years ago as a political protest against the paternalistic and dogmatic ways of doing psychotherapy" (Haavind, 2003, p. 35). "We saw the relationship between the therapist and the patient as significant for the process of change because the two parties could work as allies in developing shared understanding and personal confirmation" (p 37). Thus, orthodox authoritarian perspectives have been critiqued from both inside and outside psychoanalysis.

Both McWilliams (2000) and Killingmo (1997) have argued that most "classical" analysts were less authoritarian than such critiques depict, but there was evidently

enough truth in the stereotype to inspire these reactions against analytic rigidity. Many contemporary, well-respected theorists have multiple professional identities and connect to several communities and discourses. Nonpsychoanalytic feminist scholars (e.g., Haavind, 1982; 2003), and narrative therapists (e.g., White, 2007) have also addressed power issues in psychotherapy. There are also parts of the classical psychoanalytic perspective that includes analysis of power and social justice.

2.1.4. Classical perspective

As I have noted, the precedent of going back and forth between clinical discoveries and larger questions was set by Freud. Even though traditional psychoanalysis has often been framed as orthodox and not sensitive to issues of culture and power, I think that is not the whole truth. Freuds´ writing on jokes, slips of the tongue, religion, taboo, civilization, and the "narcissism of minor differences," among many others, have had major effects on clinical practice. His writing about the death drive seems to have been inspired in the context of the Second World War, and his writing about civilization (and its discontents) addressed the interpenetration of the clinical with the societal.

Some have suggested that Freud´s own experience in a hated minority during second World War influenced his theories (Gay, 1998; Gaztambide, 2015). As a Jew in the World War II era, Freud was a target for humiliation and subordination (Gilman, 1992). Gaztambide (2015) has argued that such experiences greatly influenced the development of psychoanalytic theory, as Jews became projection screens for Germany's disowned badness. Freud managed to contain such projections (Bion, 1963), and digest them, finally returning the projected badness to humanity in the form of a theory about the drives and defenses of all human beings. Others influenced by Freudian psychoanalysis have contributed to analyzing

social power issues in the clinical setting. Davids (2003, 2011) talks about internalized racist structure; Menzies (1960) and Young-Bruehl (2007) have each investigated social defenses.

2.1.5. Bridging society and the clinic

Sometimes it is hard to know what is inside versus what is outside the clinic. Just as individuals and cannot be separated from the culture in which they live; clinical practice cannot be separated from the surrounding society. There is ample evidence that we all tend to internalize messages from the larger society, not merely from our families of origin (e.g., Urwin et al., 2013). We can also exert influence on our culture. Similarly, the clinic and its context are interpenetrating (Fors, 2018a, 2018c). In discussing Young-Bruehl's work, Debiak (2019) notes that at some point, psychoanalysis stopped conceiving of patients' homosexuality as a pathology and began theorizing about homophobia as a social problem. In this shift, we began seeing society itself as the "patient":

> Young-Bruehl also draws on history, social psychology, sociology and other disciplines to critique not the homosexual or the trans person, but instead homophobia. Note this important shift. Young-Bruehl is critiquing and pathologizing homophobia, not homosexuality. (Debiak, 2019).

Contemporary contributors from several psychoanalytic fields belong to this intellectual tradition. Feminists such as Chodorow (1978, 1989, 2000), Kristeva (2004) and Butler (1990) have used psychoanalytic ideas to theorize about society, gender, and inner psychic life. So have psychoanalytic scholars in the anti-racist movement (e.g., Akhtar, 2007; 2014, Altman, 2006; Holmes, 1992, 1999; Tummala-Narra, 2015, 2016). But, even in the "old days," psychoanalysis was more politically oriented than is often acknowledged. Gaztambide (2012, 2015) paid attention to the nuances, showing how Freud was more

pragmatic and flexible than he is often described, and his caseload more diverse than often depicted; he calls attention to his efforts to develop pragmatic, helpful therapies for poor people. Freud experimented with more active therapy methods, advocated psychoeducation, and was a pioneer in social activism (Danto, 1998; Freud, 1919/1955b; Gaztambide, 2012). In Vienna and Berlin in the 1920s, for example, Freud both morally encouraged and financially supported the development of pro bono clinics (Danto, 1998; Freud, 1919/1955b). Many psychoanalysts in that era were driven by motives of social responsibility (Danto, 2000).

2.1.6. Social justice concerns in nonpsychoanalytic psychology

Psychology and psychotherapy outside the discourse of psychoanalysis are not without a tradition of taking up social justice issues. In the paradigm of critical psychology, for example, Prilleltensky and Nelson (2002) have addressed how psychology may be used practically, with a social justice aim, but also with more discursive purposes, to deconstruct norms of normalcy that can operate oppressively. This focus echoes that of some radical lesbian feminist writing (Kitzinger & Perkins, 1993) that critiques the normalcy dimension of psychotherapy, in which the goal is to change people´s minds instead of changing the societal forces that have caused their suffering. The participatory action research field proposes collaborative interventions in the service of democracy and social justice (e.g., Brydon-Miller, 1997; Frisby et al., 2009); feminists in the cognitive-behavioral field have made important contributions to power-sensitive ways to conduct therapy (Hays, 2016; Brown, 2004; Worell & Remer, 2003); and scholars from the narrative therapy tradition (e.g., Haavind, 2003; White, 2007) have done so as well.

2.2 Theoretical Framework – Theory Integration: Theories on Privilege and Prejudice

My work examines power themes in the clinical encounter from several perspectives and suggests that there are multiple ways to look at power in psychotherapy. In my fourth paper (Fors, in press), I discuss four common types of power issues in psychotherapy: professional power, transferential power, socio-political power, and bureaucratic power.

As these concepts are explored in more detail in that text, I provide here a very short definition of terms. By *professional power*, I refer to the inherent power in an asymmetrical relationship in which the therapist has formal responsibility, knows more about the patient than vice versa, gives the patient a diagnosis, writes a medical record, gets paid, and so on (Aron, 1996). By *transferential power*, I refer to power themes emerging because of unconscious parts of the relationship, such as emotional dependency expressing itself in transference (e.g., Freud, 1915; Greenacre, 1954). By *socio-political power*, I refer to the whole range of power issues embedded in questioning normativity, neutrality, intersectional issues of gender, race, age, class, sexuality, and similar issues; that is, unconscious aspects of politics and especially the politics of pathologizing. By *bureaucratic power*, I refer to the operation of complex organizational systems such as those governing access to health care or disability status.

All my texts address these four dimensions to different degrees. For example, the paper on collaborative reading of medical records explores both the professional aspect of power asymmetry in which one person writes about the other, and transference issues that may emerge when patient and therapist read the medical record together. The normative aspect of diagnosis (along with the value of discussing it with patients) is addressed, as well as the bureaucratic aspect of how documentation is a tool for people to get their rights in a complex health care system. The paper on geographical narcissism addresses mostly socio-political power aspects of urban colonization and consequent biases that may affect

psychotherapy, including the underlying assumption that urban norms are healthier and rural norms less mature. But that paper also addresses bureaucratic aspects of access to treatment, including what is seen (or not seen) as professional competence.

In the third paper (Dresecher & Fors, 2018), Jack Drescher and I address power involving the pathologizing of minorities and discuss whether minority stress itself should be a diagnostic category. We take up aspects of power coming from socio-political issues that arise in the transference; in particular, we discuss how a shared minority status may be enacted between a patient and a therapist. Thus, while we mainly address power at a socio-political level (that is, pathologization or de-pathologization of minority people), we consider other kinds of unconscious power, such as transferential power, as well.

In the fourth paper, via a discussion of the case of "Sonja," I try to illuminate different aspects of power in a treatment setting. Although the central power dynamic in this paper is bureaucratic power, all four types of power make their appearance in this text.

In the final text about relative privilege (Fors, 2020b), I address mostly how social power issues, both conscious and unconscious, inevitably come into the consulting room, and how they increase or decrease the impact of the first power dimension (normal power asymmetry based on the professional relationship). I also investigate social power in transference and countertransference and the power of internalized unconscious racism, sexism, homophobia and other attitudes related to power differentials (e.g., Davids, 2003, 2011; Fanon, 1952/2008; Layton 2002, 2006a, 2006b; Weinberg, 1972). I comment on how social power is enacted (e.g., Bourdieu, 1984; Butler, 1990; Persson, 2012), consciously and unconsciously.

In the work, I keep several perspectives in awareness at the same time, as I find them differentially useful in illuminating different themes. For example, I see internalized racism as an attachment issue (Fonagy & Higgit 2007), as an introjection that is

disowned by projection (Akhtar 2014), as an inner structure (Davids, 2003, 2011), as part of a normative unconscious (Layton, 2002, 2006a, 2006b), as a social defense (Young-Bruehl, 1996), and as an ineradicable aspect of society (Yancy, 2015). Sigmund Freud´s drive model (e.g., his 1930 theorizing about competition) and Anna Freud´s 1937 concept of "identification with the aggressor" address aspects of the same phenomena. All these perspectives represent different versions of psychoanalysis (attachment/mentalizing; object-relational; relational; ego-psychological; critical whiteness; drive; ego defense). I find them all useful and not mutually exclusive or in inevitable competition.[5] Writing as a philosophical pragmatist, Goldberg (2002) similarly stresses the clinical need to be open to plural versions of psychoanalysis:

> Although there may be a good deal of disagreement, it does seem to be the case that differing schools of psychoanalysis help many people, and they seem to do so in roughly equal numbers. To be sure, one particular patient may not profit at all from one approach while doing quite well in another, but no school of treatment is a complete bust or can claim one hundred percent effectiveness. They all work. None can trumpet its superiority over the other based on a track record of cure or improvement or patient appreciation. We presently have no comparable statistics, so we rely on folklore. Therefore, the relevant question is why and how such diverse, and even oppositional, ways of practice can enjoy relatively equal effectiveness.
>
> Unfortunately, that question is usually either dismissed or not even asked. The preferred question we typically hear is how so many thoroughly erroneous or wrong-headed approaches have managed to fool so many people!

[5] Finding which of these theories is *most* accurate, for *which* clinical situation, would be a different kind of project, with a less general clinical applicability than I have attempted.

> There is a good deal of attention paid to issues of deviance or difference, rather than to those of consensus. We tend to listen to others while marshaling an argument, rather than being open to what may be beneficial for a particular patient. (p. 244)

Hence, drawing on different sources and theories that address power and privilege offers several perspectives that might overlap and supplement one another. There follow some theories on privilege and power that I use in the work.

2.2.1. Empirical studies on Privilege and Internalized Dominance

Several empirical studies (e.g., Galinsky, Magee, Inesi, & Gruenfeld, 2006; Kraus et al. 2012) have found a correlation between having power and a tendency not to take others' perspectives. Such findings are consistent with the research of Piff, Stancato, Côté, Mendoza-Denton, and Keltner (2012), who noted that higher social class predicts unethical behavior such as lying, cheating, and stealing, and that upper-class individuals are more likely to have narcissistic features (Piff, 2014). It has also been suggested that men as a group are more likely to have narcissistic features than women (e.g., Grijalva et al., 2015; Darvishpour, 2002) and that male scientists tend not to respect evidence of gender bias within science (Moss-Racusin, Molenda, & Cramer, 2015) – a phenomenon that may represent both a denial of privilege and a devaluation of female researchers. Because the privileged have the power of definition, the topic of how privileges tend to make us less ethically oriented is seldom addressed. Instead, immoral behavior tends to be projected onto the lower classes. For example, Johannisson (1994) describes how the term kleptomania was invented in the late 19th century to distinguish the mob's immoral stealing from the "classier" thievery that upper-class ladies committed at the new, tempting shopping centers built in that era. As a

parallel, immoral behavior is also often projected onto other minorities, such as common stereotypes of Jews as greedy, black people as lazy, and gay men as sexually promiscuous. Contemporary ways of explaining unfairness in Western culture often include references to one's own talent, diligence, or intelligence. Upper-class Westerners tend to attribute social differences to their own choices, autonomy, and hard work[6] (Kraus, Piff, Mendoza-Denton, Rheinschmidt, & Keltner, 2012).

2.2.2. Privilege and Drive Theory

Starting with Freud, several writers influenced by his drive-conflict model have explored the psychology behind privileges. In *Civilization and Its Discontents*, Freud (1930/1955a) wrote about human tendencies toward greed, competition, and aggression. He believed that simply changing the outer circumstances of hierarchy (e.g., by eliminating major differences of wealth) would not change people's inner primal aggressive drive, and he argued that we would still have a tendency toward the "narcissism of minor differences." He described civilization as an attempt, but never a fully successful attempt, to tame and counteract our primitive aggression through culture:

> It is impossible to overlook the extent to which civilization is built up upon a renunciation of instinct, how much it presupposes precisely the non-satisfaction (by suppression, repression or some other means?) of powerful

[6] As an interesting parallel, the list of religions, myths, fairy tales, and monarchies in which power and privilege are seen as sent directly from a God, or as a reward for good behavior in a previous life, is long.

> instincts. This "cultural frustration" dominates the large field of social relationships between human beings." (Freud, 1930/1955a, p. 97)

Freud's view is supported by some experimental studies (e.g., Galinsky et al., 2006; Kraus et al., 2012; Piff, 2014; Piff et al., 2012) suggesting that there is no simple solution to the problem of inequity. It appears that the more privilege one has, the more blind one becomes. Still, Galinsky and colleagues (2006) found that even small exposures to training in perspective-taking can reduce the effects of privilege blindness, greed, and entitlement; similarly, Piff, Kraus, Côté, Cheng, and Keltner (2010) found that even a small exposure to compassion manipulation (e.g., seeing a video of a child in poverty) can increase prosocial behavior among people of the upper classes.

Some evidence suggests, however, that it is easier to awaken ethical consciousness in people who do not identify with privileges. For example, in a study on social norms, environmental consciousness, and towel reuse at a hotel, Terrier and Marfaing (2015) found that people staying in standard rooms, when exposed to normative messages about the hotel's pro-environmental towel reuse program, were easier to recruit to pro-environmental practices than those staying in superior rooms. I infer from their conclusions that work toward greater awareness of power differentials and their implications is continuous, never completed, and never a waste. Freud (1930/1955a) wrote,

> Ethics is thus to be regarded as a therapeutic attempt—as an endeavor to achieve, by means of a command of the super-ego, something which has so far not been achieved by means of any other cultural activities. As we already know, the problem before us is how to get rid of the greatest hindrance to civilization—namely, the constitutional inclination of human beings to be aggressive towards one another. (p. 142)

2.2.3. Microaggression Theory – Privileges Construed as "Offensive Mechanisms"

Another way of viewing the relationship between privilege and aggression appears in psychological literature on microaggressions. This work is not related to Freud's concept of aggression as a drive, but instead refers to how people feel when subject to prejudice or insensitivity. Growing out of the antiracist movement, the term *microaggression*, coined by Pierce (1970), [7] addresses the phenomenon wherein people in a subordinated group (in the original theory, people of color, but now extended to include sexual minorities and women) experience almost invisible and very subtle verbal behavioral humiliations from people in a normative or dominant group (Pierce, Carew, Pierce-Gonzalez, & Wills, 1978; see also Nadal, Rivera, & Corpus, 2010; Sue, 2010; Sue et al., 2007).

Pierce (1970) originally described microaggression as an *offensive mechanism*, contrasting it with the psychiatric concept of defensive mechanisms. The concept emanates from the perspective of the victims of the painful behaviors of others. It does not really explain the origin of the microaggressive activity in the psychology of the privileged ones. For example, it does not describe *in what way or why* a privileged person would be aggressive toward an inferior. Ignorant behavior is not necessarily driven by aggression. Perhaps an aggressive intent is inferred by those who are the objects of insensitivity and prejudice, since repeatedly being invalidated, assaulted, or insulted constitutes cumulative trauma (Khan, 1963) that engenders cultural mistrust (Sue, 2010) and easily may be experienced, consciously or unconsciously, as deliberately aggressive.

