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How female therapists and their patients deal with being a disputable, unimaginable, or occasional Swede: Explorations of similarity of nonprivilege

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Abstract: In this qualitative study, conducted in Sweden, the authors investigated therapists´ experiences of therapeutic dyads in which both therapist and patient identified with a non-normative ethnicity, migration experience, racial identity, or experience of racialization. Inclusion criteria were based on the concepts of "similarity of nonprivilege" (Fors, 2018) and on Mattsson´s (2005) concept of "disputable, unimaginable, or occasional Swedes," inspired by critical whiteness studies. Eight semistructured interviews with female psychologists and psychotherapists were conducted. Findings were illustrated by the Minority Matrix, showing how therapists navigate sameness versus too much closeness, and manage the role of being a bridge between a minority position and Swedish society.

Keywords: Nonprivilege; Ethnic matching; Critical whiteness; Psychotherapy; Intersectionality

The two main paradigms in which ethnicity and/or racialization have been studied in the psychotherapist-patient relationship are ethnic matching (Helms & Carter, 1991; Parham & Helms, 1981; Townes et al., 2009) and models accounting for how to increase majority therapists´ abilities to understand and interact with people from cultures or belief systems different from their own (APA, 2015, 2017). The latter include *cultural competency* (Kirmayer, 2012), *cultural safety* (Papps & Ramsden, 1996; Ramsden, 1989, 2002), and *cultural humility* (Tervalon & Murray-García, 1998). Other common perspectives on power in psychotherapy include relational psychoanalysis and the "ethical turn" (e.g., Gentile, 2013; Layton, 2006; Orange, 2016), and perspectives on decolonization (e.g., Greedharry, 2008; O'Brien & Charura, 2023; Winter & Charura, 2023), intersectionality (e.g., Fors, 2018; Fors, 2021b; Hays, 2022), feminism (e.g., Brown, 2018; Herman, 2023), and multilingualism (e.g., Gordon, 2023).

"Ethnic matching" refers to the practice of pairing therapist and patient of the same ethnicity (Cabral & Smith, 2011), on the assumption that a common ethnicity will contribute positively

to the therapeutic alliance (Shin et al., 2005). The method originates in social psychological findings that individuals prefer others who resemble them both physically and philosophically (Cabral & Smith, 2011). In an American context, ethnic matching is now a well-established method. It has also been tested, with good results, with the indigenous Sámi population in northern Norway (Møllersen et al., 2009).

However, Cabral and Smith found a very low effect size (Cohen's *d*: 0.03), indicating nearly no advantages in outcomes. Moreover, they describe the effects of ethnic matching as strongly varied.

Critique of ethnic matching

Ethnic matching on a large scale has been criticized as problematic in several ways. It paradoxically supports a racist idea about difference (Fors, 2018), and it does not force majority therapists to assess their own privilege or prejudices; rather, they may continue to exist in a privileged bubble in which people who are Jewish, Black, gay, poor, trans, or coping with disabilities are not part of normal psychology and simply require extra knowledge to treat. By ignoring issues of power, it allows majority therapists to skate by without "riding into the wind" (Tang & Gardner, 1999, p. 6).

Another problem with ethnic matching is that it indirectly idealizes the notion that "birds of a feather flock together." We do not know whether this is always the case.

This study challenges that assumption and transcends that narrative through a thematic analysis of interviews with eight female therapists (based in Sweden) who *do not belong to the Swedish ethnic norm.* The interviews explore their work *with patients who also* do not belong to the Swedish norm. The focus is on how therapy still has to navigate themes like degree of Swedishness, racism, power issues, racialization, whiteness and positioning relative to the majority of society.

Similarity of nonprivilege

Fors (2018) has proposed that the sociopolitical power dynamic between patient and therapist can be understood through an intersectional Matrix of Relative Privilege which identifies the field in which therapist and patient are operating and what power negotiations are subsequently revealed. By exploring relative privilege in an intersectional matrix, Fors (ibid) adds her voice to those of feminists who argue that gender cannot be seen in isolation from issues of race, age, sexuality, and so on (e.g., Crenshaw, 1989; hooks, 1990; de Los Reyes & Mulinari, 2020); she cites recent research (e.g., Eagly et al., 2012) that broadens feminism to include a larger set of power questions.

This study investigates how therapists perceive similarity of nonprivilege with a focus on ethnicity, in dyads in which both patients and therapists are outside the Swedish norm. See Figure 1.

Her model differs from ethnic matching: patient and therapist do not necessarily hold the same ethnic minority experience. Neither is the minority position per se the main focus. Instead, patient and therapist share the navigation of being outside a norm in focus. We here flip the focus from same kind of ethnicity (in ethnic matching) to a more general focus on oppression (similarity of nonprivilege). Because the study was conducted in Sweden, we address Swedishness as a norm. We have chosen a point of departure based on being outside the ethnic Swedish norm, rather than having a particular ethnicity, a perspective based on critical whiteness studies.

