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Sarah Beller
Who Cares?: Psychotherapy as
Care Work, Explored Through
Socialist Feminist and Relational
Perspectives

ABSTRACT

This project was undertaken to better understand psychotherapy within the broader historical concept of “care work.” The methodological approach involved using key concepts from feminist socialist theory and relational theory to explore what it means to consider psychotherapy as care work. The two theories helped flesh out some of the tensions between “care” and “work,” as well as illuminated the way that the line between the two might be seen as a false dichotomy. The project has implications for psychotherapists practicing within the United States system of the “White supremacist capitalist patriarchy” who want to engage in a co-created journey with their clients toward liberation.

**WHO CARES?: PSYCHOTHERAPY AS CARE WORK, EXPLORED
THROUGH SOCIALIST FEMINIST AND RELATIONAL PERSPECTIVES**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2014

ACKNOWLEDGEMENTS

Many thanks...

to Stacey Novack, my clients, therapists, colleagues, friends and the Smith community.

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CHAPTER I

Introduction

As a very new psychotherapist, I find that it is often a challenge to comfortably “do” caring as a job (or internship). Sometimes “work” and “care” feel like opposing forces with no hope of a bridge between them. At other times, “care” and “work” seem to engage in an unsteady dialectical balance. In this paper I seek to locate psychotherapy within the historical concept of “care work” and explore the implications of that position. I will do so first by looking in at psychotherapy from the outside, using concepts from socialist feminism, the field that created the phrase “care work.” Next, I will position myself inside psychotherapy looking outward, using concepts from relational (psychoanalytic) theory. By connecting scholarship within psychotherapy about care, work, and social justice to scholarship in the fields of sociology, feminist, and economics about the same themes, I hope to strengthen the union of care workers, and provide some resources for psychotherapists hoping to engage in a joint liberation project with those who seek psychotherapy services. Furthermore, by situating psychotherapy within the larger framework of care work, I hope to mirror the psychotherapeutic action of situating the person-in-environment. Just as a “client” does not exist in a void, but rather in an intersection of social, cultural, economic and political realities, psychotherapy as practice exists in a world of social, cultural, economic and political realities. In the final section, I will use a clinical example from my own experience as a client/patient in psychotherapy to illuminate the theoretical

perspectives being considered. The following section will explain the organization of the paper, as well as justify the methods of the project.

Conceptualization and Methodology

I have chosen to use socialist feminist theory and relational theory to investigate the phenomenon of psychotherapy as care work. I chose socialist feminist theory because the concept of “care work” emerged from socialist feminist theorists themselves. Within socialist feminism, I will focus on concepts of “adjustment,” the “cyborg,” “within but not of,” joint allies working toward liberation, and non-dual conception of love/care and money/work. I chose relational theory as a second theory because it comes out of feminist scholarship, and is deeply concerned with investigating the dual aspects of care (of clients) and work (of therapists). The theories complement each other, for example in their attention to feminism, and, as noted in the introduction, balance each other in that one looks in at psychotherapy from outside fields and the other looks out at the world from within psychotherapy. I will use a method of overall discussion to interpret the phenomenon through these two lenses.

Chapter II

Care Work (and Psychotherapy as Care Work)

This section will describe the history of the concept of care work, the contemporary understanding of the concept, and the way it has been used and interpreted. Then I will situate psychotherapy within the concept, setting the stage for the next two chapters, which will each focus on a different theoretical perspective through which to explore psychotherapy as care work.

Care work: A History

In the 1970s feminist activists Selma James and Silvia Federici of the International Feminist Collective founded the International Wages for Housework Campaign. They argued that women do "unwaged, unvalued caring work" in the home for which they should be compensated (James, 2008, p. 42). Some feminists argued that the idea of wages for housework trapped women even more deeply in the home by paying them for their work there, and that Wages for Housework commercialized what Carol Lopate called "the only interstice of capitalist life in which people can possibly serve each other's needs out of love or care," (*Liberation* 1974, as cited in Tortorici, 2013). In 1975, Silvia Federici wrote "Wages Against Housework" in which she addressed some of the critiques of the Wages for Housework movement. Federici's piece directly addressed Lopate's argument with her opening words: "They say it is love. We say it is unwaged work" (Federici, 1975). Federici argued that demanding payment for housework

means “to refuse that work as the expression of our nature...and therefore to refuse precisely the female role that capital has invented for us.” In other words, women are no more intrinsically drawn to care work than are men, so if women are to do it, they should be paid.

The internal debate within feminism over care work reveals the seemingly paradoxical nature of care work itself, at least when it is considered within the Western, patriarchal polarized "either/or" framework. As Nancy Folbre explains: "It's a very gendered distinction -- women are to love as men are to money. So in a way, challenging the 'two-world' approach goes along with challenging traditional definitions of femininity and masculinity" (Mascarenhas, 2012). As we will see, by entering a "both/and" framework, it is possible to have a feminist understanding of care work that allows it to be, for example, for "love" *and* for "money," "masculine" and "feminine," simultaneously, with each reinforcing the other.

The ideas in *Wages for Housework* were not completely new. Women had been arguing for wages for housework since at least the early 20th century; Crystal Eastman called for “a generous endowment of motherhood provided by legislation” in her opening address to the First Feminist Congress in 1919 (Tortorici, 2013). Then in the 1960s, American welfare-rights activists demanded that welfare be dignified with the title of a “wage.” These efforts built upon Engels’s *The Origin of the Family, Private Property, and the State*. He said that although the first historical division of labor was one based on sex — leaving the responsibility of household management to women — it was only with the rise of private property and the patriarchal monogamous family that this division became hierarchical, devaluing women’s work. “The modern individual family,” Engels wrote, “is founded on the open or concealed domestic slavery of the wife” (1884). Feminists’ demand for payments to mothers and housewives was an

attempt to free women from the “domestic slavery” of dependency on the male wage and to make the struggle visible.

In 1983 sociologist A. R. Hochschild coined the term “emotional labor,” also referred to as “affective labor” to describe the work performed by any service employee who is required, as part of his or her job, to display specific sets of emotions (both verbal and nonverbal) with the aim of inducing particular feelings and responses among those for whom the service is being provided (Hochschild, 1983). Occupations considered to be high in demand for emotional labor include those relied on to provide compassion, such as nurses, physicians, and therapists, but can also include bill collectors, who are expected to restrict sympathy for debtors. (In 1989, Hochschild also famously coined the term “second shift” to refer to the invisible labor women continued to perform at home, in addition to their paid work performed outside the home.)

Care work: A Contemporary Definition

Nancy Folbre, a contemporary feminist economist, studies “care work” which combines both the 1970s concept of domestic labor and Hochschild’s concept of “affective labor.” Folbre contends that scholars “disagree on the very definitions of ‘care’ and ‘care work’ (Folbre, 2012, p. xiv). While a majority of scholarship specializes in analysis of either unpaid care provided within families or paid care provided through wage employment, Folbre adopts a more unified approach to care work, looking at the similarities and synergies between paid and unpaid labor. Folbre defines care work as “work that involves connecting to other people, trying to help people meet their needs, things like the work of caring for children, caring for the elderly, caring for sick people or teaching is a form of caring labor. Some kind is paid, some is unpaid” (Folbre, 2003). Care work can often, but does not have to, refer to work that is done to “assist” those who are “dependent” in some way, such as children, the elderly, and the physically or mentally ill. Care

work is disproportionately dominated by women. Folbre's work explores the complexities within the concept of care. As she explains:

We use this word [care] both to convey concern for others—as in 'I care about you' and to describe specific activities, as in 'caring for a sick child.' Care is something we both give and take, connecting us with others...Care work touches on people's greatest vulnerabilities. It often involves first-name, face-to-face, hands-on interaction. Both emotion and moral obligation come into play -- not in place of rational decision-making, but alongside it. People who provide care for others often become attached to them, entangled with them, violating the assumption that we are all wholly separate selves." (Mascarenhas, 2012).

Care, explains Folbre, is connected with power. The one who cares has some control over the person who is cared for; often the cared for person's safety, or even life, is in the care worker's hands. But the one who is cared for is powerful, too, in that they are the focus of attention. Ultimately, both one who cares and the one who is cared for are vulnerable because care challenges the assumption that each person is a contained, self-sufficient unit. The person cared for is vulnerable in that they are dependent. But, the one who cares is vulnerable in real economic terms. "Specialization in care is quite costly, for a number of reasons," says Folbre (2012, p. 32). For women who spend time out of the labor force caring for family members, for example, their lifetime earnings are substantially lowered and their economic security is reduced. Paid care work also carries a "pay penalty." Care jobs pay less than others requiring equivalent amounts of skill or education, and they even pay less than other jobs that employ a similar percentage of women (Folbre, 2012, p. 32). As Eva Kittay put it "By virtue of caring for

someone who is dependent, the dependency worker herself becomes vulnerable” (as cited in Folbre, 2012, p. 32).

Outsourcing Care

Towards the end of second wave feminism in the early 1980s, discussion about wages for housework largely disappeared. As upper class White women began to have more access to waged work outside the home, they hired *other* women, in greater and greater numbers, to do the domestic work of cleaning, cooking, and caring for their children. As Barbara Ehrenreich (2000) wrote:

Strangely, or perhaps not so strangely at all, no one talks about the 'politics of housework' anymore. The demand for 'wages for housework' has sunk to the status of a curio, along with the consciousness-raising groups in which women once rallied support in their struggles with messy men. In the academy, according to the feminist sociologists I interviewed, housework has lost much of its former cachet -- in part, I suspect, because fewer sociologists actually do it. Most Americans, over 80 percent, still clean their homes, but the minority who do not include a sizable fraction of the nation's opinion-makers and culture-producers -- professors, writers, editors, politicians, talking heads, and celebrities of all sorts. In their homes, the politics of housework is becoming a politics not only of gender but of race and class -- and these are subjects that the opinion-making elite, if not most Americans, generally prefer to avoid.

One thing that is certain about the population of household workers is that they were and are disproportionately women of color, often immigrants. Disenfranchised and “disposable” migrant populations provide much of the care work on which the US economy depends (Barker, 2012).

And, the work is still (again?) largely invisible, and domestic workers, while they may have wages, often do not have many of the other protections afforded to workers like health insurance and minimum wages.

More recently, however, discourse around care work has returned to the public sphere. This is due to a number of reasons. The first is the notion that in the post-Fordist "information economy," everyone is becoming someone who does "immaterial" labor--that is, labor that produces an immaterial good, such as a service, a cultural product, knowledge, or communication." Where jobs in production have gone overseas and/or been mechanized, the most important assets a worker can have in today's economy are knowledge, information, affect, and communication, the very kind valued in care work. Every "content manager" and "digital communications professional" and "social media associate" performs a kind of affective labor (Hardt and Negri, 2000).

Also, discourse around care work has returned to the public sphere due to, or simultaneous with, the reemergence of discourse about socialism in the United States following the financial crash in 2008 and the consequential recession. Public discussions of economic inequality had been absent for decades until Occupy Wall Street rallied young people with cries of "We are the 99 percent!" (Shenk, 2014). Since Occupy, there has been a swelling of socialist literature in new journals like *Jacobin* and *Dissent*, and a revival of it in journals like *The Nation*. Obama announced in December 2013 that income inequality constitutes "the defining challenge of our time" and Pope Francis has pronounced inequality "the root of social ills" and called for a campaign against its "structural causes" (Shenk, 2014). A return examination of these issues has coincided and spurred a re-examination of care work because, among other reasons, care work provides an important locus of income inequality.