Sue et al. (2007) note three different forms of microaggression: microassault, microinsult, and microinvalidation, all of which are often seen by their perpetrators as *innocent blunders* that have to be forgiven by the subordinated, who should strive not to be

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[7]When Black Psychiatrists of America was founded in 1969, Pierce was its first elected chair (Pierce, 1973).

seen as overreacting. One frequent outcome of microaggressions is confusion in those who receive them about whether they really occurred. Sue and his colleagues point out that because of the object's confusion about whether it really happened, microaggressive behavior can be more problematic than overt racism. It is described as so subtle that senders of microaggressive messages are not always aware of insulting the other, and when confronted with their behavior, they often minimize it, construe its effects as simply a coincidence, or insist they are the victims of a misunderstanding (cf. DiAngelo, 2018).

2.2.4. Privileges as Defensive Mechanisms

In psychoanalysis, the dynamics of prejudice have been theorized from a different perspective. Young-Bruehl (1996, 2007) described prejudice as a *social defense*, stressing that there is a tendency to overgeneralize similarities among specific prejudices when there are actually several versions of the phenomenon. She stated that in the history of understanding prejudice, there has often been a narrow interest in exploring only the prejudice by which a particular student of it has been victimized or overexplaining other prejudices from the specific angle that one is interested in, as the theorizer tries to find the one root to describe them all. According to Young-Bruehl, the sexism that strikes white women, African American women, and Asian women, respectively, is not equivalent. Nor is racism toward Jewish individuals and people of color. The prejudice of an adult is not psychologically the same as that of a child. And prejudice against black women differs, depending on whether it comes from white women, white men, or black men.

Young-Bruehl (1996, 2007) sketched three main variants of underlying dynamics behind prejudices: the *hysterical* type, occupied with hierarchy and pleased to have subordinated groups on whom one's own sexuality can be projected; the *obsessional* type, with paranoid features and fear of contamination, whose fantasies of purification include

eliminating the "bad object"; and the *narcissistic* type, who devalues others and idealizes the self. She stressed that narcissism is the most widespread of the prejudices and is a strong factor in sexism. She described antisemitism as often obsessional, classism and racism as often hysterical, and homophobia as perhaps including all these types of dynamics. She criticized the feminist movement for minimizing the narcissistic nuances of sexism. In parallel, Altman (2005) suggested that a *manic* defense lies behind society's absence of, or at least failure of, social responsibility.

2.2.5. The Stereotype Content Model

In the social psychology tradition, Fiske, Cuddy, Glick, and Xu (2002) also noted the heterogeneity of prejudice. They suggested that we tend to see outgroups as stereotypes along two dimensions: warmth and competence. We tend to feel paternalism and pity toward, for example, the elderly, housewives, and disabled people (warmth and low competence), but more competitive contempt toward homeless individuals, poor people, and drug addicts (cold and lacking competence). They argued that we attribute competence and warmth to people we admire, and coldness and competition to those we find competent but at the same time view with prejudiced jealousy. According to Fiske et al. (2002):

> Not all stereotypes are alike. Some stereotyped groups are disrespected as incapable and useless (e.g., elderly people), whereas others are respected for excessive, threatening competence (e.g., Asians). Some stereotyped groups are liked as sweet and harmless (e.g., housewives), whereas others are disliked as cold and inhuman (e.g., rich people). (p. 878)

These ideas comport with the findings of the disability researcher Davis (1995), who noted that the disabled tend to be viewed with pity.

2.2.6. The Internalized Racism Model

Inspired by Kleinian psychoanalysis, Davids (2003, 2011) emphasizes the inevitability of internalizing the societal power structure. This internalization has the function of making it possible to draw off primitive anxiety by having racialized objects on whom to project denied aspects of self. He suggests that primitive internalized racism will become activated in situations of anxiety or uncertainty; "tragically, however, it is also this fact that can, under external conditions of intense anxiety and uncertainty, turn a perfectly good neighbour into a racist enemy" (Davids, 2003, p. 9). His ideas about the inevitability of internalized prejudice are consistent with the observation of Fonagy and Higgitt (2007) that threats to attachment security predictably elicit prejudice and Layton's (2002) postulation that we all have a heterosexist unconscious.

2.2.7. Normal and Pathological Versions of Prejudice

Parens (2007) differentiated between *benign* and *malignant* prejudice, stating that benign prejudice is a part of normal child development and attachment, and constitutes a way to discriminate feeling safe with group members from having ordinary anxieties toward outgroups. Fonagy and Higgitt (2007) similarly distinguished between *normal* and *malignant* prejudice, seeing normal prejudice as a secure-base phenomenon, meaning that we tend to navigate toward what is safe and familiar to us. They described malignant prejudice as reflecting disorganized attachment and paranoia, suggesting that, in Klein's language, it constitutes a massive projective identification. These observations resonate with the findings of Ciocca and colleagues (2015), who, in a study of 551 Italian students, found that psychoticism, immature defense mechanisms, and fearful attachment style correlated with higher homophobic attitudes.

Akhtar (2007) organized prejudice into six different levels of manifestation, from mild to severe, with unmentalized xenophobia, benign provincialism, and unquestioned self-acceptance on the mild end of the scale, and paranoid megalomania and messianic sadism (with organized violence, murder, and genocide) on the extreme end. Akhtar (2014) also suggested that the phenomenon of unmentalized xenophobia occurs at the cultural level: Privileged groups refuse to mentalize the minority, using it as a target for paranoid and depressive anxieties. The majority[8] thus unconsciously need a minority group on whom to project its disowned badness. According to Akhtar (2014),

> Almost everywhere one looks, one finds that at the conscious level, the society feels unease at the existence of minority groups within it and strives to deny their presence. At the unconscious level, it longs for a minority group since that can be used as a "container" (Bion, 1967) for its own unmetabolized concerns. (p. 139)

Akhtar (2014) challenged idealized Western culture by calling attention to its tendency to minimize the West's "colonial exploitations, barbarianism of slavery, bloodshed of wars, and dreadful sin of the Holocaust" (p. 144). Akhtar's work suggests that the inverse of projecting badness onto devalued groups is the tendency to idealize the normative self. In Western cultures, heterosexuality and the heterosexually parented nuclear family are widely

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[8] Akhtar (2014) problematized the words *majority* and *minority*, emphasizing that they do not always refer to numerical facts but to social power. Men are numerically fewer than women but are never labeled as a minority; Whites were fewer than Blacks in Apartheid-era South Africa but never had minority status, nor did British colonizers of India. He added that, "Arabs who constitute only 20% of the world's Muslim population are not referred to as a minority among the followers of Islam" (Akhtar, 2014, p. 137).

idealized, even though domestic violence is a problem of significant magnitude, and the conventional family seems to be one of the most dangerous places for a woman (World Health Organization, Department of Reproductive Health and Research, 2013).

2.2.8. Privilege as Detachment

From a postmodern point of view, Layton (2002, 2006a, 2006b) emphasizes how privileges are taken for granted in the split between privilege and nonprivilege. She suggests that the normative Western unconscious includes a detachment from context, politics, and society, and she argues that cultural norms celebrating individual freedom dissociate us from our vulnerability and connections with others. Layton's theories are supported by empirical research showing that privilege and power tend to make people act selfishly and to feel less empathy with suffering (e.g., Liu & Huang, 2015; Piff et al., 2010), to feel entitled (Piff, 2014), or to be less connected to others (Kraus et al., 2012). Walls (2006) suggests that politics and social justice have implications for our work as therapists, urging that we try to make conscious the political unconscious along with other areas that are kept out of awareness.

2.2.9. Privilege Melancholia?

Layton's (2002, 2006a, 2006b) concepts of the normative unconscious and dissociation from vulnerability resemble to some degree another postmodern contribution, Butler's (1995) notion of *gender melancholia*. Gender melancholia is a theorized process in heterosexual development: Heterosexually oriented individuals are assumed to deny (or give up) the option of same-sex attraction, without grieving the possibility for same-sex love or desire. Butler posits that this might result in gender melancholia, a grief that is denied and never acknowledged. In contrast, homosexual people usually have to acknowledge and mourn their sexual orientation, as the culture signals that a heterosexual outcome is preferable and that a

homosexual identity is something to grieve, admit, and come to terms with. This use of the term is perhaps unfortunate, as it can be mistakenly equated with the term *melancholia* as used by Freud (1917/1955c), who conceptualized it as grief that turns into self-attacking, guilty introjects that prevent normal mourning. Butler (1995) instead talked about totally denied grief.

Privileges seem not often to come with the self-criticism from which Freud's melancholic patients suffered. Only some people feel guilty, self-critical depression about behaviors such as colonization, slavery, and the exploitation of women. When people admit no regret about prejudiced behavior, they seem instead to evince a denial of guilt, whose symptoms include shamelessness, problems with connections to others, and problems with dependency. This formulation resembles more the clinical concept of narcissistic depression (as contrasted with self-attacking melancholia) and is supported by research (for an overview, see Grijalva et al., 2015) suggesting that males tend to be more narcissistic than females and that Young-Bruehl (1996, 2007) was perhaps insightful in citing the narcissistic dimension of sexism. It also resonates with Layton's (2002) hypothesis that it is more common among men than among women to have an issue with dependency and with Piff 's (2014) research on how privilege tends to breed a sense of entitlement and other narcissistic traits.

Despite this potential confusion of terms, Butler's concept of melancholia has inspired many theorists. Frosh (2006) stated, for example, that melancholia is a symptom of our time, as the metaphors of psychoanalysis have evolved from hysteria, to narcissism, into melancholia, a term used in the postmodern turn of psychoanalysis to describe disconnection and denied parts of self and society. From a postcolonial perspective, the term *melancholia* has also been used in political science and cultural studies discussing the Western cultural inability to grieve the colonial past (e.g., Gilroy, 2006). Eng and Han (2000) described the process of migration and assimilation as *racial melancholia*. They argued that melancholia

coexists with mourning: “This continuum between mourning and melancholia allows us to understand the negotiation of racial melancholia as conflict rather than damage” (p. 693). They focused on those who mourn or suffer melancholia about *not* having the privileged position, as would be the case for a gay person who is coming to terms with not being heterosexual.

2.3. Theoretical Framework – The Unconscious

Because the concept of the unconscious is central to all psychoanalytic models but is defined differently by different authors, I want to clarify how I use the term. In addressing unconscious dynamics, I have been integrative, as I elaborated earlier. In psychoanalysis there is not one concept of “the unconscious,” but several. Klein emphasized unconscious phantasies connected to an object; Kohut focused on conscious, preconscious and unconscious self-representations; and Freud himself changed his theory several times (Frank, 2007). Psychoanalysis has evolved from addressing repression to focusing on other defenses, notably dissociation. As noted above, Frosh (2006) has argued that the metaphors of psychoanalysis have evolved from those pertinent to hysteria, to those of narcissism, to the area of melancholia.

There is also a tradition in cognitive science of looking at the “normative” unconscious or “implicit” processes, as the following long section from Stoycheva, Weinberger, and Singer (2014) articulates well:

> Thus, the two terms (*unconscious* and implicit) are roughly equivalent and are mostly differentiated by who is writing and for whom. They are functionally (as opposed to theoretically) differentiated in that the work of nonanalytically oriented researchers and theorists does not focus on

> the dynamic unconscious that has attracted the lion's share of attention in psychoanalytic circles, but rather on what we here term the *normative* unconscious—unconscious processes not motivated by conflict, defenses, or deprivation experiences . . . . We will use the terms implicit and normative unconscious to refer to those unconscious processes that are not dynamically and conflictually driven. This may parallel early developments within psychoanalysis. Fayek (2005) argued that Freud's original conception of the unconscious was of a system unconscious – non-repressed in its nature – but that the idea of the dynamic unconscious later became the focus of psychoanalysis . . . . Empirical data collected in the past two or three decades have supported this view, pointing to the importance of implicit/unconscious processes in people's decision making, affective responding, and interpersonal communication. Studies in social psychology and cognitive neuroscience have been especially fruitful in illuminating normative processes in what has come to be termed *causal attributions, implicit memory, implicit learning, affective primacy*, and *automaticity*. Each of these domains has applications to clinical work and to psychoanalytic theory. (Stoycheva et al. 2014, p. 101)

As I write about unconscious dynamics in internalized privileges and internalized subordination (mostly in texts two, three and five), and about how they might play out in interaction between therapist and patient, I mean both the dynamic (repressed or kept away by other defenses) unconscious and the non-repressed unconscious (Fayek, 2005; Frank, 2007; Stoycheva et al. 2014; Weinberger & Stoycheva, 2020). The non-repressed unconscious is not out of awareness because of emotional loading, but it is still unknown to

us. For example, causal attributions, implicit memory, implicit learning, affective primacy, and automaticity are areas of unconscious process that do not include repressed/dissociated or otherwise defended-against material.

In addition, I address the dynamic level of the psychoanalytic unconscious, as some of it may be out of awareness because of defenses. For example: even if a clinician rationally acknowledges that a situation of relative privilege exists, where privilege favors the therapist, and even if she acknowledges that it might be possible for her to have prejudices against a minority patient, seeing internalized racism in herself may be painful enough to provoke disowning defenses such as denial, dissociation, or reaction formation.

Sometimes these concepts overlap. It is not always clear what is part of the non-repressed unconscious as opposed to the pre-conscious part of the mind. In paper II, about urban biases in psychotherapy (Fors, 2018b), as well as in the work on relative privilege (Fors, 2018a, Fors 2020b), I invoke the concepts "unthought known" (Bollas, 1987) and "unformulated experience" (Stern 2003), as I appreciate their attention to what is unreachable not because of defenses, but because it is either implicit knowledge (Stoycheva et al. 2014) or belongs in the realm of dynamics that are pre-conscious and therefore reachable. It may also be that psychic material in the non-dynamic unconscious of some people is part of the dynamic unconscious in others. The naming of urban colonization of rural areas, for example, may awaken a new awareness generally, but in some people, it may not provoke unconscious conflict (non-dynamic unconscious), whereas in others, such a formulation may be met with denial or other defense.

Layton (2002, 2006a, 2006b) writes about the normative unconscious as the dynamic unconscious, built upon dissociation, and Davids (2003, 2011) addresses internalized racist structure as an unconscious phenomenon. The writing thus uses many relevant psychoanalytic concepts and assumes both overlap and interpenetration.

3. Methods and Methodological Challenges

My superordinate project was to explore, to generate theory from clinical experience, to integrate theories on power, and to interpret their implications for psychotherapeutic practice. My abiding concern involved all the nuances of "how." In this section I write about my two main methods: *traditional literature review* and the *case study tradition*. I come back to the theme of feminist ethics while discussing autotheory and philosophy of science. In this section I also address methodological challenges and the limits of my work.

The study depends on two methods: *traditional literature review* and the *case study tradition*. I try to formulate scientific hypotheses by extracting them from experiences in the clinic and also to infer and demonstrate how research and abstract theory on power relations can be translated into concrete clinical interventions. I try to synthesize knowledge from empirical research with knowledge from experience, implicit learning, and literature on theory. In this effort I have found useful the model of types of knowledge developed by Jesson, Matheson, and Lacey (2011, p. 17):

Types of knowledge

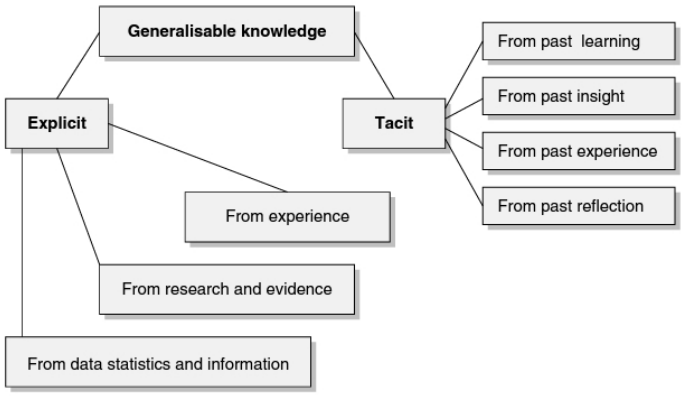

Figure 1. Types of knowledge. From *Doing your literature review. Traditional and systematic techniques* (p. 17), by J.K. Jesson, L. Matheson and F. M. Lacey, 2011, London: Sage Publications Ltd. (Reprinted with permission.) Copyright 2011 by Sage Publications Ltd.

