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Malin Fors

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MALIN FORS, MSc

Power Dynamics in the Clinical Situation: A Confluence of Perspectives

Abstract. 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, who argued for acknowledging the heterogeneity of oppression, this article 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.

Keywords: power, transference, bureaucracy, obesity, odontophopia, psychotherapy

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

Address correspondence to Malin Fors, MSc. Email: malin.fors@uit.no

issues enacted or embodied in the therapy relationship. In contrast, here, 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 what he called 'habitus,' the underlying structure of social life, including the power inherent in embodied cultural capital such as the higher classes' formulation of privilege as "taste"; Machiavelli (1532/1985) wrote about power in governance—specifically about 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 sense or another.

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 toward 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 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.

[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.

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 include: 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 their 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., Aron, 1990, 1991; Mitchell, 1984) have critiqued the assumptions underlying the Freudian construction of the problem of power imbalance in transference dynamics, 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, 1955, 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., Kirmayer, 2012; 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., Fors, 2019a; Layton, 2020; Layton et al., 2006). 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). 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 (Davids, 2003, 2011; Fanon, 1952/2008; Fors, 2018a, 2018c; LaMothe, 2014; Layton 2002, 2006a, 2006b; 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, 2019b).

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; Prilleltensky & Nelson, 2002; Smirthwaite, 2010; Smirthwaite et al., 2014; van Doorslaer et al., 2006). The question of whether to remove the diagnosis of "gender dysphoria" 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; Reed et al., 2016; 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. Here 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 Norwegian 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 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, observations about the insensitive power of bureaucracy (Clegg et al., 2016), and the equation of coerced work with slavery (Marx, 1867/1887). 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.[2]

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 Sonja 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

[2] 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.

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 was understanding and empathic 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 that her mouth was finally pain-free after many years of dental suffering. Still, it seemed important to start encouraging her to 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 warmhearted, 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, because of her learning problems, found most work demanding; she always felt like the "black sheep." She had a history of being severely bullied by 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 by 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 that she experiences serious memory losses several times 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, yet when others got to know her, she was bubbly and likable, even delightful. Still, Sonja was anxious around people and in social settings to a degree that seemed agoraphobic. In addition to her dental phobia, she had a psychologist phobia; she viewed coming to see me as crossing an important psychological threshold. I think I earned her trust by not only my patience and empathy but also by talking to her about her finances and disability pension.

Work and Family Life

At the time I met Sonja, she was working part-time in a sheltered employment[3] situation where the work seemed meaningless and she felt patronized. She cried on the bus trip to the facility and could barely cope with her daily schedule of two hours of work. At times, waiting for the bus to take her to work, she would panic and return home instead of getting on the bus.

Contrastingly, Sonja seemed highly competent in her family role: She was happily married and loved taking care of her two children. She put a lot of effort and energy into making the family work. In fact, it was the only part of her life that seemed successful. She coped adequately with all kinds of parents' meetings and children's activities, even though such participation exhausted her. Sonja engaged herself to participate, she said, because she was afraid of becoming crazier if she did not. In settings where she was "the mum" she felt less shy and

[3] "Sheltered employment" in Scandinavia is government-subsidized work for people who would struggle in the ordinary workforce, such as those who are cognitively or psychiatrically disabled.

inhabited, a more competent self-state. I learned that her previous breakdown, when her regular physician had become so worried, came after NAV (the Norwegian Labor and Welfare Administration) tried to force her to work a few more hours a week. Sonja had no capacity for such flexibility, as she was already not attending to her sheltered work as much as required. 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 with the situation as well and their marriage fell into 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 suffered with massive pain in her joints and muscles since she was about eight 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 someone 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 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, at some point, it was also Sonja's idea. She clearly had a weight problem, 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 poor self-confidence and history of trauma (not the whole truth as I understood it)—Sonja was put on the list for the 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, poor self-confidence, anxiety, depression, and avoidance be seen as a good candidate for that type 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 concerns, 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 curb my anger and fought hard to keep my neutrality intact. 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 she could not be recommended for bypass surgery because of her poor dental health. Because food needs to be chewed with particular care after this type of surgery, he was unwilling to authorize it until she 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.

However, it turned out 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. For some time, she said, she believed those who would carry out the surgery were predatory. It turned out she had "missed" several follow-ups and was nearly 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 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 continue—which indeed it did for some time—was that she expected to feel too anxious to call after the operation. At that point, she said, 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.