The Wage Penalty

In "Forced to Care: Coercion and Caregiving in America," Evelyn Glenn, a professor of women's studies and ethnic studies, agrees with Folbre that the situation of paid and unpaid caregivers are closely intertwined and should be examined together. The forms of coercive pressure on caregivers, Glenn says, have varied in degree and directness, but have a net consequence of keeping care labor "cheap" -- that is, free in the case of family care labor and low waged in the case of paid care labor. In their article "The wages of virtue," England and Folbre provide empirical evidence that care workers face a "relative wage penalty." This means that they receive, on hour, lower hourly pay than would be predicted given the other characteristics of the job, the skill demands, and the qualifications of those holding the job. The authors posit four reasons for the wage penalty: economic dependence of those who need care, the association of care with women, the difficulty of achieving productivity gains per worker, and the tendency of market wages to be less in jobs that people are seen to do out of "love," or intrinsic motivation. The hypothesis that care work is paid less because of its association with women harkens back to the Wages for Housework campaign. People may view, explain England and Folbre, the qualities required in psychotherapy, for example, like empathy and patience, as "natural" rather than "arduously acquired." As Folbre writes: "Conventional definitions of skill tend focus on physical or cognitive attainments, devaluing emotional skills such as ability to feel empathy for others." Care work may therefore be devalued, even relative to other equally female-dominated jobs such as administrative work. England and Folbre explain the last theory by saying that there is a sense that mothers should provide care out of love, not for money. Care workers are implicitly expected to "prove" their proper motivation by accepting a wage penalty. As Folbre has argued previously (Folbre and Nelson 2000), the dichotomy-loving tendencies in Western thought

encourage the notion that one works for love or money, but not both. This leads to the anxiety that "commodifying care" in effect makes "the sacred profane" (ibid.). Again, this illuminates the paradoxical nature of life under the capital; care workers are simultaneously idealized and put on a pedestal, but denied the material respect of decent wages. In other words, there is a split created between care for others and self-interest, as though both are not operating simultaneously all the time.

The "Paradox" of Care

The concept of care work emerged when feminists began to trouble the definition of what counted as "work" under capitalism. Care practice, they claimed, had been coded as leisure, but was in fact work, and those "supposedly spontaneous expressions of women's nature" were instead skillful, learned practices (Weeks, 2011, p. 24). Women, they argued, are trained from a young age to perform this relational, caregiving, extra-shift work.

Just as women's work had been coded as natural love, under the power of the capital "care" can sometimes mean just its opposite. Marxist feminist theory sets paid and unpaid care work (including reproduction) as the often invisible but enabling force behind capitalism; care work is the work of producing and maintaining human capital--good workers. Capital can extract surplus value from waged labor only because the wage laborer is supported by unwaged labor, mainly in the form of the wife. If care is the process by which new slaves are sculpted to fit easily into their roles, "care" is in fact a process of injury, by which one's humanity is systematically removed. Because of its invisible yet essential role in capitalism, care work is simultaneously highly valued and publicly devalued. This paradox within care work gives rise to opportunity. Because care work is publicly devalued by, yet deeply essential to the capitalist project, care work is a potential locus of revolution (Weeks, 2011).

"Wages Due"

In "A Very 'Careful' Strike – Four hypotheses," Precarias a la Deriva (2005) writes (translated by Franco Ingrassia and Nate Holdren):

only if the maids, the whores, the phone sex operators, grant-holding students or researchers, telephone operators, social workers, nurses, friends, mothers, daughters, compañeras, lovers... only if the caregivers, which all women are and everyone should be (que somos todas y que habríamos de ser todos) rediscover the fundamental role of the labor (remunerated or not) of care and of the social wealth it produces and we withdraw from the invisibilization, hyperexploitation, infravalorization or social stigma of which care is the object, only then will we be prepared to extract from care its transformative force.

A la Deriva argues that "Once brought into the light, the revolutionary potential of care could become the logic that governs our lives, replacing...that other logic which underlies it: that of the imperatives of profit." She therefore sets up real care as an oppositional force against capitalism; care as a value that could supersede profit. If care became the dominating value rather than profit, and everyone became a caregiver ("which all women are and everyone should be"), the entire social, economic and political environment would be transformed. As the world exists now, she writes:

The interests of capital determine [everything]...But, why not begin to imagine and construct an organization of the social that prioritizes persons, that attends to our sustainability – from access to health care to the right to affect – which orients toward our enrichment as human beings – from the access to knowledge, education, and information

to the freedom to move around the world – that listens to our desires? This is the biopolitical challenge.

One strategy- a "caring strike"--that she suggests for constructing this new radical system echoes the theme of the "Wages Due" song, written in 1975 by Boo Watson and Lorna Boschman:

“What do you think would happen if we women went on strike? / There’d be no breakfast in the morning, there’d be no screw at night / There’d be no nurses treatin’ you, there’d be no waitresses servin’ you, there’d be no typists typin’ you-o-o-o”). The song illustrates the power of the understanding that women’s unpaid care work in the home is connected to their underpaid labor in the workforce. The caring strike, A la Deriva writes, "would be nothing other than the interruption of the order...in the moment in which we place the truth of care in the center and politicize it." By situating psychotherapy within care work and connecting it to other forms of care work, I hope to help break down some of the artificial separations imposed by capitalism and increase strength among those who do care.

"Freedom-Centered" Feminism:

As described above, the Wages for Housework campaign was criticized for seeming to work within the terms and conditions of the very system that had marginalized it. These criticisms recall Marx's description of the program of raising wages as only "better payment for the slave" (Weeks, 2011). In “The Problem with Work: Feminism, Marxism, Anti-work politics, and Postwork imaginaries,” Weeks focuses on "the project of feminism in a freedom-centered frame" (2011). Freedom, she writes, "is seen as a practice, not a possession, a process rather than a goal." Furthermore, it is "a double-sided phenomenon": it is destructive, in that it is an "antidisciplinary practice" but it is also a creative practice-a collective practice of world building.

Freedom is also a relational practice; it depends on collective action rather than individual will, and this is what makes it political.

Weeks argues that work has been "relatively neglected...as an arena in which to develop and pursue a freedom-centered politics" because it has been viewed as a domain productive of, and dependent on, hierarchies, a "scene" in which gender, race and class are constructed and performed. Yet, she recalls various gendered laboring practices that are both put to use by, and potentially disruptive of, capitalist and patriarchal social formations. The ultimate paradox, then, is that work itself is not only a locus of un-freedom, it is also a site of resistance and contestation. And here is the trick of care work: "feminized modes of labor, [such as care work], marginalized by, but nonetheless fundamental to, capitalist valorization processes could provide points of critical leverage and sites of alternative possibility. Her project is to explore how "critical consciousness, subversive practices, and feminist standpoints" (like the caring strike, for example) might be developed in the midst of these "feminized modes of labor." This does not mean not asking for wages, but rather demanding something beyond it.

Psychotherapy as Care work

In many ways, psychotherapy fits well within the frame of care work. Psychotherapists perform activities of care, such as listening. And they are also expected to perform affective forms of care, such as showing concern. Lastly, therapists are expected to feel, not only perform, genuine care, epitomized in "empathy." Psychotherapy is extraordinarily intimate; the patient, or client, or consumer (we will discuss the language of psychotherapy in chapter 3; each word connotes a different relationship to "care"), confides their secrets, their fears. Yet, it is also removed; in most practices, the psychotherapist does not "disclose" much of themselves. This dual nature of the psychotherapy session, intimate, yet often one-sided, is characteristic of much

care work. Yet psychotherapy has another seeming paradox, one that is rarer when discussing care work: psychiatry was once dominated by men, and Freud is often held up as a very epitome of patriarchal efforts to pathologize and marginalize women.

How did Freudian psychoanalysis become a piece of "women's work"? A 1986 report from the APA on "The Changing Face of American Psychology" stated that whereas women represented 14.8 of new psychology doctorate recipients in 1950, they constituted 50.1 in 1984 (Howard et al., 1986). Today, women outnumber men in doctoral psychology programs by a ratio of at least 3 to 1. The figures are similar for other mental health disciplines: Men account for less than 10 percent of social workers under the age of 34, according to a recent survey. And their numbers have dwindled among professional counselors — to 10 percent of the American Counseling Association's membership today from 30 percent in 1982 — and appear to be declining among marriage and family therapists. And in psychiatry, women represent 55 percent of current US psychiatry residents (Norris, 2012).

One explanation for this phenomenon is that managed care (the system by which, to contain costs, certain types -and amounts-of treatments are authorized while others are excluded from reimbursement), decreased therapists' incomes in the 1980s and 1990s. This coincided with women entering the "work" force in greater numbers. "Usually women get blamed when a profession loses status, but in this case the trend started first, and men just evacuated," said Dorothy Cantor, a former president of American Psychological Association who conducted a landmark study of gender and psychology in 1995. "Women moved up into the field and took their place" (Carey, 2011). But in "The Feminization of Psychiatry: Changing Gender balance in the Psychiatric Workforce," Wilson and Eagles offer another explanation for the proliferation of women therapists: "Women may pursue the specialty because they have innate abilities suited to

psychiatry and they may well start with more positive attitudes... With a little reluctance, we as male authors accept the evidence that women, in terms of their abilities and attitudes, are collectively better predisposed to become psychiatrists than their male counterparts" (2006). So even today, the paradoxes in care work remain powerful. Are women "coerced" into caring professions because they are paid less and men can get better paying jobs? Are women "naturally" better at caring (as these last writers imply)? And what are the implications of these assumptions; in terms of pay, and in terms of the nature of care work itself? Can care work be a political site of resistance? And if so, how? The following two sections will explore the phenomenon of psychotherapy as care work through first the framework of socialist feminist theory, then through the framework of relational theory.

Chapter III

Socialist feminism

This section will use the theorists Barbara Ehrenreich, bell hooks, Kathi Weeks, Shulamith Firestone, Nancy Folbre and others to elucidate some of the important concepts in socialist feminist theory that will be used to explore psychotherapy as care work. The perspective of socialist feminism can help to both clarify and problematize the issue of psychotherapy as care work. First we will begin by defining some terms.

What is Socialist Feminism

The term “socialist feminism” came to be used in the early 1970s. In *What is Socialist Feminism*, Barbara Ehrenreich (1976), an activist and writer, explains how she and her peers decided to use the term: "We were searching for a word/term/phrase which would begin to express all of our concerns, all of our principles, in a way that neither "socialist" nor "feminist" seemed to...it is much too short for what is, after all, really socialist internationalist anti-racist, anti-heterosexist feminism." bell hooks expresses the enemy of socialist feminism through her phrase "White supremacist capitalist patriarchy." hooks writes that she began using that term "because I wanted to have some language that would actually remind us continually of the interlocking systems of domination that define our reality." Throughout this chapter I want to keep in mind that these interlocking systems are related, dependent on each other. Though here

we will focus especially on the "capitalist patriarchy" elements, it is nevertheless crucial to consider the ways that both socialism and certain feminisms have erased people of color and White supremacy from the discourse. I hope to avoid that in this paper.

In the 1976 essay mentioned above, Ehrenreich summarizes "Marxism" [a strand of socialist thought developed by the revolutionary socialist Karl Marx (1818-1883)] and "feminism," both of which are such sprawling topics that entire libraries are devoted to each individually. But her summaries provide helpful introductions. She writes that "Marxism addresses itself to the class dynamics of capitalist society." These class dynamics are characterized by "systemic inequality," which arises from processes that are intrinsic to capitalism as an economic system. Marxism holds that a minority of people own the means of production, which are all the factories, natural resources, stores, the internet, and whatever else is used to produce and distribute wealth. The majority of people must work out of necessity, under conditions set by the minority owning class. Since the minority means-of-production-owning class makes profits by paying the workers less than the value of what the workers produce through their labor, the relationship between the two classes is necessarily one of "irreconcilable antagonism." What maintains this system of class rule is, ultimately, force. The capitalist class controls, directly or indirectly, the means of organized violence represented by the state--police, jails, etc. According to Ehrenreich, "Only by waging a revolutionary struggle aimed at the seizure of state power can the working class free itself, and ultimately all people."