The illustration (figure 1.) shows the confluence of sources to generalizable knowledge and names explicit knowledge from experience, research and evidence, and from data, statistics and information, side by side with more tacit knowledge such as past learning, past insight, past experience and past reflections. Jesson et al. (2011) emphasize that all these types of knowledges are possible resources in generating generalizable knowledge. Part of my goal is to address power dynamics that are not conscious but are often intuitively recognizable once they are named; that is, dynamics that may be simultaneously obvious and invisible. This position is consistent with empirical research on the nonconflictual unconscious, or implicit processes (Stoycheva et al. 2014; Weinberger & Stoycheva, 2020) and with the early thinking of Polanyi (1958) (see also Grant, 2007) and Bernhardt (2019). Further, I think this approach comports with McWilliams´ (2020) observations about the "psychoanalytic ethos."

3.1. Traditional Literature Review

Traditional literature review, also referred to as "critical literature review" or "traditional narrative review," involves not only finding what is already written but also synthesizing, inferring a critical approach, pointing out contradictions, exploring ideas, discussing implications, and presenting a fresh perspective. Jesson et al. (2011) emphasize that it should not be a simple summing up but should include an interpretation. In the traditional literature review, "subjectivity is implicit" (ibid, p. 73). In contrast to the *systematic literature review,* in which one searches databases by key words and thereby structures the choice of literature in a specific way, in a traditional literature review, a topic is pondered from different angles following the interest and passion of the writer. In my own case, since I wanted to translate abstract theory into practical, applied work with clients, and then to investigate power issues

in the clinic and take my observations back to the level of theory, the form of the traditional literature review suited my needs best.

My first paper had a slightly more structured style in approaching the literature on shared records, but otherwise, that process could describe all of my work. I essentially vacuumed both PsychInfo and PubMed for papers on empirical studies on open psychiatric records (and found only a few). Mostly, the literature review style involved following my interests, reading volumes of papers, digging into the reference lists of my favorite articles, digging deeper, comparing theories, reading and reflecting on empirical research on topics related to those I was investigating, coming back to the clinic and to my own life experiences, and sometimes testing out hypotheses with students, who gave me wise and curious questions in return. Then I would repeat the process, digging into even more reference lists, searching for meaning, identifying more questions than answers.

Each time I discovered a new field that seemed to have relevance to the power issues I was trying to understand and describe I tried to read enough to be sure that the papers I had found were part of a respected field, not just one or two articles claiming to be representative of some larger discipline. Despite issues that have been identified as inherent problems in this approach, traditional literature review has been considered a legitimate research methodology: “The main challenge to the traditional style is based on a critique of the process. Critics assert that the design and method for a traditional review is too open and flexible” (Jesson et al., 2011, p. 24).

Flexibility can be construed as both the weakness and the strength of this method. The creativity and curiosity involved in developing and exploring ideas, generating hypotheses and theories, identifying research gaps, discussing contrasting discourses, and synthesizing knowledge into something new become possible through a method in which the choices of the investigator are honored over the structure of the design. The down side

includes the risk of cherry-picking data and choosing literature on the basis of personal prejudice, or ignoring ideas at variance with one's own, whether such blindness involves an intentional political agenda or an unintentional conformational bias.

The effort to minimize such contaminations included reading in great depth and breadth and consulting multiple sources when covering new topics. I tried to be open to competing perspectives. Given that human beings have inevitable conformational biases, however, I cannot make the naïve claim to be totally neutral (cf. Goldberg, 2002). Owning one´s preconceptions and limitations seems to me more consistent with both research ethics and feminist ethics than defensively seeking total objectivity. Relevant to this choice, some eminent psychologists supporting qualitative research (e.g., Gergen, 2015) have masterfully critiqued the assumption that science can ever be entirely neutral or antiseptic. I have addressed the problem of bias by being open about my background and about those prejudices of which I am conscious, rather than claiming objectivity.

3.1.1. Precedent for using literature review and case studies

Contemporary philosophers of science question whether conventional empirical research is the only legitimate avenue to knowledge. The American Psychological Association has, at various points, considered qualitative inquiry, case study, theory development, and phenomenological study to be valuable as well. APA recognizes both qualitative and quantitative methods (as in its Division 5). (See also American Psychological Association, 2020). The Society for Theoretical and Philosophical Psychology (Division 24) is an official part of APA.[9]

[9] Hypothesis-generating and case-based dissertations have been previously acceptable to the University of Oslo for the degree of dr philos (for example, Joranger, 2015).

Such precedents follow the body of work from philosophers of science (e.g., Reichenbach, 1938/2006) who distinguish between the context of discovery and the context of justification in science, seeing both contexts as critical to scientific activity. The eminent American educator Ernest Boyer (1990) posited four types of scientific scholarship: the scholarship of discovery, the scholarship of integration, the scholarship of application, and the scholarship of teaching. The *scholarship of discovery* expands on the well-established body of science; for example, to develop new models, uncover new knowledge, or synthesize existing knowledge in new ways. Such scholarship to develop theory coexists with the more classic tradition of *hypothesis-testing*. The *scholarship of integration* involves interpreting and bringing new insights to original research, noting intellectual patterns, and making connections within and across disciplines. *The scholarship of application* involves finding new ways in which existing knowledge can be used or identifying new intellectual problems that arise in the process of applying prior knowledge. I would argue that my work comports with Reichenbach´s (1938/2006) context of discovery and Boyer´s (1990) scholarships of discovery, integration, and application.

3.1.2. The criterion of falsification

In all submissions, I have referred to empirical findings in all areas where they were available. The theory-generating work is built upon prior theoretical contributions as well as on empirical findings from, for example, studies in social psychology. The fact that the work is theory-generating does not mean that the conclusions are not testable and potentially falsifiable. Empirical scientists can do studies that test whether the model proposed in paper V in fact a useful way of thinking about relative power in a clinical dyad. It is possible to examine empirically, for example, whether clinicians and/or patients can identify these four suggested patterns; it is also possible to film clinical sessions to see whether the dynamics I

have posited are evident to raters, and so on. Such studies are, in fact, already emerging. In their dissertation in clinical psychology at Lund University, Johansson Huamán and Andersson (2019) are investigating the "dyad of privilege favoring the patient" to see if the proposed patterns identified in the monograph are relevant to young clinicians working with older patients. I think it would not be hard to develop scientific studies of urban bias, the topic of the second submission, in any of the ingenious ways in which researchers have studied unconscious racism, sexism, or heterosexism.

The main hypothesis of my (co-authored) first paper can be tested as well. It is an empirical question whether collaborative reading of medical records would contribute to better clinical outcomes. There are some research findings, cited in that article, relevant to our overall recommendation about letting patients, even severely disturbed ones, have access to their medical files and also have the opportunity to discuss them with their therapists, but more study is necessary. Paper III and paper IV are less testable in a classical empirical way, even if it would be possible to interview clinicians about their experiences or to film sessions. They are both case papers, suggesting themes that might occur when both therapist and patient are from a minority background (Drescher & Fors, 2018) and emphasizing that there are multiple power themes at play in treating patients, including bureaucratic power (Fors, in press).

That said, there is ongoing controversy within science about whether the positivistic position (Popper, 1963) is the only valid, scholarly, scientific position (e.g., Jesson et al., 2011). The scientific status of the field of philosophy has seen a parallel debate. Williamson (2000, 2018), for example, frames philosophy clearly is a science, but not as a natural science. He points out that not all – mathematics being a relevant exception – rely on traditional experimentation. This discussion is extensive and beyond the scope of this work, but many philosophers of science would regard a theory-generating work as scholarly and

scientific even if not all parts of it are immediately testable. (Einstein's work is often cited to exemplify this position.) I believe that some of my work lends itself to traditional empirical testing, and some does not, at least currently. (For more context, please refer to the radio debate between Tännsjö and Ruin (Mogensen & Lunderquist, 2016, 25 September) and the controversy between Hawking and Wolpert, Fuller and Derbyshire (Institute for Arts and ideas, 2019, April 21). There is also a debate within psychoanalysis about its scientific status and its epistemology (e.g., Fonagy, 2015; Hilsenroth, Katz, & Tanzilli, 2018; Lingiardi & McWilliams, 2017; Orange, 2003; Shedler, 2010; Stänicke, 2014; Stänicke, Zachrisson & Vetlesen, 2020). Fonagy (2015) argues that psychoanalysis can *not* be regarded as a science, and yet he contributes to outcome studies and cites randomized controlled trials in areas I would assess as psychoanalytic (one among many examples is Bateman & Fonagy, 2013). Shedler addresses this complex question as follows:

> There are aspects of psychoanalysis that are best understood as hermeneutic. Certainly analytic listening, or the process by which we discern disavowed aspects of mental life in patients' manifest communications, is largely hermeneutic. But other aspects of psychoanalysis fall under the categories of empirical questions and causal propositions. The theories that implicitly or explicitly guide analytic listening contain many causal propositions. We can employ hermeneutic methods where they facilitate understanding, and empirical methods where empirical research does. (Shedler, 2002, p 431.)

There is now a strong empirical basis for certain psychoanalytically described phenomena. Weinberger and his colleagues (Stoycheva et al., 2014; Weinberger & Stoycheva, 2020) have examined the empirical evidence for numerous hypothesized unconscious processes. Shedler (2010), with a plethora of empirical citations, argues that

psychodynamic treatment is as evidence-based as any therapy. Specific psychoanalytically oriented treatment methods (e.g., IPT, MBT, ISTDP TFP) have been studied empirically (see section about *Theoretical Framework: Heterogeneity of Psychoanalysis* in this Extended Summary).

In a review of empirical psychoanalytic scholarship, Leuzinger-Bohleber, Solms, and Arnold (2020) conclude that there is scientific support for psychodynamic concepts (e.g., implicit emotions; Lane, 2020) as well as for the effectiveness of psychoanalytic therapies. Solms (2020) notes that psychoanalysis builds upon scientific claims about the emotional mind that are now widely accepted in neighboring fields.[10] The *Psychodynamic Diagnostic Manual* (PDM-2) (Lingiardi & McWilliams, 2017) drew heavily on traditional RCT research and included many contributors from the scientific research community. My own work is psychoanalytic in that it refers to a body of knowledge and reflects a psychoanalytic ethos (McWilliams, 2020). It also draws on empirical research in fields other than psychoanalysis.

The relationally oriented psychoanalyst, psychologist, and philosopher Donna Orange (2003) argues that science without a social constructivist position inevitably means reductionism:

> Reductionism is the practice of making such reductions and claiming that nothing important has been left out. This practice is recognizable by its implicit or explicit 'nothing but.' Mind is nothing but brain; the envy I feel for my patient's Ivy League education is nothing but projective identification;

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[10] "Our three core claims about the emotional mind, I submit, are the following: 1) The human infant is not a blank slate; *like all other species, we are born with a set of innate needs*. 2) *The main task of mental development is to learn how to meet these needs in the world*, which implies that mental disorder arises form failures to achive this task. 3) *Most of out methods of meeting our emotional needs are executed unconsciously*, which requires us to return them consciously in order to change them." (Solms, 2020, p. 26.)

> mania and depression are nothing but chemical imbalances; and so on. Whatever has been reduced needs no further explanation or understanding. (p. 473).

From the perspective of pragmatic psychology, Fishman presents a related argument, noting: "For Popper, these preconditions include the deductive theoretical principles that we simply have to assume without being able to prove them; for Kuhn, these preconditions are scientific paradigms; for Quine and Feyerabend, they are webs of belief; and for Wittgenstein, they are language games" (Fishman, 1999, pp. 87– 88).

3.3. Self-Disclosure – Auto-Theory – Autoethnography

My choice to approach the work in a transparent, self-disclosing and auto-theoretical way follows several academic traditions and serves several purposes. In this section I describe how this choice is consistent with the traditions of postmodern feminism, the qualitative research method, autoethnography, the case study method, auto-theory,[11] and relational and classical psychoanalysis. I argue that this approach comprises an ethic, a method, and a way to frame research inquires. I have consistently written in a highly self-disclosing style and use my own experience while exploring in-depth understanding and formulating theory. I use this as a *style of writing*, a *method of investigation* and an *overarching way to formulate inquiries* for research. I aim to be transparent in several meanings: for science, for myself, and for clinical aims.

For example, the idea of sharing medical records with the patient and discussing them in treatment builds upon scholarship about transparency and self-disclosure

[11] The terms autotheory, auto-theory, and autoethnography are used in overlapping ways depending on which contributors are using the term.

as following an autoethnographic logic and serving a clinical aim. By self-disclosure, I mean the intentional self-revelations that Rachman (1998) has called "judicious self-disclosure" and Akhtar (1995) has called "technical self-disclosure" (see Skolnikoff, 2011). In other words, I argue in favor of self-disclosure with a purpose, viewing it not always as a technical mistake or acting out of countertransference – although such possibilities can surely occur and be rationalized within the paradigm of conscious self-disclosure.

Another way of being transparent is sharing with readers my mistakes, the conscious parts of my countertransference reactions, and the ways I put together my ideas. This transparency reflects the goal of honesty in and about the clinical encounter. It also involves building context; for example, sharing my own social positions of both privilege and nonprivilege and my thoughts about the impacts of those positions on the clinical process.

3.3.1. Autoethnography

McLeod (2011) states that autoethnography, which means including personal experience in research, has its place in work in which one aims to find synthesis and build theory: "It allows the audience to enter the experience itself" (p. 209). The tradition of autoethnography arose from the postmodern and poststructuralist traditions with the aim of addressing social justice while finding subtle dynamics and striving for courage and honesty. McLeod (2011) states that autoethnographic studies

> open up subtle aspects of important topics and phenomena that tend to be beyond the reach of other methodologies". .. .There is also an inevitability about personal experience research: any attempt to sideline or ignore personal experience methods in qualitative research can be viewed as a manifestation of a false consciousness that seeks to deny the underlying nature of human

> science as an activity undertaken by persons who are reflective agents. (p. 217).

Being autotheoretical acknowledges the inevitable subjectivity of the researcher. From this perspective, researchers who self-identify as "objective" are seen as embodying not objectivity but unawareness of the ways their biases affect the questions they ask and the ways they pursue answers. Claims of objectivity make it difficult for others, as well, to see such inevitable biases. According to this critique, subjectivity is not absent, but hidden.

Jesson et al. (2011) view transparency as a way to try to articulate both tacit knowledge and the explicit knowledge of experience, and yet to systematize it beyond "personal opinions." The aim is to integrate it with empirical research and the explicit knowledge of statistics, data, and hypothesis-testing science. For example, in a systematic reading of their own autobiographical experiences of psychotherapy Råbu,et. al. (2019), suggest that both positive and negative reports of therapy can make valuable contributions to professional development. They argue that "engagement with the conduct and procedures of autoethnographic inquiry make it possible to gain new insights into fundamental processes of knowledge construction" (p. 16). They offer their own experiences in the service of adding depth and promoting theorizing on subtle dynamics and self-awareness. Bernhardt and colleagues (2019; Bernhardt, Nissen-Lie, & Råbu, 2020) have similarly argued that being a therapist always draws on personal subjectivity. This position is consistent with the conclusion of Heinoen and Nissen-Lie (2020) on the basis of a meta review of 31 research studies on therapeutic effectiveness:

> According to the consistent findings of this review, more effective therapists are characterized by interpersonal capacities that are professionally cultivated but likely rooted in their personal lives and attachment history– such as empathy, verbal and non-verbal communication skills and capacity to form and repair alliances – especially with interpersonally challenging clients. (Heinonen & Nissen-Lie, p. 27, 2020).

For this reason, relational psychoanalysis intentionally explores the subjectivity of the analyst (Aron, 2000).