	Patient: privilege	Patient: nonprivilege
Therapist: privilege	*Similarity of privilege*	*Privilege favoring the therapist*
Therapist: nonprivilege	*Privilege favoring the patient (confused subordination)*	**Similarity of nonprivilege**

Figure 1. Matrix of Relative Privilege: Similarity of nonprivilege. From Fors (2018, p. 127).

Unimaginable, occasional, disputable, and indisputable Swedes

Basing her recommendation on critical whiteness studies, Mattsson (2005) suggests that a sliding scale be included

in the Swedish norm. She posits that there are "*unimaginable", "occasional", "disputable", and "indisputable" Swedes.* With respect to Swedishness, Mattsson (ibid) presents five factors that are regularly used in research: (1) being born in Sweden, (2) having Swedish citizenship, (3) blood ties (i.e., whether or not one's parents were born in Sweden), (4) culture and language (including assumptions about being Christian, modern, Western, and speaking Swedish as a native language), and (5) appearance (distinguishing those who "look Swedish" and those who "look different"). In both research and with the popular use "Swedish," the various definitions have intermingled (Mattsson, 2005). Mattsson (2005) refers to those who meet all principles as "indisputably Swedish." They can be envisioned as having an inner core composed of blended dimensions of Swedishness layered upon one another. In parallel, they create a marginalized group of "occasional Swedes" who, separately from their own perceptions of themselves, are defined alternately as "Swedes" or "non-Swedes." "Unimaginable Swedes" are people who, regardless of how they view themselves, are not perceived as Swedes based on any of Mattsson's criteria (Mattsson, 2005).

Mattsson (2005) argues that the presence of a normative Swedishness must be understood in a wider context and in relation to assumptions pertaining to "the white westerner." This position is influenced by postcolonial research and critical whiteness studies, which investigate how people are categorized as either white or non-white (Werner, 2021) and have described how racism is shaped by power dynamics in which whiteness is the presupposed norm and arises in relation to non-whiteness.

Purpose

Our purpose has been to contribute to the limited knowledge of therapists´ experiences of therapies in which both therapist and patient have, in a Swedish context, a non-normative ethnicity. Our points of departure are Fors's (2018) concept of *similarity of nonprivilege* and Mattsson's (2005) concept of *indisputable Swedes*. We focused on dyads in which *both therapist and patient* share experiences of a non-normative ethnicity, immigration, racism, or racialization. In other words, they are similar in not being indisputably Swedish in various ways. We focused on how therapists experience the content, form, and power balance in therapies where both they themselves and their patients were of non-normative ethnicity.

Method

Participants

The study was conducted as a degree thesis in the psychology program at the University of Gothenburg in Sweden, where both primary authors were students, and the third author was a supervisor. Eight women, ages 27–55, participated in the study which was conducted 2022. All were licensed psychologists or psychotherapists, based in Sweden, who volunteered for the study after seeing a Facebook advertisement recruiting professionally active psychologists and psychotherapists. The original idea was to include all genders in the study, but those who showed interest were exclusively women. Inclusion criteria for participation were: a) professionally active psychologist and/or psychotherapist; b) with a non-normative ethnicity and/or experience of immigration, racism, or racialization; c) who have worked clinically with patients of a non-normative ethnicity and/or experience of immigration, racism, or racialization. We chose the broad inclusion criterion of non-normative ethnicity to achieve a broad sample (cf. Mattsson, 2005). In this case, having a non-normative ethnicity can be equated with not being *indisputably Swedish*; in other words, we looked for individuals outside of the inner core of those who fulfill Swedishness in accordance with all Mattsson's (2005) criteria.

The wording of criterion b generated a very broad, heterogeneous group. We intended to reach participants with experience of being outside the Swedish norm without specifying or limiting how they were marginalized. We included individuals who had immigrated, whose parents or grandparents had immigrated, who were racialized as nonwhite, who were adopted, or who were Jewish, Roma, or Sámi. Such heterogeneity fulfilled our purpose of examining any experiences of being outside the norm of indisputable Swedishness.

Implementation of interviews

Semi-structured interviews were conducted using a guide constructed by the authors, pilot-tested by one author, and revised based on feedback. The interviews were

conducted in January, February, and March 2022 via the online platform Zoom. They were conducted individually and from 45-60 minutes. The video files were then erased, and the audio files saved locally on the authors' computers and mobile phones.
Upon completion of the thematic analysis, they were erased.