Feminism, Ehrenreich writes, addresses "the subjugation of women to male authority, both with the family and in the community in general." Feminism, she explains, seeks to fight against the "objectification of women as a form of property," and "a sexual division of labor in which women are confined to such activities as child raising, performing personal service for

adult males, and specified (usually low prestige) forms of productive labor.” As with Marxism, the control that men have over women ultimately rests on “what is clearly a physical advantage males hold over females,” in other words, “on violence, on the threat of violence” (Ehrenreich, 1976).

"Socialist feminism" is not just some forced combination of the two theories. Rather, it is a synthesis that included the premise that class struggle is not confined to the workplace, but is in every arena, including the “domestic,” and that there is no way to understand the specific way sexism acts in our lives without putting it into the historical context of capitalism. Weeks (2012), a contemporary socialist feminist scholar writes that "one of socialist feminisms' major achievements was to rethink dominant conceptions of what counts as labor and attend to its gendered relations...[Socialist feminists posed the question:] was domestic labor properly inside or outside capitalist production?" One of socialist feminism’s important contributions was to situate care work as an intersectional location of capitalist and patriarchal oppression. Weeks also writes that early socialist feminist theories, as we saw in the previous section, explore the possibility that “revolutionary projects” could emerge from the “marginalized” position of care work. Although Weeks believes that the essentialist, dualistic thinking that separates men’s spaces/work and women’s spaces/work proved to be problematic, the idea that marginalized work can be a revolutionary space is useful when considering care work.

Psychotherapy Within the White Supremacist Capitalist Patriarchy

Another important perspective on care work is that it can be interpreted as mobilizing and enabling the very system that marginalizes it. In *Dialectic of Sex*, radical feminist Shulamith Firestone (1970) lays out exactly why care work, specifically psychotherapy, located fully within the white supremacist capitalist patriarchy could potentially be so pernicious:

The term that best characterizes this neo-Freudianism is 'adjustment.' But adjustment to what? The underlying assumption is that one must accept the reality in which one finds oneself. But what happens if one is a woman, a black, or member of any other especially unfortunate class of society?...one must also adjust to the specific racism or sexism that limits one's potential from the beginning, one must abandon all attempts at self-definition or determination. (p. 58-59)

Why were psychiatrists unable to truly help women? she asks. They couldn't help them, because the only way to truly help them is for them to help themselves through "revolution" (Firestone, 1970, p. 61). Yet, she concedes, "half a century later women are waking up. There is a new emphasis on objective social conditions in psychology...the large number of women in these fields may soon start using this fact to their advantage. And a therapy that has proven worse than useless may eventually be replaced with the only thing that can do any good: political organization" (ibid., p. 64). Firestone assumes that political revolution and psychotherapy are mutually exclusive. That if psychotherapy enforces adjustment, it necessarily dampens revolution. Yet this dualistic framework comes out of the very same patriarchal, western tradition the Firestone purportedly challenges. Can revolution and care work coexist? Might one even be intertwined with the other? Can someone demonstrating the symptoms of depression, anxiety, or a variety of other "illnesses" readily join a collective political action group without *some*, perhaps, "adjustment"? Later in the book, Firestone acknowledges that "political action" can exist in places that look very dissimilar to a traditional revolutionary battleground: "Over the centuries strategies have been devised, tested, and passed on from mother to daughter in secret tete-a-tetes, passed around at 'kaffee-klatsches'...or, in recent times, via the telephone. These are not trivial gossip sessions at all (as women prefer men to believe), but desperate strategies for

survival” (ibid., p.123). I am trying to posit whether meetings between politically motivated psychotherapists and suffering clients may in fact not be "trivial [therapy/adjustment] sessions" at all but instead meetings to formulate "strategies for survival." Care work, as Folbre (2012) states, “emphasizes concern for a care recipient’s well-being, not their happiness” (p. 7). Short term “happiness” might be served by “adjustment,” but true “well being” must include the liberation from oppression, and, according to socialist feminism, a restructuring of the entire political-social-economic system.

Within but not of

Donna Haraway (1985), another feminist (neo-)Marxist scholar, best known for her *Cyborg Manifesto* (1985), writes: "Cyborg imagery can suggest a way out of the maze of dualisms in which we have explained our bodies and our tools to ourselves... Though both are bound in the spiral dance, I would rather be a cyborg than a goddess." Haraway is sometimes described as “postgender,” in that she rejects the tropes of male/female. Additionally, she rejects the distinctions between work and love, and politics and non-politics. A “goddess,” to Haraway, might represent the position that revolution can only be achieved through harnessing the female power of domestic/marginal spaces (i.e. Firestone’s “kaffee-klatsches”). But Haraway suggests instead the image of the cyborg--both machine and organism--as a metaphor for “women” (“there is not even such a state as 'being' female”) who exist both inside and outside--exploited by and complicit within networked hegemony. Other authors have also taken a “both/and” approach, such as Elizabeth King Keenan (2001), who writes that therapists “can operate within, but not be completely of dominant power structures” (p. 211). The perspective of “within, but not of” is useful for conceptualizing care work within capitalism. Keenan imagines

psychotherapists as something like double-agents, doing enough to stay within the system, while practicing resistance to its disciplinary structures whenever possible.

Abramovitz (1998), too, is convinced that the “false distinction” between macro and micro work, between work located squarely within the system and work outside of it, must and can be done away with. Abramovitz situates the problem discussed by Firestone specifically within the context of social work, and social work can be seen as a case study of what might be possible in psychotherapy in general. Abramovitz writes that the social work profession “can boast of a long history of progressive activism directed to individual and social change. At the same time, observers within and outside social work have often accused the profession of serving as a handmaiden of the status quo.” In the period from 1896-1914, she writes, the social-change-oriented settlement house movement (SHM) vied for control with the older more individually oriented charity organization society (COS). Until the late 19th century, most social work practice followed the COS model, which dictated that personal failures and receipt of public relief caused poverty. In sharp contrast to COS perspective which “blamed the victim,” SHM argued that poverty stemmed from adverse social conditions. In 1924 a pioneer of group work Eduard Lindemann warned that social workers who “placed all the blame for maladjustment upon the individual and none on the social order must in the end become servile to those whose interests are vested in that social order.” This was Firestone’s point. Yet, Abramovitz details how some social workers *within* the movement rebelled against this model. The “rank and file movement,” for example, helped social workers accept political action as a legitimate professional function. *They fought to improve their own working conditions so that they could better serve their clients.* However, the draw toward “professionalization” proved too strong to resist. The psychiatric-model emphasis on inner problems gave social work a way to serve

middle class people as well. By expanding its clients to include middle class, the new “psychiatric” social workers could collect a fee. This demonstrates how being complicit in the system (i.e. dependent on wages), social workers could benefit financially from serving as “handmaidens” of the dominant power. By obscuring the outside/social context and placing the problem within the individual, social workers could make more money. Yet the “rank and file” movement, in contrast to the movement towards “professionalism,” shows the potential of radical care work/psychotherapy. In order to do radical work liberating others, the rank-and-filers understood that they had to work to liberate themselves.

Joint allies

Dawn Belkin Martinez, a contemporary social worker and writer, creates a vision for what socialist feminist psychotherapy would look like. Central to this vision is the spirit of mutual liberation embodied in the rank and filers. Martinez first explains the problematic nature of psychotherapy under capitalism, expanding Firestone’s concept of “adjustment.” Martinez (2005) writes: “The dominant discourses on mental health and mental illness under capitalism are biological/medical models that treat most forms of mental illness as ‘pathologies.’ Ignoring the economic, political and social causes of a number of widespread mental health problems, these discourses ‘blame the victim’ when individuals deviate from the narrow range of accepted behavioral norms.” The broad acceptance of the “biological/medical model” is not an accident, according to Martinez. Rather, it is useful to those in power because it keeps “patients as *objects* to be manipulated and controlled for the benefit of capital.” The medical/biological discourses around mental health “reinforce people's' problems and, once they are internalized, keep them locked into self-subjugating social narratives.” Thus, there is not a true attempt to create wellness, because wellness would involve changing the economic, political, and social fabric. In

her vision for “life after capitalism,” Martinez imagines that “individuals in health care systems will be viewed as *subjects*, working alongside physicians and other health care workers toward their individual and collective empowerment.” The distinction between object and subject is an important one, and one that will be echoed in the relational theoretical perspective. To Martinez, the concept that care workers will see both themselves and their “patients” as “subjects” means that they will all be working together in a “joint project” (Martinez, 2005). An essential component of this is the removal of the “hierarchical system” that places psychotherapists as “revered experts” (ibid.) Instead, the psychotherapist-client relationship is co-constructed.

Love

In "Love and Money," Folbre (2012) challenges the assumption that "that care is motivated either by love or money and that these two different motivations represent hostile worlds." A common assumption, she states, is that paying money for care undermines love, so care provided for love should not be paid. And on the other hand, care provided for money does not and should not entail love. Folbre, however, emphasizes the ways in which “love and money often combine and intersect, sometimes (though not always) in complementary ways.” This perspective leads her to “reject a common usage of the term “commodification” as a pejorative term applied to any service provided for money, implying that such service is stripped of emotion or concern for others” (Folbre, 2012, p. 2). The term “care work,” instead, suggests that love and money need not be seen as mutually exclusive. Folbre emphasizes “love” as a significant motivator of care workers. Care workers are driven to work, then, by forces beyond “extrinsic rewards” like “the gratification of helping others” or “a genuine desire to make the care recipient better off.” Love is powerful, to Folbre, because it cannot be explained by capitalism. A similar view is expressed by Jaleh Mansoor, an art history scholar with a focus on

Marxist theory and feminism. She writes of the existence of a “fold” that “is inclusive of the negative remainder that capitalism has not fully penetrated and replicated in its own logis: filiation, the last traces of that mysterious thing Marx called ‘species being,’ creaturely warmth mixed with ‘emotional’ suffering, that irreducible nexus of potential-within-attachment that gets called love.” Love, in this view, can exist alongside capitalism, but not simply or cleanly—“it’s a delicate dialectic, more like lace than machinery” (Mansoor). Thus, as the authors in the next section emphasize, there is great danger in forgetting the threads of care work that are work, not love.

Money

There is an important argument for why we cannot allow "care" to eclipse "work" in considering care work. Miya Tokumitsu (2013) writes: "There’s little doubt that ‘do what you love’ (DWYL) is now the unofficial work mantra for our time...Its real achievement is making workers believe their labor serves the self and not the marketplace." But, she writes, “emotionally satisfying work is still work, and acknowledging it as such doesn’t undermine it in any way. Refusing to acknowledge it, on the other hand, opens the door to the most vicious exploitation and harms all workers. Nothing makes exploitation go down easier than convincing workers that they are doing what they love.” Tokumitsu is writing about and from the perspective of academia. In her analysis, care work is in fact denigrated by the DWYL ideology because it is not included in it. It is instead considered "unglamorous work that keeps society functioning." But she is referring mainly to care workers who have not achieved “professionalization” (i.e. she mentions specifically “personal care aid” and “home care aid”). I would argue that most care workers who practice psychotherapy, in contrast, consider themselves more in line with her view of academics (i.e. doing work that is “creative” and

“intellectual”) than her view of care workers (i.e. doing work that is “repetitive, unintellectual”). Thus, I think her critique of DWYL applies to psychotherapists not in that they degraded by their exclusion from the category, but that they are, like academics, at risk of exploitation. Furthermore, she agrees with Folbre on the particularly devastating consequences for women: “What unites all of this work, whether performed by GEDs or PhDs, is the belief that wages shouldn’t be the primary motivation for doing it. Women are supposed to do work because they are natural nurturers and are eager to please; after all they’ve been doing uncompensated childcare, elder care, and housework since time immemorial. And talking money is unladylike anyway” (Tokumitsu, 2013). This tongue-in-cheek statement reveals the danger of equating women with love, men with money-- women who do work, or humans who do work seen as “feminized,” won’t get paid (enough) for it.