3.3.2. Feminist tradition of subjectivity

Feminist academics have long argued that the personal cannot be separated from the political (e.g., hooks, 1990) and that the influence of the personal is inevitable in theory-building (e.g., Siegel, 1997). There is also a relevant debate inside feminism, in which "third-wave" feminists have criticized some feminist theory for dissociating itself from feminist practice:

> Historical struggles played out in the realm of young feminist organizing and recorded in the memos, meetings, and projects of such organizers, are reflected in autobiographical writing by third wave authors, which, in turn, echoes theoretical expressions of 'academic' feminism. In performing an analysis that crosses the popular-academic divide, I am actively refusing the narrow parameters of the frequently invoked binarism in which academic work is condemned as an elitist expression of the ivory tower and set in opposition to the 'real' political work going on in the 'outside' world. (Siegel, 1997, p. 49).

Harding (2004, 2009) thus argues that one's personal experiences and social locations determine how one sees the world. Acknowledging experience and subjectivity as a part of social science is conventional in postmodern feminism (e.g., Butler, 1990). That discourse addresses strategic essentialism (Spivak, 1987) and plays with the deconstruction of identities and categories such as gender (Butler, 1990, 1993). Coming out of the feminist tradition, focusing on the embodiment of knowledge and social justice, Stacey Young (1997) coined the word *autotheory* to depict texts that combine theoretical knowledge with self-disclosing personal writing:

> The power of the autotheoretical texts lies, in part, in their insistence in situatedness and embodiedness. The writings' autobiographical nature clarifies the origin of their insights, and thus underscores the contingency of their claims (indeed, of claims about social reality in general). It also works as an invitation to the reader to examine her own multiple positions… … These texts combine autobiography with theoretical reflection and with the authors' insistence on situating themselves within histories of oppression and resistance. (p. 73-74)

Although autobiographical writing has been addressed from different perspectives for several decades (Smith & Watson, 1998), perhaps the best-known writing in the autotheoretical tradition is Maggie Nelson's (2015) "The Argonauts," in which the author ponders her own life experience in theoretical terms while living with a partner under testosterone treatment when she herself is pregnant. The two lovers' bodies are changing at the same time in heterosexual and queer ways, respectively. Illuminating the experience by connecting it to theory on gender issues, psychoanalysis, culture, and philosophy, Nelson

reaches beyond common theoretical analysis. The historian Scott (1991) suggests that it is a minority empowerment issue to make subordinated experiences visible.

Consistent with the feminist emphasis on embodiment, scholars from the black power movement and critical race theory have addressed the fact that skin color affects how any given researcher sees the world (Ahmed, 2007; Yancy, 2015). They argue that a "color-blind" approach amounts to committing micro-aggressions (cf. Sue, 2010, DiAngelo, 2018). Sara Ahmed (2007) even characterized whiteness as a "bad habit."

The open way in which I try to approach power issues in psychotherapy is thus centrally informed by feminist ethics. Inevitably, everything starts with oneself. Following psychoanalytic writing on power issues, the gender studies scholar and psychoanalyst Katie Gentile (2013, 2017) has suggested that power issues are always *encounters* that make us remake our very self. For example, skin color is not an entity or attribute that we can experience outside the system of racism. Acknowledging the meaning of power issues and embracing the striving for social justice, we are never free from embodying one or another version of domination or subordination. For example, we might embody generations of privilege and the associated questions of accountability and guilt (e.g., Frie, 2017; Layton, 2016b; Suchet, 2004, 2007). This way of acknowledging our own interaction with science is also emphasized in the field of feminist action research (e.g., Brydon-Miller, 1997; Frisby et. al., 2009). McLeod (2011) argued that mentioning countertransference in case descriptions is by definition self-disclosing.

3.3.3. Psychoanalytic perspectives on self-disclosure

Self-disclosure in professional writing has also been a significant motif in classical psychoanalytic literature. In trying to convey his understanding of unconscious processes, Freud (e.g,.1900, 1936) talked about his own dreams and slips; his protégé Theodor Reik

talked about his deeply personal intuitions and experiences (Reik, 1948; Safran, 2011). Looking as deeply and honestly as possible into both case material and one's own subjectivity is a traditional psychoanalytic method and a part of investigating both transference-countertransference experiences and enactments.

Some analysts (e.g., Kohut, 1979) have written about their own experiences in the guise of talking about a patient (in Kohut's case, "Mr. Z"). Bromberg & Aron (2019), Harris (1998), and Atwood and Stolorow (1979) suggest that "disguised autobiography" has been used in psychoanalysis to a much greater extent than previously acknowledged. Bromberg and Aron (2019) found autobiography have been used by Sigmund Freud, Anna Freud, Wilhelm Stekel, James Jackson Putnam, Melanie Klein, Helene Deutsch, Joan Riviere, Margaret Little, Karen Horney, Sandor Ferenczi, Elizabeth Severn, Heinz Kohut, and Harry Guntrip. It is widely believed that Anna Freud (1923) wrote about herself in describing a case of masochism (Bromberg & Aron, 2019; Blass, 1993; Young-Bruehl, 1988), that Freud´s (1899) description of Mr. Y is himself, and that Klein (1940) was referring to herself when writing about Mrs. A, who lost her young son. Much theorizing – about screen memories (Freud, 1899), as-if-personality (Deutsch, 1973), and narcissism (Kohut, 1979), to mention a few critical areas – might not have been possible in the absence of such personal perspectives.

Subjectivity is often framed as a disturbing flavor or as only an anecdotal support for psychoanalytic pedagogy. My work instead assumes that it has had a major and valuable role in theory-development. Rather than adopt the stratagem of disguised self-disclosure, I have opted for the directness of first-person discourse. I agree with Bromberg and Aron (2019) that "if psychoanalysis is a science of subjectivity, then its object of study is not only the patient's subjectivity, but the analyst's, and the theorist's as well." (p. 696).

Finally, there was also a technical, practical reason that I adopted a self-disclosing style in the writing: Doing so made it possible for me to put nuances of power into words. This mirrors the position of Råbu, et al. (2019), who argue that subjectivity can add a layer that is hard to capture through traditional quantitively oriented research. Since some shades of power dynamics are so subtle that major theories or formal explications of power dynamics fail to catch them all, I found concrete examples useful, both for formulating thoughts and for highlighting nuances. Because the aim was to make complicated ideas accessible and practical, and to show their value for the art of psychotherapy, it stands to reason that I should also exemplify them.

3.4. Case Study Method

The case study method also sometimes called "descriptive case studies," is used to scrutinize persons, situations, groups, and events, in the service of gaining in-depth understanding (Yin, 2012). With a lens on a specific case, one can explore a phenomenon comprehensively. Investigating layers of complexity, which is not possible when studying extensive statistical material, can be done through this method. This is thus a good option when one wants to describe something in depth, generate theory, suggest a new treatment or theory, or hypothesize from a special situation. McLeod (2011) notes the wide range of case study research and argues that it aims to build contextualized knowledge and theorize in a depth not possible with other methods. Noting its wide use in organizational research and its significant role in psychotherapy and counselling research, McLeod (2011) predicts it will be more widely accepted in the future as a legitimate scientific tool.

In psychoanalysis there is a well-established, ongoing tradition of writing about single cases. Famous patients such as Anna O, Little Hans, and Mr. Z have been broadly discussed (Breuer, 1893; Freud, 1909, Kohut, 1979). The single-case study method is

also a part of the contemporary research in psychoanalysis (e.g., Stänicke, 2014). Often associated with psychoanalysis, the approach has been applied well beyond that field. Case studies have generated significant knowledge in many different areas, inside and outside of psychology.

The study of the female chimpanzee Washoe, who managed to learn about 350 words and showed grammatical skills, self-awareness, and empathy (Gardner, Gardner & Van Cantfort, 1989), both contributed to our understanding of language-learning and influenced the debate on the ethics of animal treatment. Neuropsychologists and neurologists came to understand a great deal about the frontal lobe by studying the personality changes in Phineas Gage, whose brain was penetrated by an iron bar (Harlow, 1848, 1868/1993; O'Driscoll, & Leach, 1998). Watson and Rayner (1920) showed through the case of "Albert" how classical conditioning works, and Jones (1924) demonstrated in the case of "Peter" how fear of rats can be cured. The tragic case of the epilepsy surgery of "HM" (Scoville & Milner, 1957), probably the best-known patient in the history of neuroscience, illuminated processes of memory (Squire, 2009). In the field of autism research, Asperger (1944/1991) showed via several cases the combination of traits that later was named after him.

I am trying to highlight here the value of a method whose validity has often been criticized. Case studies have evident risks, including contamination by the subjectivity of the researcher, overvaluing anecdotal evidence that cannot be re-tested, problems with transparency, and problems with the researcher's memory. Nevertheless, along with others (e.g., Smith, 2012; Yin, 2012), I believe that the case study method has some benefits and has a place in the larger tapestry of scientific writing, especially in generating theory. When Smith (2012) systematically reviewed 409 single case studies published in peer-reviewed psychological journals in 2000-2010, he concluded that this research "is largely in accordance with contemporary criteria for experimental quality" (p. 1). Yin (2012) states:

> Single-case study . . . has been commonly criticized for having little or no generalizability value. To understand the process requires distinguishing between two types of generalizing: *statistical generalizations* and *analytic generalizations*. . . . For case study research, the latter is the appropriate type. Unfortunately, most scholars, including those who do case study research, are imbued with the former type. . . . A single or a small set of cases cannot generalize in this manner, nor is it intended to. Furthermore, the incorrect assumption is that statistical generalizations, from samples to universes, are the only way of generalizing findings from social science research. In contrast, analytic generalizations depend on using a study's theoretical framework to establish a logic that might be applicable to other situations. . . .To the extent that any case study concerns itself with generalizing, case studies tend to generalize to other situations (on the basis of the analytic claims), whereas surveys and other quantitative methods tend to generalize to population (on the basis of statistical claims)." (pp. 38-51).

I have used clinical and personal material for in-depth exploration of dynamics and patterns that may be generalizable to other situations. For example, in the text about relative privilege between patient and therapist (Fors, 2020b/Fors2018a), I use cases in which the patient has relatively more social power than the therapist to theorize about dynamics that may arise when individuals must handle being emotionally dependent on an "inferior." I attempt to understand the psychology of this situation and suggest where similar dynamics might be present in comparable non-clinical situations.

By including reflections on my own psychology, and by writing about patients

with whom I feel I have failed, I hope to achieve a credible transparency that may offset some limits and risks of the case study method. Transparency in the development of his theory and willingness to change his mind publicly were among the intellectual virtues of Sigmund Freud (even if his first theory of neurosis seems to have been more correct than his third; Sletvold, 2016). These are also qualities I admire in Otto Kernberg (e.g., 2002).

Fishman and Messer (2013) argue for professional attention to pragmatic case studies. They invite contrasting conceptualizations of the same case, which they refer to as "visions of reality," arguing that this procedure adds depth and moves beyond what one perspective alone could offer. This combining of perspectives is most visible in the paper on the case of Sonja (publication IV), whose material I examine through different power logics and perspectives. The fifth paper, in which I address relative privilege, offers the same shifts in perspectives.

3.5. Ethics in Writing about Cases

Writing about cases raises several ethical considerations (e.g. American Psychological Association, 2017, 2020). The Norwegian Regional Ethical Committee (2013/935/REK nord; nord; 2019/275/REK nord) and the Research Foundation for Finnmark Hospital Trust have addressed the ethics of writing about real cases. According to Norwegian law (Helsepersonelloven §21, § 23 and Helseregisterloven §2), fully anonymized material is not seen as confidential health information and may be published. After protocol assessment, the regional ethical review board waived the need for extensive board review for my writing (2013/935/REK nord; 2015/1446/REK nord; 2019/275/REK nord, 18.02.2019). All the vignettes in this thesis are either heavily disguised or anonymized and published with the patient's consent – as, for example, the case of Isabel and the case of Sonja. Occasionally, I have combined prototypically similar experiences from several patients into one fictive case.

In all situations, I have tried hard to preserve emotional truth. The act of asking for permission introduces another ethical dilemma as well; it inserts a new, foreign element into the therapy (Bridges, 2007). In this process of asking for consent I have had advice from the head of the board of the Research Foundation for Finnmark Hospital Trust (Torben Wisborg), from our Research Leader (Mette Kjær), and from my mentor (Nancy McWilliams). I have also consulted with the data protection officer for Finnmark Hospital Trust and have followed the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2017).

Chamberlain (2006) has addressed the potential colonial aspects of writing about cases, comparing it with the ignorance that characterized early field studies in anthropology. She highlights the fact that the clinician's voice interprets the situation. Accordingly, it has been important to me to check with patients about whether the story is consistent with their memory and their experience of any situation I have put into writing.

With respect to the fourth paper, a paradox arose: The patient did not wish to read the actual paper. But she wanted to hear, and (as I interpret her response) greatly enjoyed having been told, the reactions to her case when, before it was published, the paper was presented anonymously at a conference. This experience calls to mind one of Aron´s (2000) anecdotes about mutuality:

> I had one talented supervise who was tape-recording her sessions for use in supervision and in a case seminar. One of her patients said to her, "You know, it's fine for you to tape and present me in class, but I'd really like it if in turn you tape-recorded the class discussion and supervision and let me hear it. After all, maybe it would be valuable for me to be let in on the discussion." I asked myself and my supervisee, would this reflect aspects of mutuality or symmetry? (p.239)

Even with consent, however, some ethical issues remain. When can we trust the patient's consent as an adult, given the transference and emotional dependency that can pervade therapy? Is informed consent really possible in a therapy relationship? Aron (2000) observes that "When we speak, for example, of 'informed consent' as an ethical principle, we as psychoanalytic clinicians must grapple with the problem of whether to take a patient's manifest acquiescence at face value" (p. 232). I have no definitive answer to this problem. But I would not have published these patients' stories if I were not sufficiently convinced that their consent was valid and that their material had been adequately disguised.

3.6. A Comment on Style

As I have emphasized, I have tried to write clearly, in ways that are clinically accessible, managing my own tendency to think in the more abstract language of contemporary psychoanalytic feminist and relational theory. I have found that writing straightforwardly is challenging – explaining complicated issues in a commonsense, clinically applicable way seems to require a particularly thoroughgoing knowledge of the material.

4. Presentation of Publications I-IV

4.1. Paper I

Fors, M., & McWilliams, N. (2016). Collaborative reading of medical records in psychotherapy: A feminist psychoanalytic proposal about narrative and empowerment. *Psychoanalytic Psychology, 33*, 35-57. http://dx.doi.org/10.1037/pap0000019

In the first paper, I address the undertheorized question of sharing patients' medical records as part of the therapeutic process in psychoanalytic psychotherapies. This is a theory-generating essay showing how collaborative reading of medical records can be integrated with the overall goals of psychotherapy. Traditionally, sharing records with psychiatric patients has been controversial – not only because psychiatric patients are often seen as unstable, dangerous, or too fragile to handle information about themselves, but also because therapists are not used to having their assessment questioned. Their resistance to sharing records could be understood as an unwillingness to be exposed. My co-author and I suggest that sharing records as a matter of power ethics forces therapists to be more careful with their own writing and to remain vulnerable in the face of having their work inspected. This intervention is theoretically anchored in the feminist psychotherapy tradition, which has focused on power issues and the ethics of power.

Through examining empirical research on the effects of patient access to medical records (mostly in somatic settings, since there are very few studies in psychiatric settings) and anchoring it to theory on both power ethics and core technical elements in psychotherapy and psychoanalysis (mostly relevant to the therapeutic alliance and empowerment of the patient), we develop some proposals. We address implications for psychoanalytic work, such as self-disclosure and interruption of the transference.

We argue that collaborative reading of medical records is not an either-or issue but rather a matter of *how*, *when,* and *for what purpose*. Contrary to common assumptions, we posit that this intervention may be of *more benefit* to more seriously disturbed patients and those with significant personality disorders than to less troubled individuals. We discuss the case of "Isabel," a woman with a borderline personality organization and a history of destructive enactments, who was notably helped by reading her medical records, a privilege she was initially denied because her doctor assessed her as too dangerous and unstable to read

about herself.