Yet, I remained 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 painted a rosy picture of post-operative life: *"When you are less heavy—maybe your body will feel less stiff and painful."* Although certainly 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. Perhaps she was slightly paranoid. Maybe she was not cognitively competent to understand what was going on. Perhaps it was something with *her*.

When I attended a meeting with NAV to explain her psychiatric condition and argue against the surgery and instead for permanent disability money, the NAV representative—to my surprise—confirmed that gastric bypass was in Sonja's treatment plan. The NAV representative saw herself as being responsible for *motivating* Sonja toward the surgery, and then following 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 Sonja and I discussed her situation and we spoke with 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 this development, I received an invitation. Doctors Edvardsen and Dale asked me to join them at a medical obesity conference at which they were speaking. Their thought 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 Sonja 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 reporting her weight. He had an overall view on health and talked vividly about her pain conditions and her oral health. The presentation from Dr. Edvardsen included her sense of paralysis in not being able to help Sonja.

My presentation focused on Sonja's trauma, dissociation, and the issue of what self-state she could count on to commit to the post-surgery eating regimen. The question I raised, as to how someone who could not even reliably brush her teeth could manage the post-operative regimen, 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 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, she was assigned to me for continuity. 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 make reading in English especially difficult, I saw that the need 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, honestly, it was my interest, not hers. She trusted my anonymization. I asked her to think about her consent for several weeks and checked in with her weekly, letting her know she could retract her consent at any time. But she insisted, and, eventually, I accepted her decision. I hoped this might actually turn out to be an empowering decision: A mental health professional had heard what she was saying and 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 weight 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 benefits.

Bureaucracy and Powerlessness

What has been most striking to me about this confluence of various sources of power is that *everyone* in this story seemed to feel powerless. The source of power was projected by all of us somewhere else. In addition, many of the players in this story felt 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 psychiatric clinic. The NAV official felt powerless in response to the requirement for a treatment plan, and consequently followed bureaucratic rules that were clearly 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 et al. (2016) contrast Weber's relatively positive view of bureaucracy with 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 felt 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, making the comment that he felt uncomfortable about doing assessments on his own and 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 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., 1981). 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" (p. 101). Menzies goes on to suggest 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 et al. (2016), of an impersonal (or anti-personal), badly functioning bureaucracy.

In line with Menzies's (1960) empirical findings, we might conclude that all of us attending the obesity conference, where we suddenly became 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 ŕesponsiblé by themselves and to some extent by others, and in other roles people are described as îrresponsiblé." (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 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 (Marx, 1867/1887), forced 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; yet most people who drown in Finland can indeed swim, but are drunk (Lunetta et al., 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 of 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 discussed 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 (e.g., Fors, 2018a). 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 convincing 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 ventured into this psychological territory.

Empowerment in Integration—Power in Professionals

Where is Sonja's empowerment situated and when did it arise? A critical moment is easy to identify: 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 churning 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 swirling in a pool 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 of, 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 gently pursuing the traumatic origins of her odontophobia. Sonja's road to empowerment started with this experience of a person whose power was not as far removed from her own as the doctors' power was. There may have been a deep personal unconscious significance for Sonja in finally gaining a healthy set of teeth. Once relieved of mouth pain, perhaps she was ready to "bite back," fighting for her rights, and also "biting" into the work of psychotherapy.

Consent

In terms of consent two questions arose: I wondered if I should trust Sonja's consent or consider it as 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 more vulnerable psychologically, unable to determine 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.

To me, Sonja's delighted reaction to the conference presentation weighted her consent 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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Malin Fors, MSc, is a Swedish psychologist and psychoanalyst living in the world's northernmost town, Hammerfest, Norway. She has worked for a decade for Finnmark Hospital Trust and also has a busy private practice. She is an assistant professor at the UiT The Arctic University of Norway, and a guest lecturer at Gothenburg University in Sweden. She is the 2016 recipient of the Division 39 Johanna Tabin Award for her book, *A Grammar of Power in Psychotherapy*, released by APA Press in 2018 and recently published in Swedish. Malin was featured in a demonstration DVD in the APA Psychotherapy Video Series, released in October 2018. In the spring of 2020, she was the Erikson Scholar at Austen Riggs Center, MA.