Because our ability to do political work as psychotherapists partly depends on how much we “need” money/status ourselves, it is crucial that hand-in-hand with advocating for our clients, we must advocate for ourselves as well. The result of being financially trapped (or psychologically trapped in the drive for “professionalization”--which comes with status as well as material benefits), is that psychotherapists are forced to be complicit with the interests of power/state, because that is the way to get more money (and power). Thus self-liberation and liberation for clients truly goes hand in hand.

Summary

The central concepts from socialist feminism that are useful for interpreting psychotherapy as care work include “adjustment,” Firestone’s “kaffee-klatsches,” the cyborg, “within but not of,” joint allies working toward liberation, and non-dual conception of love and money (care and work). This section took concepts from outside psychotherapy, and positioned

psychotherapy within them. The next session will explore concepts from relational theory, to see how concepts from within psychotherapy itself can further help us position psychotherapy as care work.

Chapter IV

Relational Theory

In this section I will grapple with the topic of psychotherapy as care work through the framework of relational theory. Relational theory, it is important to note, draws heavily on feminist scholarship, and developed largely out of conceptual shift that feminism created. Thus, there are many continuations and overlaps between the two theories. In this section, I will explain key concepts in relational theory, and investigate how relational therapists grapple with both the “care” and the “work” of psychotherapy. I will attempt to highlight how relational theorists imagine psychotherapy, as paid “care work” in economic contexts described in the previous framework, to have potential as authentic and liberating space.

Relational Psychotherapy as a Set of Values

Contemporary relational theory does not so much advocate specific therapeutic techniques, but rather a recognition that two people are always interacting with one another in any dyadic clinical situation (Berzoff, 2011, p. 222). Relational theorists challenge the assumption that a therapist can objectively analyze a client. In contrast, relational theorists see the clinical encounter as composed of two subjects, each possessing subjectivity-- i.e. perspectives, experiences, feelings, beliefs, sensations and desires. Relational theorists often hold that there is more that is the same about a client and a therapist than is different. This is a

shift away from the medical, Freudian model of seeing the client as the pathological one to be helped by a therapist who is always already healed (Berzoff, 2011, p. 222).

According to many contemporary relational theorists, Sandor Ferenczi (1873–1933) was the first psychoanalyst to truly consider the impact of the analyst’s subjectivity within the clinical encounter, and many trace the origins of relational theory and practice to the conflict between him and Freud over the analyst’s role (Aron, 1991, p. 47). A variety of other theorists such as Melanie Klein, Harry Stack Sullivan, and D.W. Winnicott also put human relationships at the center of the psychoanalytic endeavor in their work with clients throughout the first eight decades of the twentieth century (Berzoff, 2011, p. 222), but it was not until the 1980s that the term “relational theory” was coined by Greenberg and Mitchell in their text *Object Relations in Psychoanalytic Theory* (1983). Greenberg and Mitchell divided psychoanalytic theories into a (Freudian-derived) “drive” model, and a “relational” model, attempting to show the conceptual differences between the two groups, as well as the strands of consensus. Since then, contemporary relational psychoanalytic theory has grown as field; some of the leading thinkers and writers in the field from whom this paper will draw from include Jessica Benjamin, Lewis Aron, Mal Slavin, and Robert Stolorow and George Atwood, founders of “Intersubjective-Systems Theory.” In this section I will also draw somewhat from the field of “relational-cultural” theory, which formed in the 1970s through the work of psychiatrist Jean Baker Miller; though it has a different origin than relational psychoanalytic theory, the two share certain conceptual similarities.

To understand the origins of relational theory, let us first look briefly at the modern scientific Western tradition that influenced Freud, the founder of what I will refer to as “classical” or “traditional” psychoanalysis.

A Brief History of Relational Theory

The “Cartesian myth of the isolated mind.”

Stolorow and Atwood explain that “traditional Freudian theory” is “pervaded by the Cartesian [of or relating to French philosopher Rene Descartes] ‘myth of the isolated mind’” (2012, p. 442). Descartes (1641) philosophy was one of dualisms and bifurcations, between mind and body, cognition and affect, inside and outside. He “pictured the mind as an objective entity that takes its place among other objects, a ‘thinking thing’ that has an inside with contents and that looks out on an external world from which it is essentially estranged” (Stolorow, 1992, p. 4). Freud introduced the idea of the unconscious, but similarly understood the psyche to be a “container of contents” (wishes, drives, urges); the mind, according to Freud, is a distinct “thing,” that, “precisely because it is a thing, is ontologically decontextualized, fundamentally separated from its world” (Stolorow, 1992, p. 4). Furthermore, “Western” science in the modern period of the late 19th and early 20th centuries embraced the concept that truth could be known through Bacon’s scientific method. In its early days, psychology as a field sought to demonstrate its validity by modeling itself on hard sciences (Jordan, 2000, p. 1006). So these two concepts-- that the “self” was a distinct, isolated “thing,” and that it could be observed and known-- pervade Freud’s theory of psychoanalysis (Jordan, 2000; Stolorow and Atwood, 1992).

Postmodernism and psychology.

Contemporary relational theories and practice ascended in the broader zeitgeist of postmodernism. Postmodernism suggested a relativistic stance toward “truth,” and submitted that the observer can never be separate from the observed-- that is to say, that “the subjectivity of the researcher always affects what we can know about the subject” (Berzoff, 2011, p. 235). From the late 1980s to the present, many fields such a feminism, critical race theory, structural theory,

philosophy, literary criticism, linguistics, sociology, political theory, and anthropology began to question the assumption that anything essential and true can be known about a text, a scientific problem, or a person. In the field of psychology, postmodernist theory led to the deconstruction of concepts like “identity” that had previously seemed “fixed, continuous and coherent” (Berzoff, 2011, p. 235). Under the influence of postmodernist theory, psychologists began to see concepts like “identity” as “as fluid, discontinuous, and created out of language, out of power relations, and within systems of meaning” (Berzoff, 2011, p. 235). While modernists once spoke of the self as separate, individual, and bounded, postmodern theorists critiqued the idea of a separate, distinct “self” as based in Western power arrangements (Benjamin 1995; Hoffman 1998; Mitchell 1997 as cited in Berzoff, 2011, p. 235). Foucault asserted that psychological theories are always discourses of power, in that they define bodies of knowledge and contain the values and worldviews of the dominant culture. As such, they are used for disciplinary practices and as forms of social control” (Berzoff, 2011, p. 235). Relational theory meshed with the deconstructivist tendencies of the time; just as the subjectivity of the therapist in the room was revealed, so too was the subjectivity of Freud in the landscape of psychoanalysis. His theories were revealed as from a specific person in a specific place and time.

Freud, Ferenczi and the role of the therapist.

For Freud and his successors, though, “the health, rationality, maturity, neutrality, and objectivity of the analyst were idealized” (Aron, 1991, p. 247). In Freud’s *Observation of Transference Love* (1915) he advocated that the analyst practice “abstinence” throughout the treatment to allow the patient’s drives and cravings to truly emerge, so that they could be examined (and hopefully controlled or dissipated). In the interest of helping the patient, the analyst must refrain from “all such spoiling” so that the patient is “left with unfulfilled wishes in

abundance” (Freud, 1919, p. 164). He envisioned the treatment taking place as in a scientific laboratory, but one that was emotionally, rather than physically sterile. In this setting, the analyst’s actions (“spoiling”) would be potential confounding variables.

Informed by his own clinical practice, Ferenczi, a follower of Freud’s, began to advocate a more active role for the analyst that contested Freud’s opinion of the benefit of therapeutic abstinence. Ferenczi saw pure objectivity on the therapist’s part as a way of distancing himself from the client, including from the client’s traumatic experiences (Berzoff, 2011, p. 224). In Ferenczi’s view, a “neutral” “abstinent” stance could harm, rather than heal, the patient.

Ferenczi and his colleague Rank went beyond methodology and reexamined the theoretical and technical foundation of psychoanalysis. In a series of ground-breaking publications, Ferenczi delineated his attempts to introduce a more active role for the analyst (Rachman, 2007, p. 77). They hoped to expand beyond Freud's emphasis on what the analyst “should not do,” and explain what he *should* do. Ferenczi believed that the “rule of empathy” should be the core of clinical interaction (Rachman, 2007, p. 77).

Furthermore, Ferenczi disagreed with Freud’s emphasis on biological “drives,” and instead looked at trauma as a crucial factor in determining human behavior. Freud’s “seduction hypothesis” held that his patients’ reports of childhood sexual abuse were largely pathological fantasies expressing their oedipal urges. Ferenczi presented a radically different hypothesis; what if the reports were taken as evidence of real traumatic experiences? Ferenczi held that in the everyday life of the individual the “persistent traumatic effects of chronic overstimulation, deprivation, or empathic failure is what causes neurotic, character, borderline and psychotic disorders” (Rachman, 2007, p. 81). By using empathy, the therapist could help patients heal from past trauma, rather than re-traumatize them through cold emotional distance.

For sixty years, Ferenczi's empathic method was marginalized in the field of mainstream psychoanalysis in favor of the Freudian medical model. But relational theorists returned to the theories Ferenczi set forth, and saw how they fit with other postmodernist trends (Rachman, 2007, p. 83).

Core Ideas of Contemporary Relational Psychotherapy

A “two-person psychology.”

Relational theory is based on the concept of a “two-person psychology” or a “regulatory-systems” conceptualization of the analytic process (Aron, 1991, p. 248). This suggests a view of the “patient-analyst relationship as continually established and reestablished through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by, each other” (ibid.). The “two-person psychology” draws from contemporary feminist ideas about the mother-infant relationship. This is an example of how feminist theory created a conceptual shift that paved the way for relational theory. Aron writes that traditional psychoanalysis' neglect of the mother's subjectivity in the mother-infant dyad is in many ways analogous to its neglect of the therapist's subjectivity in the analytic dyad. “Only with the recent development of feminist psychoanalytic criticism,” he writes, “has it become apparent that psychology and psychoanalysis have contributed to and perpetuated a distorted view of motherhood (Dinnerstein, 1973; Chodorow, 1978; Balbus, 1982; Benjamin 1988)...We have been slow to recognize or acknowledge the mother as a subject in her own right” (Aron, 1991, p. 245-246). Past (mostly male) psychoanalysts viewed the mother as simply an object for the infant's desires and drives. Contemporary feminist theories, however, view the mother as a subject with desires, feelings, and drives of her own as well. The mother (or caretaker) and infant both affect each other in a continual loop. In some ways, psychoanalysis has considered the patient as an “object” to be

studied. But in terms of possessing subjectivity in the room, “psychoanalysis has considered analysts only as objects while neglecting the subjectivity of analysts as they are experienced by the patient” (Aron, 1991, p. 247). Aron explains that adopting a “two-person psychology” (or a “relational perspective”) opens up “the possibility for the investigation not only of subject-object relations but of subject-subject relations” (ibid.). As Stephen Mitchell (1988) stated, “If the analytic situation is not regarded as one subjectivity and one objectivity, or one subjectivity and one facilitating environment, but two subjectivities- the participation in and inquiry into this interpersonal dialectic becomes a central focus of the work’ (p. 38). Since it is impossible to “examine” one subjectivity in the room, the relationship is then the way of experiencing, rather than neutrally studying, the other’s subjectivity. Both individuals struggle to make contact and to articulate themselves in the context of the “intersubjective field” (Mitchell, 1988, p. 38).

Intersubjectivity.