We suggest that collaborative inspections of medical files can strengthen the therapeutic alliance, increase mutual understanding of the patient's problems, support the patient's self-respect, and contribute to personal empowerment. We believe that such a process comports well with psychoanalytically oriented psychotherapies. We conclude that there are at least three different potential benefits of collaborative reading of the medical record in psychotherapy: its informational value for both therapist and patient, its relational value in equalizing aspects of the relationship and conveying that no information is hidden, and, most consequentially, its therapeutic value. Involving the patient in diagnostic dilemmas and treatment possibilities may encourage insight, mentalization, and memory. We also consider situations in which collaborative reading of medical records is not recommended or may be ill-timed; for example, when the therapy is in a period of significant acting out or when it is in a phase of severe ongoing devaluation of the therapist. The paper is theory-generating and built methodically upon case studies and literature review (Jesson et al. 2011; McLeod, 2011; Yin, 2012).

4.2. Paper II

Fors, M. (2018b). Geographical narcissism in psychotherapy. Countermapping urban assumptions about power, space and time. *Psychoanalytic Psychology, 35*, 446–453. http://dx.doi.org/10.1037/pap0000179

The second paper addresses urban biases in psychotherapy, as formulated through an arctic rural lens. I argue that there is ongoing urban colonization behavior towards the rural, not only in the sense of exploiting crops and devaluing rural knowledge, but also in the sense that urban-trained health personnel may pursue lucrative work opportunities in the

"hinterland" and frequently (and probably unconsciously) condescend to local people. I address consequences for the therapeutic alliance and the establishment of trust in therapy. Using research from the fields of rural psychology, post-colonialism, and minority stress, informed by philosophical and psychoanalytic theories on privilege and applying metaphors of cartography, I address how urban norms on power, space, and time may contribute to ongoing, cumulative microtrauma for people in rural areas. I frame urbanity as a seldom-addressed privilege and study implications of the misrepresentation of the rural world on the "map" of psychotherapy.

As I try to "countermap" (Wood, 2010) urban biases on power, space, and time and explore some consequences of the frame, self-disclosure, ethics, and interpretations, I address topics that include urban valuing of specialized expertise over wisdom, urban disconnection from weather and distance, urban colonizing behavior, the dumping of incompetent professionals into rural areas, and the urban sense of entitlement to anonymity. In theorizing an urban "omphalos syndrome" and the geographical narcissism that goes with it, the aim is to validate rural experience and foster rural empowerment in the field of psychotherapy. The paper is not about cultural competence toward patients in rural areas. Instead, it adopts a contrasting perspective that problematizes urbanity. This choice parallels the strategy in gender studies of looking into male privilege rather than into special features of womanhood. It is comparable to formulating problems in terms of heterosexism instead of explicating subcultural gay issues, and to addressing the privilege of able-bodiedness instead of focusing on how to treat "the disabled."

While addressing the unnamed power dimension of urban-rural, I theorize in a psychoanalytic language about issues that may be meaningful to address outside a psychoanalytic or even psychotherapeutic frame (e.g., in a general health context or in the context of addressing exploitation of rural areas).

The paper is both clinical and not clinical; it finds its home in the interface between psychosocial studies, postcolonialism, feminist theory, and classical psychoanalysis. It builds upon critical literature review (Jesson et al., 2011) and the case study tradition (McLeod, 2011; Yin, 2012) and autotheoretical writing (McLeod, 2011; Scott, 1991; Smith & Watson, 1998; Young, 1997).

4.3. Paper III

Drescher, J., & Fors, M. (2018). A dialogue on cultural and minority issues in PDM-2 through the case of Frank. *Psychoanalytic Psychology*, 35, 357-362. http://dx.doi.org/10.1037/pap0000199

The third paper was coauthored with Jack Drescher. I use the case material as well as the diagnostic manual PDM-2 as an empirical base and comment on relevant dynamics with reference to the *dyad of similarity of nonprivilege*. Dr. Drescher described Frank, a male, Jewish gay patient treated by a male, Jewish gay therapist. I address some benefits and limits of the PDM-2's attention to "non-pathological conditions that may need clinical attention (minority stress)" as applied to that case. With reference to this therapy, in which a minority therapist treated a minority patient, I address historical milestones in the direction of social justice for gay and lesbian people, emphasizing that we need to go beyond simply considering homosexual individuals as *healthy* to acknowledging the *cumulative trauma* of living in a heterosexist world in which heterosexuality is usually seen as preferable. The battle to de-pathologize homosexuality has been long and painful; the category was not removed as a diagnosis from the ICD until 1990 (Drescher, 2015). In this context I discuss which of Frank's problems seem to be symptoms of psychopathology and which seem to be symptoms of minority trauma.

I then go further, addressing some of the privilege blindness inferable in PDM-2, despite the evident good intentions of its authors. For example, in its case formulations, the manual consistently assumes that the therapist is a majority person and suggests cultural competency and transference issues connected to the situation in which *societal privilege favors the therapist*. Through the case of Frank, I comment on how PDM-2, despite its greater attention to minority issues than is true of other classification systems, gives no extra help for issues that arise when a minority therapist treats a minority patient. I posit that distortions of envy, internalized subordination in both parties, countertransference, idealization, disappointment, and unspoken wishes to be understood by someone on whom sameness can be projected are characteristic of such dyads.

Finally, a theoretical contribution of this paper is to conceptualize themes that might evolve when patient and therapist are in a state of similarity of nonprivilege. The paper is a theoretical paper in the tradition of traditional literature review and the case studies tradition (Jesson et al., 2011; McLeod, 2011; Yin, 2012).

4.4. Paper IV

Fors, M. (in press). Power dynamics in the clinical situation: A confluence of perspectives. *Contemporary Psychoanalysis.*

Through the case of "Sonja," in the fourth paper I explore different power themes in therapy. Sonja was a traumatized patient with severe avoidant dynamics and an overall psychotic level of functioning (per PDM-2) who was being pressured by her country's health care system to have her obesity treated surgically. The case includes several interactions with her general practitioner and an obesity expert. Her struggle with this directive, along with her efforts to claim her legitimate right to disability support, brought to

light numerous power issues, including feminist concerns about women´s bodies as targets of social control (K. Gentile, 2013, 2017; Harjunen, 2017; Nutter et al. 2016), the insensitive power of bureaucracy (Clegg et al., 2016), and my own relative privilege as a therapist of normal size (Fors, 2020b/2018a).

The patient was ultimately able to use her avoidant tendencies on her own behalf, in the service of counter-power. I used her situation to demonstrate that in clinical work, there are usually several power themes in interplay, simultaneously and synergistically. I go on to explore the possible meanings of the subjective feeling of powerlessness shared by all the authorities in Sonja's treatment situation: We all felt oppressed by power from somewhere else. In the paper I suggest there are four common types of power dynamics that affect psychotherapy: professional power, transferential power, socio-political power, and bureaucratic power. The paper draws upon case studies (McLeod, 2011; Yin, 2012) and traditional literature review (Jesson et al., 2011). I use the case to make power themes and power exchanges visible and to generate hypotheses about them.

4.5. Paper V

Fors. M. (2020b) *Relative Privilege in Psychotherapy.* Unpublished paper. (Theoretical foundation for Fors, M. (2018a). *A grammar of power in psychotherapy. Exploring the dynamics of privilege*[12]. Washington, DC: American Psychological Association.)

[12] *A Grammar of Power in Psychotherapy* (Fors, 2018a) is a full-length book in which I argue that the ways in which external societal power issues inevitably enter the therapy room follow previously unnamed patterns that I call a "grammar" of power. (See also Wittgenstein, 1953). Here I extract the main theoretical contributions of the book, postulating four core patient-therapist dyads with different power dynamics: privilege favoring the therapist, privilege favoring the patient, similarity of nonprivilege, and similarity of privilege.

The fifth text is a theoretical, theory-generating contribution (Boyer, 1990; Reichenbach, 1938/2006) in which I explore how a conceptual intersectional model of social power in psychotherapy might be framed. I address different kinds of power across varying categories of difference (race, class, sexual orientation, etc.) without equating those categories, and theorize about how an integrative model of relative privilege could be a useful tool for analyzing how social power is ongoingly negotiated in clinical dyads. As a theoretical contribution I suggest a matrix of relative privilege as a way to view the interaction of social justice issues in psychotherapy. By comparing and contrasting different prototypical situations, I demonstrate that the relative privilege paradigm invites a wide range of nuanced technical choices. The theoretical and clinical value is an in-depth understanding of subtle power exchanges and the consequent utility of this conceptual framework for therapists. The underlying assumption is that power dynamics are inevitable and that no one is above or outside of societal structures. Prejudices and internalized versions of entitlement, blindness, or domination belong not merely to others or to people in the past. In the paper I posit that we have to take into account clinically that they also are to be found in ourselves as therapists.

Many people in the critical psychology movement who identify as feminist, antiracist, and gay-affirmative have made contributions to psychological theory and to therapeutic practice consistent with power-sensitive ethics (e.g., Akhtar, 1995; Brown, 2004; Benjamin, 2017; Chodorow, 1978, 1989, 2000; Comas-Díaz & Jacobsen, 1991; Corbett, 2001; Davids, 2011; Drescher, 2002, 2015a, 2015b; Emanuel, 2016; Goldner, 2011; Goodman & Severson, 2016; Hays, 2016; Leary, 1997; Layton, Hollander, & Gutwill, 2006; Lundberg, Malmquist & Wurm, 2017; Magnusson & Marecek, 2012; Nakash & Saguy, 2015; Orange, Atwood, & Stolorow, 2001; Suchet, 2004, 2007; Tummala-Narra, 2015, 2016; Walls, 2006; Worell & Remer, 2003). But to my knowledge, no previous writer has tried to

address various dyads of relative privilege in a systematic way. Instead, the most common way is to address *one* sociological dimension at a time (see Young-Bruehl, 1996).

The aim here is, through simplification, to explore an overall conceptual model of intersectional power, including heterogeneity of sources of oppression as well as fluidity in how the dyadic relationship is seen, depending on what is accentuated in the therapy at the moment. Notwithstanding Young-Bruehl's (1996, 2007) and Solomon´s (2012) observations that the origins of prejudices are plural, nuanced, and complex, I find it useful to generalize about the experience of relative privilege in the clinical dyad. I suggest that social external factors either increase or decrease the "normal" power asymmetry in the therapeutic relationship, and I describe how the "normal"/ "asymmetrical"/ "tilted"/ "mutual but asymmetrical" therapeutic relationship (Aron, 1990, 1996; Greenacre, 1954; Mitchell & Aron, 1999) is affected by the dynamics of societal privilege and nonprivilege that inevitably enter the therapy room. Even though power is always contextualized (Foucault, 1981), and not all social power dimensions are equivalent, I argue that regardless of the different implications of various social categories, they share the categorization of privilege versus nonprivilege.

I explore four paradigmatic situations: when therapist and patient have similar levels of social power, when either therapist or patient has greater privilege than the other, and when both therapist and patient have similar levels of lack of privilege ("nonprivilege"). I explore how these circumstances affect the therapeutic relationship. I offer a "matrix of relative privilege" (figure 2.) as a tool to explore these four treatment scenarios.

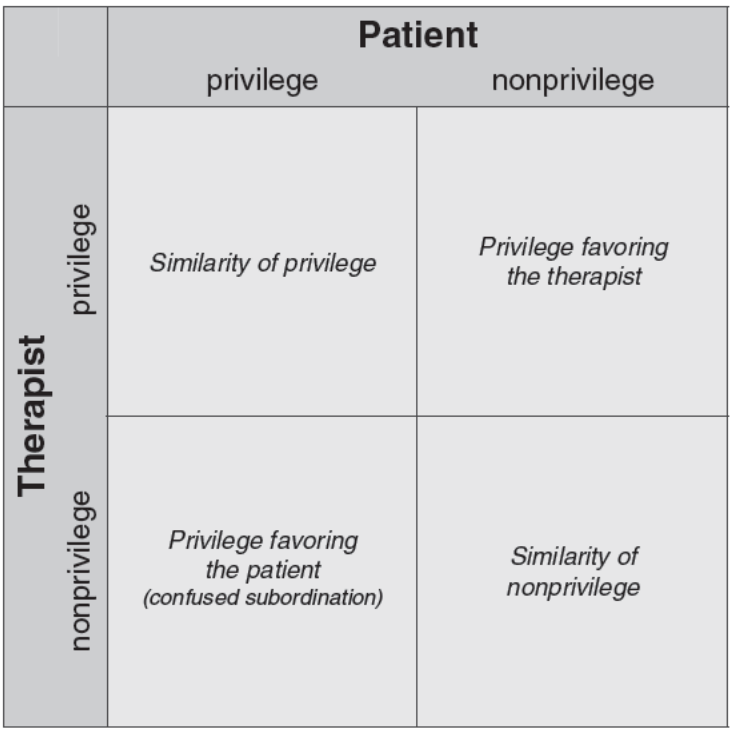

Figure 2: Matrix of relative privilege. *From A Grammar of Power in Psychotherapy: Exploring the Dynamics of Privilege* (p. 27), by M. Fors, 2018, Washington, DC: American Psychological Association. Copyright 2018 by the American Psychological Association.

1) *Similarity of privilege.* Patient and therapist share the same social privileges. For example, both therapist and patient are white academic heterosexual men.

2) *Privilege favoring the therapist*. The therapist has social privileges and the patient is in a distinct position of relative societal subordination. For example, the patient is gay and the therapist is known to be heterosexual.

3) *Privilege favoring the patient (confused subordination)*. The patient has a position of societal dominance compared to the therapist. For example, an older, authoritative male patient is in treatment with a young female therapist.

4) *Similarity of non-privilege.* Patient and therapist both belong to subordinated groups –

either the same group or different marginalized groups. For example, both patient and therapist are lesbians, or one is lesbian and one is an immigrant.

In this theorization, the assumption is that there is no dyad in the matrix of relative privilege that is preferable. All may be handled beautifully, and all may be addressed disastrously. Even in the condition of overall similarity of privilege (which is sometimes assumed to be preferable in the cultural competency discourse), I note that there is no automatic understanding among those with the same minority status (or the same cultural competence). Other issues involving power tend to arise in the clinical situation, including fear of not being adequately neutral, fear of overdoing politics, and projection of sameness, envy, and disappointment.

The text belongs in the interface between postmodern feminist writing, sociological theory, philosophy, social psychology, gender studies, ego psychology, and relational psychoanalysis, and builds on critical literature studies, case studies, and autotheory. To bring nuance to complicated power issues, the text (as well as the book, Fors, 2018a) has a self-disclosing authorial style, written in a feminist tradition that embraces the idea that the personal is political and that the subjective view is a legitimate way to embody knowledge (K. Gentile, 2013, 2017; Nelson, 2015; Suchet, 2007). It draws upon case studies (McLeod, 2011; Yin, 2012) and traditional literature review (Jesson et al., 2011).

I offer the concept of relative privilege as the answer to the questions I posed earlier in this document, all of which involve expanding clinical repertoires and attuning therapists to the reality of social power dynamics so that they can find individualized ways to explore power dynamics in psychotherapy. The matrix of relative privilege brings social justice concerns into the technical sphere, not simply the ethical sensibility, of the consulting room.

5. Conclusion and Final Discussion

In my application of different perspectives to power in psychotherapy, one issue has emerged with utter clarity: The deeper one digs, the more complexity there is to find. In embracing the idea that knowledge is an ongoing process and a conversation, rather than a positivistic fact, I hope I have raised questions that others will pursue. Since part of my goal is to address power dynamics that are not conscious, and there is always more to uncover, full enlightenment is not a reasonable goal. Therefore, I emphasize that an ongoing attunement to one's own possible blind spots is more important than searching for definitive answers. These different angles of vision on power issues – medical records, the PDM-2, the therapeutic relationship, geographical space, and the bureaucratic system – all eventually are related to the clinician's therapeutic role – not just to the therapist's conscious attitude but to less conscious issues such as vulnerability, loss of power, narcissism, internalized dominance, and painful feelings such as internalized subordination, internalized racism, and homoerotic countertransference. There is an ethical center to this project: I hope to have made a contribution that helps colleagues to bear power they may not have seen themselves as having, to try to use it for good ends, and not to project it elsewhere.