In *The Patient’s Experience of the Analyst’s Subjectivity*, Aron (1991) defines “intersubjectivity” as “the developmentally achieved capacity to recognize another person as a separate center of subjective experience” (p. 246). Intersubjectivity involves the realization that just like you, the person sitting across from you has a mind that thinks. Jessica Benjamin (2004), a leading relational psychoanalyst, defines “intersubjectivity” in terms of a relationship of “mutual recognition”-- a relation in which each person experiences the other as a ‘like subject,’ another mind who can be ‘felt with,’ yet has a distinct, separate center of feeling and perception (p. 5).

Her expanded relational perspective also includes the awareness of multiple self-parts, in both analyst and patient, that create different dyadic pairings within the same relationship. Her concept of intersubjectivity also emphasizes not just the fact of mutual influence (Stolorow and

Atwood), but the consciousness that there is “a bi-directional dance between patient and analyst that each person registers differently” (Benjamin, 2009, p. 441). Thus, each person registers the other’s mind, the relationship, and the knowledge that the other person experiences the same relationship differently.

“Countertransference.”

In traditional psychoanalysis, “transference” refers to the patient’s feelings toward the analyst, based on his or her experiences, personality structure, and psychopathology. The analyst was to be as anonymous and neutral as possible (to practice “abstinence”) so the transference feelings would be as purely as possible revealing of the patient. “Countertransference” was used to refer to the analyst’s non-assessment-based reactions to the client. Because an analyst was expected to be neutral and objective, and well-analyzed himself, countertransference was viewed as “an unfortunate, but hopefully rare, lapse” (Aron, 1991, p. 247). Some relational therapists oppose the term “countertransference” and “transference” because of the different positions they suggest for the therapist and the client. Aron (1991), for example, writes that “In my view, referring to the analyst’s total responsiveness with the term countertransference is a serious mistake because it perpetuates defining the analyst’s experience in terms of the subjectivity of the patient” (p. 248). The term *countertransference* “obscures the recognition that the analyst is often the initiator of the interactional sequences” (ibid.). Relational theorists challenge the idea that an analyst could ever appear completely anonymous; even a pose of attempted “neutrality” would reveal many things to a patient. As Aron (2006) writes, “self-revelation is not an option; it is an inevitability” (p. 40). This takes Ferenczi’s advocacy of an active therapist one step further; a therapist, Aron says, could not be neutral and objective even if he wanted to. He is always giving off signals that are interpreted by the patient.

Relational Theory and Care

Mutuality, not symmetry.

The inevitability of self-exposure on the part of the therapist does *not* imply, for relational theorists, that therapists should be entirely spontaneous, reacting to a client however they would with a friend. The therapy relationship is not that of regular friendship in that, among other reasons, it is intentional in its primary aim, which is to help the patient. Relational therapists attempt mutuality, but not equality; roles are different. Although therapist and client both participate in creating the intersubjective field, they do so “asymmetrically.” The point of the relationship is to explore the client’s internal and external world, not the therapist’s. Aron writes that “mutual influence does not imply equal influence, and the analytic relationship may be mutual without being symmetrical” (Aron, 1991, p. 266). According to Aron, mutuality means “reciprocity and commonality” but not necessarily “symmetry or equality.” There may be mutuality between client and therapist without suggesting that they are equal in power, or advocating that they should or could be. “Psychoanalysis, then, is mutual but inevitably asymmetrical- inevitably because it is the patient seeking help from the analyst, who is the professional and is invested with a certain kind of authority and responsibility” (Aron, 1991, p. 266).

Mutuality, according to Jordan (2000), is about a quality of engagement and being real, with a constant awareness of what the possible impact will be on the other person, the patient. Therapists must practice a kind of “anticipatory empathy” about how things will impact the patient (p. 1011). The authenticity of the therapist is informed by the possible impact on the patient, and is used in the service of the growth of the patient. But it does involve real responsiveness on the part of the therapist and “real responsiveness often involves real

vulnerability as well for the therapist” (p. 1011). Jordan describes a kind of “fluid expertise”; “both people bring strengths, wisdom, gifts, troubles and blind spots to this relationship. The therapist holds some special expertise in the area of mental suffering and relationships. Patients bring knowledge about themselves, wisdom about many matters, and insights about the therapist that are invaluable” (Jordan, 2000, p. 1011).

The intersubjective analytic third; the moral third.

The concept of “the third” is used across a variety of schools of psychoanalysis. It has been developed and extended by theorists, including Ogden, Green, and Benjamin, but it is often defined ambiguously and inconsistently across schools (Aron, 2006, p. 356). The relational concept of the “analytic third” plays on themes like Winnicott's transitional space and Lacan's "name of the father," but is distinct. For some, the third refers to a space beyond the dyad, a context within which we emerge; for others, the third is an emergent property of a dyadic interaction, and yet for others, the third is a dyadic achievement that creates the psychic space necessary for reflexive awareness and mentalization (ibid.). Here I will elucidate some meanings of the third, especially as the term is used within the theoretical framework of Benjamin's intersubjective theory, which I believe is most relevant to the question of the therapist's ability to “care” for their client.

Thomas Ogden (1994) writes that therapist and client ideally create what he calls the “analytic third” or what others have called a “third space,” which is neither the client's mind in isolation nor the therapist's mind in isolation but a space that they cocreate and can reflect upon together” (Berzoff, 2011, p. 226). In a “two-person psychology,” where the concept of a “mind” as a singular unit is only a metaphor, the “analytic third” is the “place” from which both client and analyst can recognize their own and the other's subjectivity. Ogden also describes the

“analytic third” as a “third subject, unconsciously co-created by analyst and analysand, which seems to take on a life of its own in the interpersonal field between analyst and patient. The third subject stands in dialectical tension with the separate, individual subjectivities of analyst and analysand in such a way that the individual subjectivities and the third create, negate, and preserve one another” (Ogden, 1994, p. 17). Aron uses the metaphor of a triangle to express how the “third” creates “room to breathe” in a dyad that would otherwise be just a two-dimensional line (Aron, 2006, p. 354-55). The line between two points creates a dynamic of either/or, whereas from the third point, one can adopt the attitude of both/and.

Jessica Benjamin (2007) expanded the idea of the third and introduced a new phrase, “the moral third” or the “third in the one” to express the “ability to maintain internal awareness, to sustain the tension of difference between my needs and yours while still being attuned to you” (p. 13). In calling this the moral third, she suggests “that clinical practice may ultimately be founded in certain values, such as the acceptance of uncertainty, humility, and compassion that form the basis of a democratic or egalitarian view of psychoanalytic process” (p. 34). Thus, it is intimately connected to the desire to provide care.

She compares the analyst’s “moral third” to a mother’s experience with her infant: “The parent accepts the necessity of asymmetry, accommodating to the other as a way of generating thirdness and is transformed by the experience of opening to mutual pleasure. This, of course, is what therapists DO in a hundred different ways, every day” (cited in Brown, 2005, p. 44). For Benjamin, movement is essential to the experience of being in the third; rather than a static place, it is one in constant adjustment: “In my view of thirdness, recognition is more than verbal speech, it begins with the early non-verbal experience of sharing a pattern, a dance, with another person” (Benjamin, 2007, p. 7).

Disconnections and repair.

In spite of, or, as relational therapists might say, implicit in, attempts to “care” about and for the client, disconnections are inevitable and ubiquitous; people misunderstand one another, hurt one another, fail one another empathically, and simply let one another down (Jordan, 2000, p. 1007). A key feature of relational theory lies in Ferenczi’s view that the trauma of a disconnection is compounded by the analyst’s failure to acknowledge it, even to himself. In “Confusion of Tongues” (1933) Ferenczi writes of the therapist’s “professional hypocrisy:”

We greet the patient with politeness when he enters our room, ask him to start with his associations and promise him faithfully that we will listen attentively to him, give our undivided interest to his well-being and to the work needed for it. In reality, however, it may happen that we can only with difficulty tolerate certain external or internal features of the patient, or perhaps we feel unpleasantly disturbed in some professional or personal affair by the analytic session. (p. 225)

Here, Ferenczi acknowledges how the analyst’s subjectivity can negatively affect the client. If the analyst is distracted, upset, or anything but completely attuned, present and open, the client will sense it in some way. That, however, is a normal, nontraumatic experience in daily life.

What makes it potentially traumatic is the therapist’s desire to pretend that his attention is completely undivided. So, says Ferenczi (1933), “I cannot see any other way out than to make the source of the disturbance in us fully conscious and to discuss it with the patient, admitting it perhaps not only as a possibility but as a fact” (p. 225). When therapist can acknowledge the inevitability of such experiences, the “symbolic repetition of old wounds [therapists] have struggled to avoid, [therapists] are less likely to become dysregulated and so are able to make use of what has been revealed” (Benjamin 2009, p. 444). Thus, “what usually solidifies re-

traumatization in the analytic dyad is not the enactment itself but the analyst's failure to acknowledge, which the patient correctly grasps as the avoidable failure" (Benjamin, 2009, p. 444).

Thus, a neutral, uninvolved, inexpressive position on the part of the therapist may actually interfere with therapeutic healing. People often enter therapeutic relationships due to trauma from early relationships. In other words, failures of empathy, to different degrees. If the therapist remains "neutral," the patient might be left with a repetition of the original relational failure; this can be retraumatizing; harming, rather than healing. For instance, in the original relational context the child might have learned that she was not responded to when sad. She was told she wasn't sad or her feelings went unnoticed or she was made to feel bad for feeling sad. If the therapist similarly gives the impression that she should not be feeling how she is feeling, or that he doesn't care how she is feeling, a retraumatization can occur.

When these interactions happen frequently, the acute disconnection settles into a chronic disconnection. Then the less powerful person twists herself to fit into the only relationship that exists, one that is not characterized by mutual empathy or mutual interest in the other's growth. Carol Gilligan (1982) talks about this as "keeping yourself out of the relationship in order to stay in the relationship" (as cited in Jordan, 2000, p. 1007). In this process, one loses authentic connection both with the other person and with oneself. By acknowledging the "professional hypocrisy," however, the therapist can hopefully avoid the insult on top of injury. The sadness will still be there, but the connection can be repaired.

Beyond doer and done to.

What holds the therapist back from being honest, with herself and her client, about the limits of her care? Benjamin writes "the analyst, like a mother, may feel that her separate aims,

her being a person with her own needs, will kill the patient. She cannot distinguish between when she is holding the frame in a way that is conducive to the patient's growth and when she is being hurtful to the patient; when is she stressing the patient beyond what he can bear? How can she bear in mind the patient's need to safely depend on her and yet extricate herself from feeling she must choose between his needs or her own? Such a conflict may occur when an anxious patient calls on the weekend, or when the analyst goes away" (2004, p. 14). The analyst's "free time" (i.e. on weekends or vacation) are negative reminders that the caring enjoyed by the client is "work" for the therapist.

Yet, Benjamin explains how this is not only *not* paradoxical with true care, but how the situation can even be used to strengthen the relationship and the "treatment." Like the mother, the therapist must recognize her own belief that "leaving is tantamount to killing" (Benjamin, 2004, p. 16). By modeling self-preservation, the therapist can show the client that neither party needs to be "killed" for the relationship to continue. By acknowledging the feelings on both sides, encouraging the client to share her feelings, and sharing the therapist's own experience with the client, the client can move back into a belief in empathic possibility.