My scholarship has tried to highlight the inconsistency of thinking of the pain of minority trauma and minority stress as a deficit, yet at the same time *not* construing the dominance side of dominance-subordination situations as pathological or toxic. A significant challenge to therapists involves tolerating the implications of this perspective on power. It may be difficult to endure, for example, the exposure of having one's own written records discussed in an honest, mutual way, the pressure of having to write with consistent respect, and the ethical demand to reflect on who "owns" the material. This perspective on power challenges clinicians to tolerate seeing themselves not only as good therapists but, for

example, as inevitably part of the colonization process when they are urban-trained mental health workers in a rural setting. According to feminist ethics, the safest way to stay ethically in relationships characterized by discrepant power is to hold on to the questions and tolerate the fact that power dynamics are subtle and shifting and often need to be named – at least internally by the clinician. I hope that my postulating an underlying grammar of power will encourage therapists toward further reflection, exploration, and growth as effective clinicians.

I construe science as an ongoing dialogue. All my writing pursues an implicit ideal of encouraging further conversation. In the paper on collaborative reading of medical records (Fors & McWilliams, 2016), finding a dialogue with the patient is central. Implicitly the process also involves mentalizing a dialogue with other health personnel who will read our records or who have written the notes we are reading. Editorial commentary (Jurist, 2018) on our paper about the PDM-2 (Drescher & Fors, 2018) has supported the effort to frame the manual as an ongoing conversation about diagnosis and not as a finished classification system.

> Fors provides a powerful critique of the PDM-2 for assuming that the therapist is a majority person in referring to "they" as minority patients. For anyone who has seen the films *Black Psychoanalysts Speak* (Winograd, 2014) and *Psychoanalysis in El Barrio* (Christian, Reichbart, Moskowitz, Morillo, & Winograd, 2016), this microaggession is as unfortunate as it is familiar, and it must be addressed in the next edition. It is particularly important for a psychodynamic manual to distance itself from the posture of authoritative White privilege at this juncture in history. The PDM-2 makes no claim to be anything but a work in progress; diversity is not well addressed in this second edition, and it should be going forward. (Jurist, 2018, p. 365).

The case of Frank had previously been published in more detail (Drescher, 2009), followed by commentary from four scholars with intersectional perspectives (Person 2009; Roughton, 2009; Sherman, 2009; Young-Bruehl, 2009). In discussing the case in the context of the PDM-2, we found ourselves considering new issues and exploring new theories relevant to the case.

Paper IV about Sonja involves several levels of conversation. It emerged out of a three-way conversation in a conference on obesity, where a patient's general practitioner, obesity expert and I each pondered the case from our respective angles of vision. The guest editor of the journal associated with the conference has floated the idea of inviting a scholar to write a commentary on that paper, to be co-published with it, but this has not been decided yet. Another article (Fors 2019a), which I did not include in this thesis because it was not as relevant to clinical practice, also emphasizes the need for ongoing self-examination and conversation. In it I discuss the dangers of moral omnipotence in critiques of Donald Trump. This paper was published with commentary by K. Gentile (2019).

Another recent paper (Fors, 2019b) addressed a classic article by Miller (1985) about his supervision with Heinz Kohut on the case of a gay patient. Sandmeyer (2019a) wrote a critique emphasizing Kohut's heteronormativity that was published in the *Journal of the American Psychoanalytic Association* as that year's winner of the Ralph Roughton Award. Three analysts were invited to comment (Finlon, 2019; Fors, 2019b; Strozier, 2019), followed by a response from Sandmeyer (2019b). The discussion moved far beyond the patient, whom Miller treated in 1978-1981 and wrote about in 1985 (Miller, 1985). I view this conversation, several decades later, as an example of how theory develops and how scientific conversation is itself a narrative, in this case questioning what "reparative therapy" is and whether it can be ethically conducted even with the best of intentions. That question reaches far beyond Miller´s patient.

Through the above detour into other writing I have done, I am emphasizing continuity and conversation in science. I believe the discourse of narrative therapy and narrative knowledge parallels the contemporary psychoanalytic emphasis on dialogue and conversation. White (2007) points out that writing up a case is a narrative process itself, and McLeod (2011) notes that adding the voice of the researcher is part of a narrative approach. Although a full investigation of the narrative therapy paradigm is beyond the scope of the dissertation, I wanted to note some apparent parallels in how each tradition addresses implicit knowledge.

I have offered the work as a stimulus for further conversation rather than as some final word on power. I hope others will take the conversation forward. One way of doing so would involve clinical demonstrations of the ideas that provide opportunities for others to see how the theory translates into practice and to critique it accordingly. I have done this in a demonstration DVD (Fors, 2018c) developed by the American Psychological Association. In the full monograph (Fors, 2018a), there is an appendix with suggested questions for further exploration in supervision, at clinics, and with oneself. It is suited for teaching purposes and classroom discussions involving the theoretical contributions (Fors, 2020b).

As noted above, a conversation about geographical narcissism (Fors, 2018b) has already been more far-reaching than I had expected, not only to other academic fields such as rural medicine, philosophy, mental health, and planetary health (e.g., Abelsen, et al., 2020; Horwitz & Parkes, 2019; Malatzky et al., 2020; Couch et al., 2019; McGrail et al., 2020; O´Sullivan et al., 2020; Reeve et al., 2020; Reid, 2019). In addition, the term "geographical narcissism" has entered debates in the mainstream media in Australia (Baker & Hess, 2019a, 2019b; Diprose, 2019a, 2019 b; Gillespie, 2019; Neilson, 2019), the United States (Baker, 2019; Obor News, 2019), Taiwan (Baker & Hess, 2019c; MoneyDJ, 2019),

and Spain (Baker & Hess, 2019d). The article (Fors, 201b) has been shared on Facebook and on private blogs addressing rural health and injustice in access to hospitals. (It even showed up in a Taiwanese-English language course https://www.youtube.com/watch?v=JpZlHVUQHI8).

My point here is that connections between the scholarship of discovery (Reichenbach, 1938/2006), scholarships of integration and application (Boyer, 1990), and narrative knowledge (White, 2007) are not only conversations between academia and the clinic but also between academia, politics, and popular culture. They illustrate the feminist assumption that one can never be outside or above a social or scientific system (K. Gentile, 2013, 2017; Gergen, 2015; Harding, 2004, 2009; hooks, 2000; Smith & Watson, 1998; Young, 1997). I believe these practical conversations and applications of my work not only bridge theory and practice and honor the ethics of the ordinary (Das, 2012), but they are also in the territory of the philosophy of pragmatism (Fishman, 1999; Goldberg, 2002) and in rhythm with contemporary psychoanalytic emphasis on dialogue and conversation in and outside the clinic (e.g., Auestad, 2015; Frosh, 2010; K. Gentile, 2013, 2017; Greedharry, 2008; Orange, 2003; Suchet, 2004).

I am anticipating the possibility of critiques from several perspectives. Those who embrace a traditional positivistic view of science may say that I am not neutral or that I am cherry-picking data. I do not make the naïve claim to be totally neutral (cf. Goldberg, 2002). Instead, I argue that owning one´s preconceptions and limitations seems to me more consistent with both research ethics and feminist ethics than defensively assuming objectivity. (Here I note my agreement with many scholars previously quoted that the positivistic research paradigm is not neutral, either). The flexibility in traditional literature review can be construed as both the weakness and the strength of my work.

As discussed more fully in the methods section, the creativity and curiosity involved in developing and exploring ideas, generating hypotheses, and synthesizing knowledge into new formulations required a method in which the choices of the researcher are prioritized over the structure of the design. In that context, one weakness of my work is that I can never be completely certain I am not choosing literature on the basis of personal prejudice, or ignoring ideas that contradict my own, whether such blindness involves an intentional political agenda or an unintentional conformational bias. I think this question applies to all kinds of research, but it is more central to the investigatory process. My efforts to read in great depth and breadth, and to consult multiple sources when covering new topics, were ways to try to minimize this contamination.

I believe I might also run into critical reactions from individuals representing different human rights fields, who may find the intersectional purpose reductionist and insufficiently attentive to their specific focus (ethnicity, race, sexuality, religion, etc.). In response, I would argue that the purpose has been to find patterns and not to explore particular areas in which power operates. That is important work, done by others, but I believe it would have been limiting for these purposes. Others might find the dyads on relative privilege reductionistic and point out that any relationship always holds several different power dimensions. I would say that this observation is both true and not true. Sometimes the dyad of relative privilege shifts during the therapeutic process, when different aspects of the relationships are emphasized (age, gender, race, etc.). Power patterns may be fluid, and different dynamics may be at play in different stages of the therapy. And yet I think it is possible to identify a general relationship.

I suspect that some readers will not agree with the critique of the cultural competence discourse, partly because they see my position as less optimistic than that discourse has been. If there is no destination of enlightenment or competence, why try to

improve our overall understanding of power relationships? I would respond that research gives significant support to the observation that human beings inevitably create hierarchies of dominance, distance themselves from vulnerability, and minimize their own privileges. I suspect these human predilections will not change. I therefore argue for the discipline of self-reflection as the best available counterpower.

I can also be criticized for blind spots. My only response is my attitude of humility about what can be known: Blind spots are by definition blind, and the unconscious is truly unconscious. In trying to develop a more power-sensitive paradigm for psychotherapy I have suggested acknowledging mistakes in an honest and not self-reassuring way, recognizing prejudices within oneself, and (most critically) keeping the discussion alive. The main corrective to anyone's blind spots includes critical responses to that person's ideas, empirical testing of the involved hypotheses, and other scientific engagement with the writer's claims. I have accordingly made several suggestions and recommendations for further investigation.

Because shame reactions may foreclose exploration and increase defensiveness, all these questions are posed in a tone that I hope will encourage reflection on power dynamics with minimal shame. Ultimately, I hope to contribute to a climate among colleagues in which exploration of one's darker sides becomes a normal part of discussing clinical work. I hope I have been self-reflective and honest enough myself to have produced a body of work consistent with an ethical approach to power dynamics, in which I acknowledge the limitations of my knowledge.

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Power Dynamics in the Clinical Situation:

A Confluence of Perspectives

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Power issues in psychotherapy are often addressed from the perspective of intersectional and societal power, enacted or embodied in the therapy relationship. Following the thinking of Young-Bruehl (1996), who argued for acknowledging the heterogeneity of oppression, this paper posits a heterogeneity of power themes in psychotherapy. Four areas of power are highlighted: Professional power, transferential power, socio-political power, and bureaucratic power. All these kinds of power are explored through the case of "Sonja," with the overall aim of illuminating power issues in psychotherapy and illustrating how they may operate simultaneously and synergistically.

In contemporary psychoanalytic writing, there is increasing emphasis on appreciating unconscious power dynamics. Many of these have been conceptualized by earlier philosophers and political theorists. The application of their ideas to psychotherapy, however, is relatively new and insufficiently theorized. I propose to examine four types of power as they affect the clinical situation, through the case of a patient whose experiences suggest that power themes are complex, fluid, various, and heterogeneous. Often, we talk about power

issues in psychotherapy only from the perspective of intersectional and societal power issues enacted or embodied in the therapy relationship. In this paper, in contrast, I want to use the case of "Sonja" to explore a larger range of power issues that affect psychotherapy.

Most theoretical writing on power (for an overview see Haugaard, 2002) addresses political or sociological power rather than interpersonal power or the power endemic in treatment relationships. For example, Marx (1867/1887) wrote about the violence and power of capitalism; Bourdieu (1984) addressed power in habitus, taste, and privilege; Machiavelli (1532/1985) wrote about power in governance – specifically about out how a sovereign ruler can maintain power. Weber (1920/1997) addressed questions of the legitimacy of power, arguing that bureaucratic power is preferable to that of a charismatic leader. Power was also an interest of the liberal philosopher J. S. Mill (1859), who worried about the "tyranny of the majority." Such preoccupations are ancient: Plato's concern with issues of power led to his suggestion that a good society should be ruled by philosophers (Malnes & Midgaard, 1994). If one interprets the term broadly, virtually every social or political theorist has written about power in one or another sense.

Scholars addressing human right issues (e.g., Crenshaw, 1989; hooks, 1990, 2000; Lugones, 2010) have focused on systems of discrimination and on exposing how power works subtly, implicitly, or overtly in norms favoring, for example, white, male, heterosexual, western, industrialized people, and is reflected in colonization behavior towards non-western societies, rural areas (Fors, 2018b), animals (e.g. Donaldson & Kymlicka, 2011), and nature. Contributors to this literature include, among others, feminist scholars investigating power in language (e.g., Kristeva, 2004; J. Gentile & Macrone, 2016), postmodern feminist writers (e.g., K. Gentile, 2013, 2017), intersectional scholars (e.g., Crenshaw, 1989; hooks 1990, 2000), queer theorists (e.g., Butler, 1990), and writers addressing critical whiteness (e.g., Yancy, 2015) or critiquing norms on ableism (e.g., McRuer, 2006; Vaahtera, 2012). Power is

also addressed by postcolonial contributors (e.g. Fanon, 1952/2008; Greedharry, 2008; Spivak, 1987). A seminal twentieth-century influence on theories of power is Foucault´s poststructuralist[1] understanding (e.g., 1981) that power is located in action rather than position; Foucault described power as fluid, relational, and always in interaction with counter-power. He also addressed the link between knowledge and power.

This summary of perspectives on defining and investigating power is far from complete and is not intended to be so. But it does call attention to the myriad ways in which the topic has been approached. Political scientists and philosophers have addressed power by trying to define what it is, to specify when it is legitimate, to discern how it operates, and to infer whether it is located or fluid, ranging from a focus on international conflict to the exploration of more subtle issues of agenda-setting, norms, and influence. All these angles of vision can be relevant to the operation of power dynamics that affect psychotherapy. Thus, there are multiple way to think about power issues in therapy relationships.

Power in psychotherapy

In psychotherapy, there are several issues operating simultaneously that may be understood via different perspectives on power. Certain clinical situations involve overt control; that is, power that is manifest and acknowledged. For example, the therapist has the obligation to assign a diagnosis even if a patient objects to the label. Even when therapists try to make diagnostic decisions in collaboration with patients (Fors & McWilliams, 2016; Worell & Remer, 2003), in a disagreement, the clinician's view typically prevails over that of the patient. If the patient disagrees, one cannot refrain from diagnosing as psychotic a person who is evidently suffering a schizophrenic break or from diagnosing with a personality

[1] Foucault had some objections to being called poststructuralist or postmodernist, but he is often labeled as such. I do not intend this characterization to be disrespectful.

disorder a patient who evidences a borderline psychology. In extreme situations, therapists also have duties to contribute to involuntary hospitalization, to report patients to child protection services, or to attest that the patient should not have a driving license or a gun.

Power issues in clinical treatment seldom, however, involve overt domination (A decides for B against B´s wishes). Instead, psychotherapy is replete with nuances of power that appear in such areas as relational asymmetry, emotional dependency, and norms of normalcy. These power operations are sometimes exquisitely subtle and often unconscious to one or both parties to therapy.

Four perspectives on power in psychotherapy

I submit that in the field of psychotherapy, power issues are most evident in the following four areas:

1) Professional power

The first perspective involves the asymmetry inherent in a professional relationship. The clinician has extensive information about the patient; the patient lacks similar data about the clinician. The therapist is paid to see the patient, keeps a medical record, and in most cases has more extensive psychological knowledge. This kind of power asymmetry involves overt, observable factors. Power themes arising from the explicit power operations named above would be included here: reporting to child services, involuntary hospitalization, assigning a diagnosis, and so on. So would more subtle, often mutual understandings of the clinician's greater authority by virtue of his or her training. In the relational psychoanalytic literature, Aron (1996), acknowledged this reality of discrepant power in psychotherapy by referring to the *mutual but asymmetrical relationship*.

2) Transferential power

A second way, and a common one, of conceptualizing power in psychotherapy concerns the implications of the transference and other unconscious parts of the therapeutic relationship. Greenacre (1954) posited that because of the emotional dependency in the patient role and the phenomenon of transference, the therapeutic relationship is *tilted*.