Benjamin expands on Ferenczi's encouragement to make the source of disturbance fully conscious. Using the analogy of the mother-infant relationship, Benjamin describes the "inevitable moment when twoness arises in the form of the mother's need for sleep, for the claims of her own separate existence" (2004, p. 24). For many a mother, Benjamin writes, "this is experienced as the moment of truth, rather like Lacan's kill-or-be-killed moment" (ibid.). For the analyst, this feeling may arise, for example, at a moment when she needs to end the session, or hang up the phone. The risk in these moments, for Benjamin, is the impulse to go towards "self-abnegation," in the form of a mother suppressing her exhaustion, or a therapist lingering on

the phone, or banishing a distracted thought of a snack, in order to “foster the illusion that mother[/therapist] and baby[/client] are one” (ibid.). In these moments, Benjamin believes that a “surrender” to the third, rather than submission to another person’s tyrannical demand or an overwhelming task, can provide an alternative, healing way out of the “kill-or-be-killed” dichotomy (ibid). The baby (and client) are soothed by the fact that mother (or analyst) “is not herself distressed, but is reflecting and understanding his feeling” (ibid).

Benjamin calls that initial panicky feeling-- that you must either kill or be killed--the “doer-done to” relationship (Benjamin, 2004, p. 6). But the third offers a way out, according to relational theorists. Benjamin writes that escape from the dichotomous either/or position is possible if “the analyst takes on the responsibility for forgiving herself and thus being able to transcend the shame of her difficulties enough to talk about and analyze them (without excessive or impulsive self-disclosure)” (Benjamin, 2009, p. 90). Until then, patient and analyst will be caught in a spot where the acceptance of one person’s subjectivity meant an obliteration of the other’s. In Benjamin’s words, they will become “thrown into the axis of reversible complementarity, the seesaw in which our stances mirror each other” (as cited in Aron, 1991, p. 203). There must be a move beyond this power struggle to a level of metacommunication that allows the dyad to return from complementarity to mutuality and recognition. What Benjamin attempts to theorize is a point of thirdness that allows the analyst to identify with the patient’s position without losing her own perspective, to move beyond submission and negation, thus reopening intersubjective space” (Aron, 2006, p. 351).

Benjamin uses the term “surrender”-- which she says refers to the ability to sustain connectedness to the other’s mind while simultaneously accepting separateness and difference (2004). Surrender, unlike submission, implies freedom from any intent to control or coerce, and

freedom from feeling controlled or coerced. Benjamin writes: “As a supervisor, I often find myself helping the analyst create a space in which it is possible to accept the inevitability of causing or suffering pain, being ‘bad,’ without destroying the third” (Benjamin, 2004, p. 27). In many ways this harkens back to Klein’s “depressive position,” yet it is distinct partially because of the existence of a third space, the place where both subjectivities are held.

Relational Theory and Work

The Therapist’s Financial Insecurity.

Rachel Peltz states that “the goals of a free market (unregulated) economy are in direct conflict with the goals of a democratic society committed to providing social safety nets for its members” (Hollander, Layton, & Gutwill, 2006, p. 67). This raises a fundamental paradox of “care work” (in the United States)-- who pays for it? Muriel Dimen writes: “Everyone-- clinician and patient alike-- wants analysts to be as invulnerable as tenured full professors, even though they actually feel about as secure as part-time adjuncts” (Hollander, Layton, & Gutwill, 2006, p. 32). The question of money puts therapists squarely in the midst of a potential “kill-or-be-killed” scenario, where taking better or more care of clients is often “in direct conflict” with making more money. Thus, the “work” aspect of therapy presents many opportunities for disconnection between therapist and client. And analysts “have been so uncomfortable with their own feelings of need and greed...that they have tended, like Freud, to treat money as a psychological problem for patients and merely a practical one for themselves” (ibid.). However, within the logic of relational theory, the constraints imposed by capitalism can also be seen as opportunities for building a more healing relationship.

Paying for care; bringing back objectivity and truth.

Malcolm Slavin and Daniel Kriegman suggest the potential usefulness of Winnicott's

concept of “objective countertransference” for understanding constraints like paying for care. According to Slavin and Kriegman (1998), Winnicott used the phrase to mean “those aspects of the therapist’s feeling about the patient that derive not from pathology in the therapist, nor from pathology in the patient, nor even from the specific character and style of the therapist as it interacts with the character and style of the patient” (p. 247). In other words, they advocate a dialectical position that embraces the relativism of postmodernism on the one hand, and yet simultaneously recognizes that certain principles of life can be perceived by two people as “real.” They expand Winnicott’s concept to refer to “the affective dimension of something broader and more fundamental in the nature of human relating: the absolutely inescapable, major conflicts of interest that exist in the background between even the two individuals who share in the closest, most mutualistic, relationship on earth” (ibid.). The fact that the patient pays the analyst for care is one such “inescapable” space where there is a “real” and perhaps, according to Slavin and Kriegman, objective conflict of interest; the therapist would rather receive money, the client would rather not pay it.

Slavin and Kriegman (1998) discuss a client who experienced “recurrent, extreme distress at ‘having to pay to be cared about’ by her analyst” (p. 255). In a more traditional Freudian model, the analysis might have focused on “meanings that historically had shaped [the patient’s] subjective world” that related to this conflict (ibid.). The analyst would have investigated why the issues of payment was so distressing to this particular client, given her specific personality and history. In fact, the analyst in this case *did* start out by focusing on that dimension. But eventually and ultimately, the analyst “conveyed to [the patient] that he could see that money was an indication of one of the ways in which their interests did, in fact, diverge. In charging her, he acknowledged, he could see that he was clearly pursuing his own interests-

which, in this respect, were quite different from and actually in conflict with hers” (ibid.) That is not to say that she did not have a unique response to the situation of having to pay for therapy. It is only to say that the therapist saw that the client seemed to need something more or different than an exploration of her feelings. Rather, she “seemed to need him to recognize that her feelings were, in part, responses to certain real implications of paying him for maintaining their current relationship. That is, she needed to have a firmer sense that her analyst was going to be able to acknowledge the existence and potential implications of the existential dilemmas created by inherent conflicts of interest” (p. 256). She wanted to be seen not as a “patient” with idiosyncratic “transference,” but as a healthy person with a “normal” response to a situation. The authors write: “She seemed to need to see if he could face the ways in which his interests were clearly different from hers and, in fact, were naturally biased toward himself” (p. 256). She wanted to see that the therapist/mother would and could understand her distress, but was not so distressed by it himself that he couldn’t even acknowledge it.

The authors explain how it might be retraumatizing for the client if the therapist implies or insists that a “healthy” concern is strange or pathological or even remarkable. Like Benjamin, Aron and Ferenczi, they suggest that the underlying reason that a therapist might engage in this pretend act is that it might be painful for the therapist to acknowledge the limits of his own care, his own limited capacity for “oneness.” Yet it is exactly by acknowledging the limits, that it might be possible to truly surpass them (Slavin & Kriegman, 1998).

The authors explain that they view the patient’s distress as adaptive because it would be strange to *not* be suspicious of the “caring” work done by therapist. “The analyst,” they explain, “is an unrelated individual who asks the patient to pay (sometimes dearly) for what is always experienced (at times by even the most grateful patients) as a relatively small investment in

terms of visible costs to the analyst. (p. 258). As Ferenczi expressed through his concept of “professional hypocrisy,” Slavin and Kriegman assert that there is something genuinely suspect about what we ask of, and promise to, our clients:

Though I, as analyst, give you little that is tangible in return- and, in fact, insist that you pay me- I expect you to trust me, open yourself up to my influence, and give free reign to powerful fantasies and wishes. I imply that the interpersonal negotiating power, as it were, that the activation of these forces within you confers upon me will ultimately lead us to reorganize you in ways that are more aligned with your real interests than you can at this point even imagine (and that, right now, either of us can actually know). (p. 258)

Slavin and Kriegman take these “kill-or-be-killed” experiences like “the pain of paying for concern, the constant reminder at the end of each hour of the limits of the therapist’s involvement” as signals of a “much broader and more basic reality of the analytic situation:” the therapeutic relationship does not carry with it the inherent investment in the patient’s interests that family and other natural, reciprocal relationships regularly entail (p. 260).

Yet, in their case example, greater clarity about the conflicting interests between therapist and patient “significantly diminished” the patient’s distress (p. 262). They refer to the attempts to avoid the clarity as “deceptive and self-deceptive blurring of their interests” (p. 262). This “blurring” is the same blurring that a therapist may experience when she feels guilty over going on vacation. Yet to speak the conflict aloud removes some of the shame for the therapist, and shows the client that the therapist can handle the separation. The “insult added to injury” made the “unrealness” of the analytic relationship, “with its painfully real limits on the expression of love and investment, even more painful and dangerous than it needed to be” (p. 262).

Social Work and Relational Theory

As a social work student, I am attuned to the way that social work is a discipline that is particularly well aligned with relational theory. In her paper “Contemporary psychoanalysis and social work theory,” Jill Horowitz (1998) asserts that “in the contemporary post-modern and relational paradigms in psychoanalysis is a refinding of elements of clinical social work theory” (p. 369). For example, social work espouses the perspective of “person-in-environment.” Similar to the idea that there is no such thing as a self without other relationships, the concept of person-in-environment suggests that a “person” cannot be conceived of outside of their context (p. 371). Also, social workers are trained in the “casework precept” of “Use of Self,” which suggests a “much fuller visibility” of the analyst/social worker/therapist than “psychoanalytic theory of the sixties had room for” (371). Furthermore, social work accepted the postmodern understanding of the power of language to both reflect and construct reality. Horowitz writes: “In [social work] graduate school I learned to call my clients ‘clients’ and to pay great respect to their reality...I learned to acknowledge and explore issues of power/authority *and* try to diffuse them” (p. 371). She explains that unlike psychoanalysts, social workers had never been blinded by what Stephen Mitchell calls “the myopic love affair with Freud” (as cited in Horowitz, 1998, p. 377). For them, the observation that there are two people in the room when psychoanalysis is going on, and neither of them are invisible or anonymous” was anything but startling (p. 377),

Horowitz reveals a strong parallel between the social work frame and the postmodern perspective of social construction. However, she states, relational therapists often ascribe their theory to (male) forefathers like Ferenczi, Balint, Fairbairn and Winnicott. Perhaps it may be helpful going forward to consider the way that Ferenczi may have been “rediscovered” only to further obscure less “professional,” primarily female Social Work theorists like Mary Richmond,

Charlotte Towle, and Helen Harris Perlman. Applying a critical postmodernist, relational lens to the power dynamics that may be playing out between social work and psychoanalysis could perhaps provide further insight into relational theory itself.

Summary

Relational theory, as we have seen, provides tools for psychotherapists to engage in caring for their clients within the context of a system where they are paid money. In the next section, I will synthesize the above theoretical concepts with concepts from the previous section on socialist feminist theory. The first set of theories articulate ways of thinking about economic contexts for care work, an outside-looking-in perspective. The second set of theories discuss ways of practicing psychotherapy, a specific form of care work, in its real-world contexts, a sort of inside-looking-out approach. Together, they can be integrated into a complex whole way of informing clinical practice, one that integrates micro and macro work.

Chapter V

Discussion

The phenomenon that this paper examines is psychotherapy conceptualized as “care work.” As we discussed in the first chapter, scholars have conflicting definitions of care work. This paper has engaged with the concept of care work primarily as it is understood by Nancy Folbre, who describes it as paid or unpaid “work that involves connecting to other people, trying to help people meet their needs” (Folbre, 2003). Chapter two examined psychotherapy as care work through the lens of socialist feminist theory. Chapter three examined psychotherapy as care work through the framework of relational theory. This last section will summarize and synthesize findings from the two theories to provide clinically useful ways of imagining and navigating psychotherapy as care work. Clinical examples will be drawn from my own experiences as a psychotherapy client and as a burgeoning therapist. Lastly, I will discuss the strengths and weaknesses of the methodology of this paper, and provide a consideration of implications for the field of social work.

Two subjects in the room

The socialist feminist lens and the relational theory lens both emphasize the importance of recognizing the subjectivity of both therapist and client, yet they do so in different ways. As we saw in chapter two, socialist feminist theorists discussed how care workers are part of the

same struggle for liberation under the system of capitalism that clients are. Therapists are fellow subjects who are under pressure to make money and want to be treated fairly. We looked at Abromovitz's (1998) description of how the radical social work "rank and file" movement, for example, fought for their own improved labor conditions as a part of their professional work. Martinez (1996) wrote that "in life after capitalism" care workers "will see themselves as helpful allies in a joint project with patients and families." Relational theorists, on the other hand, pointed to the way that therapists should recognize their subjectivity in terms of their own set of biases, beliefs, feelings and actions. Therapists, as Aron (1991) says, are not only reactive (to needs and actions of the client), but active. Like, clients, therapists can be unaware of their unconscious motives.

Both socialist feminists and relational theorists also advocate that it's imperative to view *the client* as a subject. Martinez (1996) wrote: "Rather than viewing patients as *objects* to be manipulated and controlled for the benefit of capital, individuals in health care systems will be viewed as *subjects*, working alongside physicians and other health care workers toward their individual and collective empowerment." Clients, in this view, will be listened to and respected. Similarly, relational theorists advocate a view that the client is not "only" a patient, but someone who is an expert on him or herself, and a person capable of having observations about the therapist that the therapist is not aware of.

Two people, not one

Yet both socialist feminists and relational theorists also acknowledge a certain discrepancy or antagonism natural to the therapist-client relationship. Both agree that a key to escaping it is by acknowledging its existence. Socialist feminist theorist Tokumitsu (2013) wrote: "emotionally satisfying work is still work, and acknowledging it as such doesn't

undermine it in any way.” Relational theorists, like Lew Aron, expressed this as the distinction between “symmetry” and “mutuality.” The therapist is performing a service, while the client is benefitting from one.

The cornerstone of capitalism, to a certain extent, is captured in Jessica Benjamin’s “doer- done to” dynamic. Ehrenreich explained, as discussed in Chapter two, that “since the capitalists make their profits by paying less in wages than the value of what the workers actually produce, the relationship between the two classes is necessarily one of irreconcilable antagonism. The capitalist class owes its very existence to the continued exploitation of the working class.” In this view, “kill-or-be-killed” is inherent to capitalism. Socialist feminist theorists advocate that the only true liberation would come in the form of political revolution; overthrowing the oppressors. But Jessica Benjamin (2005; 2007) suggests liberation from the doer-done-to dynamic, at least that between client and therapist, through a conceptual shift. For her, a certain liberation can be achieved through surrender to a third space that is in some ways the antithesis of capitalism. Her “moral third” is a space from which one recognizes “the tension of difference between my needs and yours,” staying attuned to both needs simultaneously. Benjamin writes that escape from the dichotomous either/or position is possible if “the analyst takes on the responsibility for forgiving herself and thus being able to transcend the shame of her difficulties enough to talk about and analyze them (without excessive or impulsive self-disclosure).” Until then, patient and analyst will be caught in a spot where the acceptance of one person’s subjectivity meant an obliteration of the other’s. Both socialist feminist theorists and relational theorists envision an ideal scenario in which both the subjectivity of the client and therapist are recognized in a conceptual space where they strengthen, rather than obliterate each other.

Always Already Political

One of the most potent criticisms of psychotherapy/care work is the concern that it “siphon[s] off rage that might more constructively be deployed in relation to social injustices” (Hollander, Layton, & Gutwill, 2006, p. 12). However, both theoretical orientations suggest paths for making psychotherapy expressly concerned with social justice. In “Psychoanalysis, Class and Politics: Encounters in the Clinical Setting,” Andrew Samuels (2006) summarizes the belief that psychotherapy, rather than dampen constructive passion for social justice, has the potential to politicize and radicalize clients and therapists alike. Samuels’ ideas help synthesize the main concepts from socialist feminism and relational theory. As we discussed in chapter two, Shulamith Firestone said: “There is a new emphasis on objective social conditions in psychology...the large number of women in these fields may soon start using this fact to their advantage. And a therapy that has proven worse than useless may eventually be replaced with the only thing that can do any good: political organization” (1970, p. 6). This “emphasis on objective social conditions” can be seen in relational theorists Malcolm Slavin and Daniel Kriegman’s use of the concept of “objective countertransference” which we saw in chapter three. Thus, through the use of relational theories, psychotherapy can perhaps begin to encourage and encompass what Firestone called “the only thing that can do any good”: political organization. Samuels writes: “I think that...experiences in therapy act to fine down generalized rage into a more constructive form, hence rendering emotion more accessible for social action. Even when this is not what happens, the potential remains for a move from private therapy to public action” (2006, p. 12). His idea is to develop the clinical setting as a bridge between psychotherapy and politics, rather than as the source of isolation from politics. And even when psychotherapy appears to only focus on the client’s inner world, he writes, “political power is experienced psychologically:

in family organization, gender and race relations, and in religious and artistic assumptions as they affect the lives of individuals...We must try to achieve a situation in which the work is political always, already” (p. 16). Samuels articulates the desire to use psychotherapy to work on issues in clients’ inner lives and outer realities, and the belief that they are deeply intertwined.

Therapy as “doing politics”

Samuels (2006) suggests that the structure of group therapy “may facilitate the politicization of the practice of therapy” (p. 16). This speaks to the interplay between “doing politics” and community, the impossibility of taking social action alone. But how would group therapy be similar to and different from explicitly political groups, like the “consciousness raising groups” of the 1970s, for example? In “Consciousness-Raising: A Radical Weapon,” Kathie Sarachild, a radical feminist founder of consciousness-raising groups of the 1960s and 1970s, writes that the two are very different. In consciousness-raising groups, she writes, “The purpose of hearing people’s feelings and experience was not therapy, was not to give someone a chance to get something off her chest ... that is something for a friendship.” Here, Sarachild associates “therapy” with “a chance to get something off her chest.” In my own clinical experience, I have had many clients report that they like therapy because it feels good to “vent.” While this can certainly feel good in the short-term, providing this space does not, in my understanding, fit with Folbre’s explanation of “care” stated in the first theoretical section of this paper. Care work, as Folbre (2012) states, “emphasizes concern for a care recipient’s well-being, not their happiness” (7). If therapy just allowed for getting something off your chest, with no deeper purpose, it would not be truly “caring” work. Sarachild associates “venting” not only with psychotherapy but with friendship. Yet according to relational theorists psychotherapy is

something that has a distinctly different purpose, as discussed by Aron (1991, p. 266) with regard to the distinctions between mutuality and symmetry.

Sarachild goes on to explain that in consciousness-raising, “the importance of listening to a woman's feelings was collectively to analyze the situation of women, not to analyze her. The idea was not to change women, was not to make ‘internal changes’ except in the sense of knowing more. It was and is the conditions women face, it's male supremacy, we want to change.” On the surface, this can of course look different from the colloquial understanding of therapy, or even from a professional understanding. Stephen Mitchell, a founder of relational theory, has even written: “An important part of the job of psychoanalysts is to interest their patients in the possibility that features of their world that they experience as powerful impediments to their pleasure and satisfaction, obstacles that seem completely outside their control and working against them, are actually their own constructions” (Mitchell, 2002, p. 62). Can the view that we are responsible for our own impediments ever be combined with the “political” position that a real, structural force, like male supremacy, is responsible? One way to bridge these two perspectives is by Sarachild’s concept of “knowing more.” “Knowing more” is in fact changing the self, but it is a change in awareness. It may involve the realization that the real, structural force is not only an “outside” set of conditions, but a way of being and thinking and living that has gotten inside us as well. Perhaps this “knowing more” is not so different than what psychotherapy can offer. Another way to articulate the bridge between these two seemingly opposite perspectives (change the person or change the circumstances) might be to view forces like male supremacy and racism, like capitalism, as examples of Slavin’s concept of “objective transference/countertransference” (1998, p. 247). As Berzoff, Flanagan and Hertz write in the aptly titled “Inside Out and Outside In,” (2011): “As much as the current field of clinical practice

is dominated by splits—long term versus short term, behavioral versus intrapsychic, biological versus social—we believe that these are false dichotomies. How can we understand and hold the complexity of our clients’ lives if we are compelled to see their concerns through only one lens” (p. 3). For a relational therapist, true care may lead to encouraging the client to become involved in explicitly political action. As stated another way, “the more deep and personal the experience, the more political and public it may turn out to be” (ibid., p. 27).

My experience as a client

To illustrate some of these above points, I will draw from the story of my own psychotherapeutic process with a male psychiatrist who was oriented towards a “traditional” style of psychoanalysis. Although it is unorthodox to draw from my own experience as a client in an academic paper, I do so in part because the choice aligns with some of the lessons from the past two chapters. First, it echoes the political decision to recognize the client’s subjectivity. When we only read literature written by therapists, we miss out on an enormous body of knowledge that can be gleaned from the people who are in the room with the therapists in every session. As Jordan (2000) states “Patients bring knowledge about themselves, wisdom about many matters, and insights about the therapist that are invaluable.” Furthermore, acknowledging that a patient in one context can be a therapist in another makes clear that the difference between the mentally “well” and “unwell” may be more subtle, and less about inner deficits, than the medical model allows for (Berzoff, 2011, p. 222). Lastly, writing from the perspective of myself as patient allows me to share a little about my own personal bias as the writer of this paper. Just as the analyst must become aware of themselves as a subject, so too must the “researcher.” Just as the analyst would do well not to pretend his or her subjectivity does not exist to the client, the “objective” researcher may do well to acknowledge her subjectivity to the reader.

Some of my own identities that influence my subjectivity include being a twenty-nine year old, able-bodied, Jewish, white, heterosexual, non-native, US-born woman. I was raised in an economically secure two-parent home. I met with Dr. Y, a white man in his 60s for therapy for six years, sometimes once a week, sometimes twice, from the time I was twenty to the time I was twenty-six. Looking back, a few aspects of our work together stand out to me as times when I, as a client, could have benefitted from tools from the two theoretical perspectives outlined previously in this paper. A year or so following our termination, I asked Dr. Y to send me his records from our time together. Some of the documents that he sent me (after asking for me to pay a copying and shipping charge) were official. A large stack of others were handwritten notes that he took during each session. One of the more striking aspects of reading these notes was that he referred to me exclusively by the term "patient." As in, "patient seems to be gaining perspective" and "patient is able to smile." This struck me because Dr. Y was a person I sat across from for six years, at least once a week, sharing my inner thoughts, fears, shames and joys. Now, through the discussion of the power of language as discussed previously in this paper, I see why his word choice shocked me so much. By referring to me exclusively as "patient," Dr. Y relegated me to a simple, unshifting identity of a sick person. This is an example of an area where I make a clear different choice in my own work. In my notes, which I also take during sessions, I try to always refer to the client by their name. I think this is not just a superficial politeness if they were to ever read them; but rather creates a deeper feeling of respect in me for their full humanity, for the fact that they are a person with a name, just like me--in other words, a subject. Working within an anti-oppression framework involves the use of language that does not reify existing power dynamics, but rather, as Horowitz in chapter three suggests, deconstructs those dynamics.

I eventually decided to stop seeing Dr. Y out of a vague sense that I wasn't making any progress and might make more with a woman. I turned out to be right. What “woman” meant, though I wouldn't have articulated it as such at the time, was someone, not necessarily a woman, informed by feminist, relational theory. Based on my own history, I now see that gender identity was a crucial theme in my life. What I needed at the time, I believe, was for someone to help me see sexism as an example of Slavin and Kriegman's concept of “objective transferences.” Instead, Dr. Y focused the attention exclusively on why I might be sabotaging my treatment by trying to leave after so many years of work with him. By focusing exclusively on my “resistance,” Dr. Y did not leave room for the possibility that there were factors outside of my own personal psychological deficits that could be contributing to my suffering, such as sexism. Furthermore, Dr. Y did not acknowledge his limited capacity for oneness, as Slavin and Kriegman's therapist does when he admits that in some ways, such as in terms of payment, therapist and client's desires are at odds. Again, I have tried to act differently in my own work. For example, I view sexism, racism and poverty as complex trauma in the lives of my clients. That does not mean that there is no possibility for progress as long as those systems exist. On the contrary, the acknowledgment of just those systems is what can allow internal progress to happen.