> Now in the artificial situation of the analytic relationship, there develops early a firm basic transference, derived from the mother-child relationship but expressed in the confidence in the knowledge and integrity of the analyst and the helpfulness of the method; but in addition the nonparticipation of the analyst in a personal way in the relationship creates a "tilted" emotional relationship, a kind of psychic suction in which many of the past attitudes, specific experiences and fantasies of the patient are re-enacted in fragments or sometimes in surprisingly well-organized dramas with the analyst as the main figure of significance to the patient. This revival of past experiences with their full emotional accompaniment focused upon the analyst, is not only more possible but can be more easily seen, understood, and interpreted if the psychic field is not already cluttered with personal bits from the analyst's life. (1954, p. 674)

In appreciation of the patient's vulnerability in a situation of unequal psychological power, Freud (1915) warned against acting out erotic countertransferences. He also cautioned analysts not to take on the role of prophet or savior on the basis of this artificially constructed position of emotional power (Freud, 1923).

Writers from the relational movement (e.g., Mitchell, 1984; Aron, 1990, 1991) have critiqued the assumptions underlying the Freudian construction of the problem, questioning the classical emphasis on the *developmental tilt* (Mitchell, 1984). They contend that classical psychoanalytic ideas on transference, conceptualizing the patient as having regressed to a childhood state, are patronizing and problematic. For example, overemphasizing regression to dependency (Winnicott, 1954, 1963, 1965) might infantilize the patient. Commenting on the relational movement, Slochower writes:

> We relationalists may be theoretically diverse, but we share an implicit and relatively distinct professional ideal. It first coalesced around the value of asymmetrical mutuality and uncertainty. Emphasizing the therapeutic potential inherent in mutually unpacking and working through what's enacted, we moved away from authoritarian models and toward asymmetrical egalitarianism (Aron, 1991). We reacted against the authoritarianism implicit in visions of interpretive accuracy; some also rejected the developmental tilt (Mitchell, 1984) embedded in ideas of parental (analytic) repair. Moderating our power and omniscience, we affirmed our patients' capacity to see us, to function as an adult in the analytic context. We rejected sharply tilted clinical models lodged in beliefs about the power of both interpretation and confrontation. Relational writers emphasized the mutative potential inherent in enactment. Unformulated experience, dissociation, and shifting self states shaped analytic process for both patient *and* analyst. Unpacking these dynamics required mutual exploration because we were implicated along with our patients. (2017, p. 283).

Relational theorists thus continue to appreciate unconscious aspects of the patient-therapist relationship, but they have emphasized more mutual, interactive processes.

According to Slochower, therapists in the *Interpersonal* tradition were the first to move the paradigm of transference beyond the notion of the regressive patient: "They formulated a model in which the patient is an adult and the analyst a participant observer (Sullivan, 1954)" (2017, p. 283). To sum up: the relational perspective appreciates transference phenomena but construes power as issuing from unconscious shared dynamics and the emotional *interdependency* of patient and therapist.

3) Socio-political power

The third perspective on power in psychotherapy includes extensive and heterogenous phenomena. In this domain are various issues of external social power as they enter the therapeutic space. It includes, for example, attention to how gender, social class, and overall social norms affect the therapeutic relationship. Such questions have been addressed by contributors from the paradigms of cultural competency/cultural sensitivity (e.g., Tummala-Narra, 2015, 2016); feminism (e.g., Brown, 2004; Herman 1992; Worell & Remer, 2003); anti-racism (e.g., Holmes, 1992, 1999; Leary, 1995, 1997, 2000, 2002); neuro-diversity (e.g., Emanuel, 2016), and overall social justice (e.g., Layton, 2016; Layton, Hollander & Gutwill, 2006; Fors, 2019). I have previously suggested the term *relative privilege* to explore these issues (Fors, 2018a).

Others have critiqued concepts such as neutrality, normality, and the politics of diagnosis (e.g., Drescher 2002; 2015a, 2015b; Drescher & Fors, 2018; Johannisson, 1994; Orange, Atwood & Stolorow, 2001; Roberts, 2005). Some have even critiqued the normativity of psychotherapy in a way that I read as more pessimistic, suggesting that any kind of psychotherapy assumes norms and operates according to agendas of power (e.g., Firestone, 1970; Kitzinger & Perkins, 1993). This area encompasses politically related, internalized processes that affect psychotherapy, including internalized oppression and

internalized privilege (Fanon, 2008; Fors, 2018a; Layton, 2002, 2006a, 2006b; Davids, 2003, 2011; LaMothe, 2014; Weinberg, 1972). Writing on this topic addresses both conscious and unconscious themes related to how our social surround affects clinical functioning (e.g. Fors, 2018a, 2018b, 2018c; 2019).

4) Bureaucratic power

The fourth common perspective on power in psychotherapy involves bureaucratic aspects of access to care. Subordinated groups are often at a relative disadvantage in obtaining treatment or social benefits. A number of writers have addressed the effects of class, gender, and sexual orientation disparities in access to health care (e.g., Johannisson, 2001; van Doorslaer, Masseria, Koolman, & the OECD Health Equity Research Group, 2006; Smirthwaite, 2010; Smirthwaite, Lundström, Albrecht, & Swahnberg, 2014). The question of whether to remove the diagnosis of "gender dysphori" or "gender incongruence" from the ICD system belongs in this area; there is a tension between the aim of reducing stigma by eliminating such diagnoses and the aim of ensuring needed services (in many countries, abolishing these diagnostic labels would make it difficult for transgender people to get access to necessary health interventions) (Drescher, 2015b; WHO, 2018). This problem has so far been addressed by keeping the diagnosis in ICD-11 but moving it from the section on mental disorders to a new chapter on sexual health (WHO, 2018).

Heterogeneity of power

I submit that all these perspectives illuminate power issues in psychotherapy and that they may operate simultaneously and synergistically. In parallel with the thinking of Young-Bruehl (1996), who argued for acknowledging the heterogeneity of oppression, I am arguing for the heterogeneity of power themes. There follows my illustrative account of

"Sonja" (a pseudonym), with whom I worked not via "classical" psychoanalysis but according to psychoanalytic ideas in the context of the public health care system. In many ways, I ended up doing more social psychiatry than psychotherapy.

Sonja was a traumatized patient with severe avoidant dynamics and an overall psychotic level of functioning. She was under continuing pressure from the Norwegian health care system to undergo surgical treatment for weight reduction. Her struggle with this directive, along with her efforts to claim her legitimate right to disability support, exposed numerous power issues, including feminist concerns about women´s bodies as targets of social control, Clegg´s (2016) observations about the insensitive power of bureaucracy, and Marx's (1867/1887) equation of coerced work with slavery. Ultimately, Sonja was able to use her avoidant tendencies on her own behalf, in the service of counter-power. I suggest that her case can be understood from all four perspectives on power. Sonja has approved the publication of her story. This issue of publication was also discussed with Regional Ethics Board which, after protocol assessment, waived the need for extensive board review (2019/275/REK nord, 18.02.2019). After telephone consultation, the data protection officer for Finnmark hospital trust found no extensive data protection impact assessment necessary.

Sonja's experience of a bureaucratic persecutor

Some time ago, as I was assessing the week´s referrals at our small psychiatric outpatient unit, one patient stood out as desperate and slightly odd. The referring physician, Dr Edvardsen, wrote: "I don´t know why I am sending this referral, but I do not know what else to do. Sonja and I both know that she has too much anxiety to show up at your clinic - but she has severe auditory hallucinations and seems depressed, so I am worried. I have known her for some time, but she has not told me previously that she hears voices. Please give me some advice here."

I called this general practitioner, who said she was worried about psychosis. I advised her to hospitalize the patient and gave her the option of our sending a psychiatrist for a home visit, since she was certain Sonja would not show up for an ordinary outpatient consultation. Dr Edvardsen called back a few minutes later, after having talked by phone with her about these options. She said they had agreed to come to our clinic together, and accordingly, we scheduled an appointment a few weeks later with a psychiatrist, a professional with a reputation for the skillful handling of avoidant patients. Sonja canceled the session. Her doctor called in on her behalf, explaining that she was seeing a psychologist at a center for pain treatment and did not want too much going on at the same time. The case was treated as closed for the present.

Odontophobia

A few weeks later, the same patient was referred to my private practice. I recognized Sonja´s name immediately. I work several hours a week for the local dental team, who regularly send me odontophobic patients for assessment and possible psychological treatment. Sonja did not arrive for the first scheduled session. When I called her, she said that she had been outside my clinic at the time of our appointment, but that I was not there (something I suspect was not true). Knowing her story from my other role, I felt patient, and I expressed empathic understanding of her anxiety about coming in. We rescheduled, and she showed up. It turned out she had already had major dental treatment under anesthesia, and when I saw her, she conveyed her sense of deep relief, after many years of dental suffering, that her mouth was finally pain-free. Still, it seemed important to start to encourage her reduce her anxiety about seeing a dentist regularly, managing dental follow-ups, and (most important) starting to brush her teeth - something she did not do because efforts to do so caused her to choke or feel nauseated.

We met a few times in my office before it was possible to schedule a meeting with the dental nurse who does CBT exposure therapy. In Sonja's case, the problem was clearly not odontophobia in its narrower sense, but dissociation, post-traumatic symptoms, and fear of losing control. I advised the dental nurse to work on relational issues, trust, and the therapeutic alliance rather than narrowly addressing the habituation curve of anxiety. This nurse is seen by her colleagues as unusually skilled and warm-hearted, and under her step-by-step care, dental treatment became increasingly tolerable for Sonja. They started with tooth-brushing, with removing tartar. Sonja gradually became more and more relaxed and proud of being able to handle dental issues. She even dared to take her children to the dentist – something she saw as a new area of competence. According to her, the turning point came when the nurse, sensitive to Sonja´s fear of white hospital garb, dressed instead in blue medical clothing – a gesture of flexibility that Sonja interpreted as thoughtful and caring.

Family history and trauma

Sonja was from a successful family. Because she struggled at school and found theoretical work demanding, she felt constantly like the "black sheep." She had a history of severe bullying from classmates and had tried to protect her parents from knowing about this. Their ignorance of her pain, however, left her extremely alone with it. Her account was that they were occupied with surface and status and did not know anything authentic about her inner world. Growing up, she felt closer to her grandparents: They were the rocks in her life, and she was reportedly their favorite.

Sonja experienced at least one instance of sexual abuse from a friend of the family. She has no explicit memories of the episode, but she vividly recalls waking up surrounded by blood and sperm. She has said that I am the first person to whom she has ever told this story. Since her childhood, she has heard several voices in her head, talking down to

her and commenting critically on everything she does. Sonja also reports several serious memory losses during an ordinary week; she seems to dissociate frequently. Despite the severity of such post-traumatic symptoms, I could not find anything overtly psychotic in her presentation; her reality testing was normal.

Sonja´s personality style was clearly avoidant. She was shy despite the fact that when others do get to know her, she reportedly comes across as bubbly and likable, even delightful. Sonja had anxiety about people and social settings to a degree that seemed agoraphobic. In addition to her dental phobia, she had a psychologist phobia; she viewed having come to see me as having crossed an important psychological threshold. I think I earned her trust by talking to her about her economy and disability pension.

Work and family life

At the time I met Sonja, she was working part-time in a sheltered employment situation. Her treatment in that role felt patronizing and meaningless to her. She would cry on the bus trip to the facility and felt that working there two hours a day was too much to cope with. Often, she waited for the bus but lacked the courage to enter it; she would go home instead of getting on the bus.

Contrastingly, she seemed highly competent in her family role. It was the only part of her life that seemed to work, and she put a lot of effort and energy into managing that area. She was happily married and loved taking care of her two children. It seemed that she coped adequately with all kinds of parents' meetings and children's activities. Although such participation exhausted her, she put pressure on herself to attend such events, saying she was afraid of becoming crazier if she did not. In settings where she was "the mum" she was less shy and seemed to inhabit a more competent self-state. I found out that her previous breakdown, when her regular physician had become so worried, came after NAV (the

Norwegian Labour and Welfare Administration) tried to get her to work a few more hours a week. She had no capacity for such flexibility, as she was already not attending to her sheltered work as much as she was expected to. This demand from the NAV induced a sense of severe stress, an increase in her auditory hallucinations, and a period of suicidality. Her husband was becoming overwhelmed as well, and their marriage was in crisis. Sonja told me she had lived with the voices for years without telling anyone, but her mental state at this point felt dire enough to impel her to tell Dr Edvardsen about these hallucinations.

Fibromyalgia and recommended obesity surgery

Another narrative slowly emerged. Sonja was diagnosed with fibromyalgia, a diffuse soft-tissue pain disorder that is generally thought to be only minimally treatable and probably incurable. She told me she had had problems with massive pain in her joints and muscles since she was about 8 years old. NAV had no documentation of her psychiatric condition, only the diffuse pain problems for which doctors had found no medical explanation. She therefore saw a pain psychologist for a few sessions before the psychologist concluded she needed psychiatric treatment and terminated her. Sonja also told me that as a condition of getting sufficient money from NAV to be able to pay her rent, she felt forced to undergo surgery for obesity (gastric bypass). To me this sounded like either a delusional belief or a grave misunderstanding. I was reluctant to believe that the Government would force a person into obesity surgery.

In Norway, everyone has governmental insurance that covers illness, but this benefit requires recipients to meet certain criteria. To receive long-term financial support based on chronic illness, in the absence of a disability pension, one needs to have *a treatment plan*. Because Sonja got no psychiatric assessment, and because the somatic situation was a bit foggy, officials at the NAV office could not provide financial support to her without a

defined plan. From Sonja's perspective, this reality turned a well-intended program into a bureaucratic persecutor.

To fill out the forms correctly, government officials needed to put something in the space for "treatment plan." They clearly wanted to help. Because Sonja was somewhat overweight, it was suggested that losing weight might be helpful for her body and might decrease her pain. I am not sure whether the suggestion came only from the NAV personnel or whether it was at some point also Sonja´s idea. She was clearly overweight, and the state of her body contributed to her severe difficulties with self-esteem. Her general practitioner referred her for gastric bypass, and despite her telling the obesity doctor about her bad self-confidence and history of trauma (not the whole truth as I understood it), Sonja was put on the list for obesity surgery.

I reacted with shock. How could a person with such severe psychiatric illness, with a disturbed sense of time, different self-states, voices in her head, bad self-confidence, anxiety, depression, and avoidance be seen as a good candidate for that kind of surgery? If she struggled with basic self-care, such as teeth-brushing, how could she be expected to commit to a lifelong diet in the aftermath of bypass surgery? How could she be seen as competent to give her consent to such surgery?

Kafkaesque bureaucracy

In the context of my own upset, I found myself viewing the approval of such a procedure as professionally unethical. I started to secretly hate the obesity expert, Dr Dale. Sonja, however, talked about him as a wonderful doctor who was very empathic and nice. Out of respect for her experience, I tried to inhibit my anger and fought hard to keep my overt neutrality on the matter. Later, I learned that Dr Dale was the first professional who had looked into the status of her teeth and asked her about mouth pain. He had concluded that her

dental health was too bad to be able to cope after surgical intervention. Because food needs to be chewed with particular care after this kind of surgery, he was unwilling to authorize it until she had had dental treatment. As the person who referred her to the dental phobia team, the first source of practical help and pain relief, he had earned Sonja's gratitude and trust.

It turned out, though, that Sonja was no longer interested in gastric bypass. Trusting that I would help her navigate through her financial rights, she canceled the recently scheduled surgery. She had felt for some time as if those who would carry out the surgery were predatory. It turned out she had "missed" several follow-ups and was almost kicked off the waiting list – but her general practitioner, with characteristic compassion, called in several times to help the surgical team appreciate her "shyness." She was kept on the list a long time, as medical personnel made exceptions to keep her scheduled for the surgery despite her refusal to commit to follow-up phone calls in which she would report her weight. Her doctor told her they had made recurrent exceptions to "help her out." Her explanation to me for letting this go on was that she indeed expected to feel too anxious to call after the operation, but that at that point she *did* want the surgery. When she then changed her mind, she did not feel free to back out because of her commitment to NAV's treatment plan. My suspicion is that she was ambivalent throughout, and that her avoidance worked in a self-protective way.