Lastly, I felt personally the effects of someone trying to practice Freud's theory of “abstinence.” Throughout my time in treatment with Dr. Y, I was often extremely tearful. Sometimes I would sob through a whole session. Dr. Y, in accordance with his theoretical orientation, would sit silently, staring at me, not “spoiling” me with any gestures or words of support or empathic communication. I wondered why nothing was changing, why nothing felt

better for years and years. In retrospect, I think that I was being retraumatized by a lack of empathic attunement.

Luckily, I had enough of a sense that something was wrong with therapy, after six years of not improving, to terminate our treatment “against the medical advice” of Dr. Y. The decision to leave was very difficult, because Dr. Y had a large collection of professional credentials that positioned him as the expert and me as the sick patient. From looking him up online, I knew that he had published numerous books and articles, had graduated from Harvard College and Yale medical school. He works closely with Otto Kernberg, a leading psychoanalyst. He did not take insurance, and charged an enormous sum of money that my parents gladly paid for his expertise. I had started treatment with him as a vulnerable young woman deeply struggling and in pain. That is probably part of why it took six years before I finally realized that this supposedly prestigious psychiatrist was not helping me. Luckily, upon treatment with a female therapist, with a much more relationally informed style, I somewhat quickly began to improve, and have been steadily improving for the past four years.

The above is a just a small sample of the ways that I was deeply hurt, invalidated, disrespected, disbelieved, and disempowered by this treatment. But, I am grateful for my experience with Dr. Y in part because, as a new therapist, I feel I have learned so much about the damage that can be done through psychotherapy, and about how I want to treat my own clients. The next section will discuss a piece of work I did as a new clinician, informed by feminist and relational values.

Surveillance: An experience as a therapist

Therapists are “mandated reporters,” which means that they, along with teachers and others who come into contact with children and other “vulnerable populations” must legally

report to the state when abuse is observed or suspected. Mandated reporting is an area, I believe, similar to payment, that is rich for exploration because of the way it has the tendency to position therapist and client in a doer-done-to relationship. Similarly, the existence of mandated reporting might be a good example of “objective countertransference.” If evidence of “abuse” becomes apparent, almost all clients (at least consciously) would rather not be “reported on.” Yet when abuse becomes apparent, in terms of self-preservation, therapists feel compelled to in order to comply with the law. If they do not, their employment and professional wellbeing may well be in jeopardy. Therapists, however, may have conflicted feelings about reporting, similar to their conflicted feelings over accepting payment.

The phrase “mandated reporter” clearly points to the idea of observation and control. The implication, to me is, is that therapists are “spies” who observe clients and report to the government, who regulates therapists’ payment, at least when it comes to Medicaid. Although as an intern I have not been a paid therapist, my future career is linked to having a good assessment from my supervisor, who is paid in part by government grants and government funded insurance.

Keenan (2001) writes that “Foucault speculated that disciplinary power succeeded by utilizing the ‘simple instruments’ of hierarchical observation, normalizing judgment, and the examination” (p. 212). In assessing abuse “normalizing judgment” comes into play. In my internship last year, doing family therapy at an Child Protective Services (CPS)-funded agency in New York City, the form that I had to fill out to report an incident asked me to check boxes that used language like “excessive corporal punishment,” “inappropriate isolation/restraint,” and “inadequate guardianship.” Who determines the meanings of excessive, inappropriate and inadequate? It is clearly not the clients. It is not us, the social workers, either, but some higher authority. Keenan writes that “Hierarchical observation (‘surveillance’) as a technique makes the

observed visible through the 'gaze' which forms one part of the overall functioning of disciplinary power...a privileged group uses the techniques of normalizing judgment to remain invisible, to set societal standard, and to obscure unconsciously the power relations" (p.214). Cultural views about what constitutes abuse vary widely, among professionals as well as the wider public. Child Protective Services has a system in place, but it is not situated as a "viewpoint" but as the "societal standard" and thus the authorship remains invisible, the power relation obscured. It is seen as the norm against which "inappropriate" or "excessive" or "inadequate" behavior is compared, not a type of behavior with its own construction.

Keenan writes: "the final aspect of disciplinary power, documentation, serves as the lynchpin of this new technology by establishing a common discourse which perpetuates a particular mode of observation and normalizing judgment, constituting the individual as 'a describable, analyzable object'" (p. 214). I do not have the option to write in my own definition of the clients' behavior; I must check a box on the form that lists the behavior using the established, judgmental language of "inappropriate, excessive, etc." Furthermore, I must list the adult as the "alleged subject (perpetrator)," minimizing a human into a label.

In my second session with Linda, a thirty-five year old Black single mother, and her 13-year old son Charlie, the following interaction occurred:

Charlie: But the school is saying I told him to beat him up, but I didn't, and my mom doesn't believe me.

Linda [to me]: I don't believe him or not believe him, I just don't know.

Me: okay so Charlie, you feel like your mom doesn't believe you?

Charlie: Yeah, I mean I understand why she doesn't believe me because I lie a lot.

Me: Hmm...so you're saying that you lie a lot? What happens around when you tell a lie to your mom? What are you thinking about?

Charlie: What do you mean?

Me: well, I mean are you thinking you don't want to tell the truth sometimes because you're afraid of getting in trouble?

Charlie: yes, my mom gets on me pretty hard.

Me: She gets on your pretty hard. What does "pretty hard" mean?

[Charlie looks at Linda]

Charlie: you know, screaming at me..[trails off]

Linda [yelling]: Fine! I beat my kid!! I know they say, don't say you beat your kid or they're gonna have to call ACS. But my parents beat me, and I beat him. But I do nothing compared to what I grew up with, because I hated it.

[Charlie starts crying and I gives him tissues]

Me [quietly]: Ok, I see a lot of feelings are coming up around this for both of you.

Charlie [still crying a little]: If you hated it when you're parents did it to you, how do you think I feel when you do it to me?

Linda: [quiet]

[a few moments of silence]

After talking more to Linda and Charlie individually, I found out that Linda beat Charlie with an extension cord and a chair and often left bruises. After talking to my supervisor, I understood that I would have to report this to CPS. Looking back at how I felt in that moment, I can see a lot of conflict that came up for me. On the one hand, I wanted to protect Charlie from being physically hurt. This also involved exploring my own cultural biases against physical discipline. Yet, this is also complicated by the fact that I myself was spanked as a child. This could have made me feel both protective of Charlie, but also protective of Linda, out of an urge not to condemn my own parents. I also had a bias against reporting because from my brief experience and knowledge about CPS, it does not seem clear to me that their involvement would necessarily help make him safe. Usually what seems to happen (and what did in fact happen in

this case) is that parent and child lie to CPS workers (out of fear of the child being removed or other damaging consequences). Through our computer system I am able to read the ACS caseworker's notes. In the interview with the ACS worker, Charlie and Linda both said that Linda never uses objects, never leaves marks, and only slaps his arm with an open hand. I had a small fear, although I think it is unlikely, that Linda would in fact punish Charlie even more for revealing the abuse that led to the investigation. Thus, the report may not have established safety for Charlie and may possibly have the opposite effect. I also felt nervous about breaking the tenuous trust that I felt had been established between myself and the family. Though I had explained the limits of confidentiality, I was not positive that I had done a good job of it, or that they had understood or remembered. But, I was also surprised that Linda had willingly told me the information. I wondered if perhaps she actually wanted me to make the report, so that she could get help around disciplining Charlie in a way that worked better. Furthermore, I had a reason to not want to report because of my fear of siding with the "oppressors." I wanted to be a "good white person." I had to look at my own desire to avoid being "bad," the "doer," in Jessica Benjamin's terms.

Although I did not discuss all of these ideas with Linda and Charlie, I did take on the task of "forgiving myself" in order to be able to speak about the situation openly with the client. I knew it was important to explore with the clients the experience of me "reporting them;" their experience of being reported on by me. Although at the time I did not know these terms, I believe that in this instance talking about our "objective countertransference" was essential. Hopefully I was able to surrender to the "moral third" in which I was able to acknowledge my own "limited capacity for oneness" (Slavin, 1998). Rather than engaging in a kill-or-be killed struggle (either I "kill" and the client is reported, or I do not report and am "killed" by acting

illegally), we were both able to see each other's needs. Rather than "blurring" our interests, I was hopefully able to model self-preservation, and avoid adding the insult to injury of pretending I could, or needed to, "die" for the relationship to continue.

I did continue working with the clients and hope the open acknowledgment of my limitations, and limitations of the therapeutic relationship, helped the relationship continue, and perhaps even strengthened it, and allowed them to trust me more.

Summary

Looking at psychotherapy as care work through the perspective of socialist feminism involved exploring the oppressive features of the white supremacist capitalist patriarchy and how psychotherapy might be seen as "adjustment" to that very system. Yet the socialist feminist perspective also revealed how psychotherapy as care work might be a spot for political resistance to the system. The socialist feminist perspective actively avoids engaging in dichotomies, such as one between love and money. Rather than seeing "working" as an inherently negative dynamic, the "work" aspect of care work serves as an important link between the liberation of care workers and those they care for. Looking at psychotherapy as care work through the perspective of relational theory involved exploring a "two-person" psychology, intersubjectivity, mutuality versus symmetry, the (moral) third, and objective countertransference. Together, the two frameworks provided paths that consistently seek to avoid dualities, whether in the form of the personal versus the political, love versus work, doer and done to, self and other. Hopefully this paper has allowed me to enter a kind of "third space" between each of these apparent dichotomies; from that space, perhaps it is possible to see how care work can be a site of political resistance even while existing in dominant oppressive structures.

Strengths and Weaknesses of the Methodology

In keeping with the theme of escaping or overcoming binary, black and white thinking, often the strengths of this methodology can also be seen as limits, and vice versa. For example, a strength of the methodology was that it was interdisciplinary. Bringing feminist, sociological and economic literature to meet psychoanalytic literature helps situate individual psychotherapy in the context of broader, macro systems. Yet this interdisciplinary methodology was also a limit, in that I have at times found comparing and contrasting socio-economic theory with psychological theory to be like comparing apples and oranges. Another limitation of the methodology was that it was not empirical (based on, concerned with, or verifiable by observation or experience). It cannot be “proven” or tested. However, this style is a strength in that it fits with the substance, in that relational theory specifically came out of a perceived over-reliance on empirical approaches in clinical work. Another limit was the bias of the researcher. Due to my own experience as a client in psychotherapy as described earlier, I have a bias against the “traditional” Freudian model. However, once again, this is also a strength, in that acknowledging and exploring a bias, rather than ignoring it, can strengthen an argument rather than weaken it. Every researcher has biases based on his or her personal experiences, identity, and education; from a post-modern perspective, it is only a matter of whether or not the bias is acknowledged or disavowed.

Implications for Social Work

This paper may challenge social work students and practitioners who read it to expand their own thinking about the way they practice care work. Hopefully, it will provide them with strong theoretical bases in some major themes in socialist feminism and relational theory for considering the practice of psychotherapy within the context of a capitalist system. Additionally,

it could contribute to existing contemporary attempts to push the field further away from the dichotomy of macro work versus micro work, and towards an integrated ethics of care work that involves both.

Conclusion

Through writing this paper I have come to discover more questions than answers. However, I have also come to discover a sense of hope as I begin work as a psychotherapist. I feel that I have begun to develop a sense of the type of “care work” I hope to practice. I feel fortified to continue to explore concepts of care, work and liberation with colleagues and “clients,” always trying to hold myself and others as co-subjects.

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