I was skeptical about her report that NAV was pressuring her into obesity surgery. She said she got the question every time she met with them: When was she going to have the surgery? I thought it had to be a misunderstanding. It was not evident that bypass surgery would help her with the pain in her joints, but according to Sonja, NAV officials tried to paint a rosy picture of post-operative life: *"When you are less heavy – maybe your body will feel less stiff and painful."* Although somewhat overweight, Sonja was not so heavy that losing weight would significantly relieve her joints. I suspected that her version of what she was hearing was an exaggeration. Maybe she was not skillful in navigating bureaucratic

systems? Maybe she was slightly paranoid? Maybe she was not cognitively competent to understand what was going on? Maybe it was something with *her*.

When I attended a meeting with NAV to explain her psychiatric condition and argue for her being instead given permanent disability money, to my surprise the NAV representative confirmed that gastric bypass was in Sonja's treatment plan. As someone representing NAV, she saw herself as having to *motivate* Sonja towards the surgery, and then having to follow up to see that she maintained compliance with that treatment plan. I felt guilty for not having believed Sonja. Subtly, I had been looking for the source of the problem in her – wondering if she was misreading what she had been told.

Obesity conference

After I discussed her situation with her and Dr Edvardsen, Sonja was referred back to the psychiatric clinic and began to address the paperwork necessary to apply for permanent disability support. Just after that development, I got an invitation. Both doctors Edvardsen and Dale wanted me to join them at a medical obesity conference at which they were speaking. Their idea was that all three of us should present the same case from our respective perspectives – a kind of 3-D look at the situation. Their position was that this patient should never have been approved for surgery, and they wanted other doctors to learn from the case. After all, this story had a happy ending: Sonja had managed to cancel surgery.

When I asked Sonja for consent to talk about her experience at this conference, she was very proud. "I lied so much to my dear doctor. I did not tell her how ill I was so she did not know how to help me. It took so many years for me to tell her about my voices. If anyone can learn from my experience, I am delighted." Meeting the obesity expert, Dr Dale, I realized again that Sonja had been more accurate than I was. I had projected badness on to him, seeing him as a surgeon in love with using his knife to "correct" women's bodies. He

turned out not to be a surgeon at all, but an experienced senior physician who had worked for many years supervising a wide range of general practitioners. He was doing all the assessments on his own, with no help from psychologists or psychiatrists (another doctor would have done the surgery). He seemed thoughtful and wise. Going through the case, I saw his compassion for Sonja and appreciated the persistence of his effort to help her cope with the program for calling in and report her weight. He had an overall view on health and talked vividly about her pain conditions and her oral health. The story from Dr. Edvardsen included feeling paralyzed for a long time, unable to help Sonja.

My presentation about dissociation, trauma, the issue of what self-state she could count on to commit to the post-surgery eating regime, and the question of how someone who could not even reliably brush her teeth could manage the post-operative regime was a new perspective for the medical audience. They had no idea how psychiatrically sick she was. We were all distressed to learn about the subtle pressure from NAV, and we were all made aware of our own accountability (in other cases, not just this one) in not offering NAV officials enough help to do realistic treatment plans – leaving them to have to create their own. A neurologist in the audience suddenly suggested that there might be a certain rare genetic disorder behind Sonja´s pain. She was tested and found negative for this condition, but the incident nonetheless evidences a level of professional cooperation not previously available to her.

When Sonja came to the psychiatric outpatient unit again, for continuity, she become my patient. She began to meet with both me and a psychiatrist. When asked for consent to publish her story anonymously, she said again that she was proud and happy to contribute. If only one doctor could learn something, it would be rewarding. I suggested that she read the account and approve it. She refused, saying she did not want to read it. “You can write whatever you want, but I do not want to read it. I am truly very happy to contribute, but

I do not want to read it." My anxiety about this response impelled me to ponder this dilemma with the head of the research board for my hospital trust, who asked, "Is it *your* need for her to read it, or hers?"

Reminding myself of her learning problems, which would be especially problematic in reading English, I saw that it was mine. I wanted to be able to say (and write) that she had read the case report. That would have made me look ethically above reproach. But it was honestly my interest, not hers. She trusted my anonymization. I had her ponder the question for several weeks and asked her several times, letting her know she could retract her consent. But she insisted, and I eventually accepted her decision. I hoped, this turned out to be a paradoxically empowering decision: A mental health professional had heard what she was saying and had validated her experience. The NAV's approval of her permanent disability pension arrived around this time. Paradoxically, she now declared, with some delight, she was not merely happy – she said she felt 44 pounds lighter. Carrying her own weigh was not a problem, but carrying the weight of powerlessness was very burdensome.

Power themes

The power dynamics affecting Sonja´s treatment are multiple and various. They include professional power, bureaucratic power, transferential power, and the power of social norms about ideal body sizes for women, attitudes toward women´s pain and somatic condition, class issues, and access to disability money.

Bureaucracy and powerlessness

What has been most striking to me about this confluence of various sources of power is that everyone in this story seems to *feel* powerless. The source of power is seen (projected?) by all of us somewhere else. In addition, many of the players in this story feel an absence of power based on a lack of information or knowledge. Dr Edvardsen described

feeling powerless in trying to help Sonja because for a long time she had no information about the severity of her psychological problems. When she did have that information, Sonja was too afraid to cooperate and come to the clinic. The NAV official felt powerless in response to the requirement for a treatment plan and consequently followed bureaucratic rules that were arguably not in Sonja's best interest.

Sonja herself felt powerless. She felt persecuted by NAV, the voices, and the sheltered work expectations. She truly saw no way out

Relevant to this last consideration, Clegg and colleagues (2016) contrast Weber's relatively positive view of bureaucracy with the Kafka's, noting that "The Kafkaesque organization … … reduces the sense of agency of outsiders; it creates a perception of disempowerment via carelessness, leading to inaction." (Clegg, et. al. 2016, p. 166). Specifically, they note that

> While Weber suggests the inevitability of the technical superiority of bureaucratic forms and describes the attendant 'iron cage′ that it produces, Kafka spoke from within this cage, telling dark and enigmatic stories of the ironic futility of bureaucratic life. While Weber told us about bureaucracy's rationality, Kafka led us through its dark labyrinth. While Weber wrote about the impersonality of bureaucracy, Kafka vividly evoked the lived experience of its supplicants being constantly confounded by its machinations. (2016 p. 157).

In Sonja′s experience, both conceptualizations apply. Sonja feels persecuted by a well-intended bureaucratic treatment plan, produced by a good-hearted NAV officer who wanted to solve the problem with the empty box on the formal sheet. On one hand, this decision turned into a Kafaesque monster, whose direction Sonja felt powerless to reverse. On

the other, the same bureaucratic system finally rescued her by approving her permanent disability pension.

> Weber was not unaware of the pitfalls caused by human behaviour in a bureaucratic setting; rather, he proposed an ideal type model that condensed the features of actually occurring bureaucracies into an artificially accentuated model. Objective analysts could use such a model as a forensic tool for actual investigations. For Weber, being a bureaucrat is a vocation, one that demands an exemplary professional ethic. Weber's focus is concentrated on the mechanics and working of bureaucracy from the insider point of view of the ideal typical bureaucrat; Kafka looks at the bureaucratic subject from the experience of the outsider, from the perspective of the subject; his interest is in the phenomenology of power rather than issues of governance. Where Weber sees a character-forming ethic Kafka sees only doorkeepers. (Clegg et al., 2016, p. 160)

Dr. Dale suggests another kind of powerlessness in his comment that he felt bad about doing assessments on his own, that he had little support from others in doing them. I felt a sense of status inferiority and helpless anger toward the obesity expert, who I assumed (wrongly, as it turned out) would not have listened to my arguments if I had called him. Dr Edvardsen's feeling of powerlessness in not getting Sonja to make her scheduled follow-up appointments led to her calling the obesity clinic to ask for an exception for Sonja, to plead that she not to be seen as a drop-out. That powerless "begging" role had the unexpected consequence of contributing to Sonja's sense that she was being persecuted by a kind of unstoppable bureaucratic invasion (e.g., Clegg et. al. 2016).

Paradoxically, Sonja´s avoidant tendencies ultimately were helpful to her because they effectively postponed the surgery long enough for her to gather enough courage to retract her consent to the procedure. This dynamic, which can be viewed in Freudian terms as resistance, may be seen from a different perspective as exemplifying the concept of counter-power explicated by Foucault (e.g., 1991). According to his understanding of such processes, the bureaucratic system is undermined by both internal and external power sources; thus, the question of who has the power is unclear and complicated, supporting his notion that power is not situated in a specific role but revealed in action.

In a seminal 1960 paper on organizational dynamics, Menzies described unconscious "social defenses" in a hospital setting, among the nursing staff and students. These processes led to numerous less-than-satisfactory clinical outcomes despite the conscious efforts of the nurses to do their jobs as well as possible. Their struggles against certain anxieties inherent in their roles created shared defense mechanisms: "The socially structured defense mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms" (Menzies, 1960, p. 101). Menzies suggests that common social defenses include denial of the significance of the individual, detachment and denial of feelings, ritual task performance, and collective social redistribution of responsibility and irresponsibility – all examples, in the terminology of Clegg and his colleagues, of an impersonal (or anti-personal), badly functioning bureaucracy.

In line with Menzies's empirical findings, we might conclude that all of us attending the obesity conference, where we suddenly become aware of our own responsibility to help NAV do reasonable treatment plans, were recovering from a collective denial of our own power to intervene and exert influence. Menzies writes: "People in certain roles tend to be described as ´responsible´ by themselves and to some extent by others, and in other roles people are described as ´irresponsible´." (p. 105). Specifically, she observed that "Each nurse

tends to split off aspects of herself from her conscious personality and project them onto other nurses. Her irresponsible impulses, which she fears she cannot control, are attributed to the juniors" (p. 105). Her observation illuminates my own inclination to cast Dr. Dale as irresponsible and to see myself as contrastingly responsible and well-intentioned.

I myself also felt powerless in the context of professional regulatory power and potential consequences to psychologists of failures to operate within accepted norms. I wanted Sonja to read the case report not only because of my own need to see myself as of the highest ethical character but also because of my anxiety about possible legal consequences if I did not insist that she read it.

Money

In Sonja's pursuit of the right to a disability pension, it seemed to be empowering for her to describe herself in the terms of a diagnostic system that provides access to governmental benefits. From a Scandinavian perspective, I felt for a long time that she was being discriminated against, that simply to get her rights to money, she was being treated symbolically as a kind of slave who had to dance to NAV's tune. But while I was writing about this construction, a contradictory thought arose; namely, that having governmental health insurance at all is a privilege. In that sense, living in Norway might be construed by itself as a privilege.

Regulation of women bodies

An obvious power theme in Sonja´s case involves the regulation of women´s bodies. Would the idea of an obesity surgery, no matter how well-intended, be suggested to a man? Would a male patient have been examined earlier than Sonja was for the condition the neurologist suggested? Is the delay in considering such a diagnosis accidental, or is it embedded in a social system in which the pain of women is taken less seriously than that of

men? There are numerous issues of relative power in the areas of women´s access to health care, including a social norm to the effect that women can simply be expected to suffer more than men (Johannisson, 1994; Smirthwaite, 2010).

The normative loading in the question of weight surgery recalls Vaahtera´s (2012) concept of national compulsory able-bodiedness. In an investigation into how attitudes about swimming affect politics in Finland, Vaahtera ponders, with dry humor, how not being able to swim is very stigmatizing there. The country has a thousand lakes, and its Government insists that every citizen be able to swim at least 200 meters to be "civically skilled" (*kansalaistaito*). She considers this a form of ableism instantiated in nationalism: The aim is to stop people from drowning, and yet most people who drown in Finland can indeed swim but are drunk (Lunetta, Smith, Penttilä & Sajantila, 2004).

A critique of the regulation of women´s bodies has been formulated by many feminists (e.g., K. Gentile, 2013, 2017), and the stigma suffered by overweight people has increasingly been seen as an issue of social justice (e.g., Nutter et. al., 2016). Harjunen (2017) addresses issues of class and gender in fatness and reflects upon the norm of seeing the overweight body as unproductive and socially unacceptable. van Amsterdam (2013), similarly investigated the intersection with body size, gender, race, class and age.

The privilege of thinness: unconscious dynamics

All the health professionals trying to help Sonja were relatively thin. Our body sizes were never mentioned with her, and my privilege as a thinner person was not named in our sessions. In retrospect, I feel a bit like a male therapist who tries to indicate his support of feminist concerns without mentioning his own gender. Offman (2020) notes that there is significant shame in talking about body size in therapy. I believe I felt shame in relation to Sonja; I wondered if I was convincingly enough while trying to support her when she told me she wanted to cancel the surgery. I may have been hesitant to investigate bad experiences

related to being overweight. There may be elements of reaction-formation and avoidance (i.e., ignoring my own privilege in thinness) in my taking the feminist position that size does not matter. We have yet to explore such issues. Because the treatment so far has involved mainly practical matters, Sonja and I have not gone into this psychological territory.

Empowerment in integration – power in professionals

Where is Sonja´s empowerment situated and when did it arise? It is easy to identify as a critical moment the point at which she got approval for the disability pension. But this is probably not the essence of the psychological process of empowerment. For someone like Sonja, whose experience involved chronic fragmentation and dissociation, being able to integrate the sense of her physical body (notably pain in her mouth and muscles) with her mental representation of that body seems to have been ultimately empowering. As has been described in the clinical literature about our most seriously disturbed patients, there doubtless were complex enactments going in in the clinical surround in which she found herself. This parallel process phenomenon (Ekstein & Wallerstein, 1972) began with a split in the field: several different health professionals felt powerless and had to accomplish their own integration step by step rather than remaining in a situation of psychological splitting (Klein, 1946).

Paradoxically, it was the obesity doctor who helped Sonja to get help for odontophobia, the first treatment she was able to make use and by which she felt concretely helped. Her experience also suggests another issue related to status and symbolic power (Bourdieu, 1984). Although a dental nurse is lower in the professional hierarchy than a doctor, it was the nurse who managed to help Sonja, first by sending her for dental treatment under anesthesia and then by pursuing the traumatic origins of her odontophobia. Sonja´s road to empowerment started with this experience of a person whose power was not quite as far

from her own status as a doctor's. There may have been a deep personal unconscious significance for her in having a healthy set of teeth. Once relieved of mouth pain, perhaps she was ready to "bite back" in terms of fighting for her rights, and also to "bite" into the work of psychotherapy.

Consent

In terms of consent two questions arise: should one trust Sonja's consent or consider it as a problematic avoidance similar to her early avoidance of treatment? This question parallels the issue that Slochower (2017) has construed as between contemporary relational and more traditional ego-psychology-oriented psychoanalysts. Is Sonja a grown-up who can make her own decisions, or is she in a more vulnerable situation in which she does not know what is in her own best interest. Is it empowering or irresponsible to publish this paper? And are those polarities the proper way to frame the question? Is Sonja so emotionally dependent on me that she is unable to know her true feeling? Theoretically, it is possible to see the question from both perspectives.

In my own mind, Sonja's delighted reaction to the conference presentation weights the answer more toward the realm of adult empowerment. (Of course, I would not have published her story here if I had not drawn that conclusion.) The fact that I pondered the question with the head of the research board and consulted the Regional Ethics board for protocol assessment, (2019/275/REK nord, 18.02.2019) made the decision easier. But it is an irony, and perhaps an enactment or a parallel process intrinsic to the type of case I am presenting, that I am referring to a bureaucratic system to justify my decision.

Concluding thoughts

Issues of power in psychotherapy can be illuminated via multiple lenses and models. I have found it fruitful to try to hold different perspectives in mind simultaneously. I have suggested that there are at least four dimensions of power relevant to psychotherapy: professional, transferential, socio-political, and bureaucratic. Most of them are unconscious or partly so. All these areas intertwine. Power themes are constantly shifting, interacting, and influencing clinical work in multiple directions.

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