Ethical aspects

Ethical considerations followed the Swedish Research Council's (2017) guidelines for good research practices. The study was conducted in accordance with requirements for consent, confidentiality, information, and use. Participants gave consent to participate during the interview and were informed of their right to revoke their participation without explanation. To achieve confidentiality, their country of birth, home city, employer, and time spent in Sweden were excluded from the work. We believe that the study falls outside of both the Swedish Ethical Review Authority and the Norwegian Health Research Act (the third author is based in Norway) because it contains neither personal information nor healthrelated material.

Reflection on our own context

The two primary authors of this study have different backgrounds. Both interviewers are female, but one is of southern European descent and could be classified, based on

Mattsson's (2005) criteria, as "occasionally Swedish" (i.e., not quite non-Swedish but not indisputably Swedish); the other meets all Mattsson's criteria for classification as "indisputably Swedish." We assume that the fact that we were women interviewing other women affected the power dynamic in the interviews and contributed to a more even balance than if we had been coded as men. In other words, with respect to gender, the interview situation was characterized by "similarity of nonprivilege" (Fors, 2018). Conducting the interviews together offered advantages for data collection but speaking with two interviewers may have diminished respondents' sense of safety and privacy.

Toward the end of the interviews, several participants asked why we were interested in these questions. In these conversations, both authors felt that the southern European background, or status as "occasionally Swedish" (Mattsson, 2005), of one author lent the study a certain legitimacy. That legitimacy was present during the recruitment process, with the less-Swedish author being the "outward-facing" person. Legitimacy conferred by virtue of the "occasionally Swedish" interviewer was not unlimited, however. During both the recruitment and interview process, our white privilege became visible during advertising and in questions about racism. Throughout the study, we attempted to examine ourselves to detect our own privilege and its implications, which hopefully generated some awareness of the epistemological limitations that come with our position.

Inspired by Harding (2004, 2009), we believe that our social positions influence how we see the world, even if our motives are egalitarian. Fors (2018, 2021a) has noted that whiteness does not care about good intentions. White privilege invites enjoyment in invisible and involuntary ways; whiteness may be projected onto us by others. Indeed, there is no position of decoded whiteness (cf. hooks, 2000; Yancy, 2015). Even though the authors had different degrees of Swedishness, we share a position of privilege as two white students and a white supervisor. One question we have asked ourselves is how our voice and this study can be of use. We are mindful of Spivak's (1987) attention to the difficulties of speaking for "the Others" and her emphasis on the need for genuine interest in learning *from* "the Other" rather than *about* "the Other" (Lundahl, 2001; Smith, 2021). Accordingly, we established the goal of learning from individuals with experiences different from our own.

Data processing and analysis

Our epistemological point of departure was critical realism, which rests on the assumption that there is one reality independent of the subject (Stoehrel, 2007). In this view, reality is possible to achieve but difficult to access (Langemar, 2008). Through language, individuals represent their particular version of reality, which research can seek to interpret (Clark, Braun, & Hayfield, 2015). Experiences of the participants in this study have thus been viewed not as objective representations of reality, but as significant and meaningful experiences of it – as are our own experiences as researchers (Clark et al., 2015).

Data processing and thematic analysis were conducted in accordance with Braun and Clark's (2006) model and followed six steps. We used an abductive analysis approach (Langemar, 2008) as well as our own. The interview guide was designed based on a theoretical framework, while the analysis was characterized by an

Table 1. ***Coding example***

Transcribed text	Initial code	Code group	Sub-theme	Main theme
It was explained to me by a supervisor that somewhere, I need to be an important representation of a Swede who understands and that this serves a kind of function.	Psychologist becomes an important representation of "a Swede" who understands	Representative of "Sweden"	Psychologist instructs patient	Becomes a go-between/provides instruction in multipl ways
(Whispers to self, "When is it most evident.") Sighs. (Silence.) When I recognize myself in the patient. And ... then it's like I tend to work a lot with myself. So I experience a lot of emotional contagion.	Recognition in patient's story	Recognition has an impact	Psychologist emotionally impacted by patient	Too close: the role a psychologist is compromised

inductive approach where we did not test a specific hypothesis even though our own reflexivity (e.g., Braun et al., 2022; Finlay, 2021) inevitably was an indirect part of both how we understood the material and how we could reflect on what respondents were able to share with us as white interviewers. Hence, our work also draws from reflexive thematic analysis.

Table 1: Coding example

Both first authors took part in transcribing all of the interviews. All personal information was omitted from the transcriptions, which were saved in a password-protected document. They were then read multiple times in their entirety by both authors, who noted their thoughts as they arose.

In the second step of the analysis, meaningful elements germane to the research questions were coded by the authors separately. Codes were entered into a table and compared between the authors. Any quotations that were coded differently were discussed and re-coded together. In the third step, the codes were organized by each author into thematic groups and were then compared. These were renegotiated until consensus was reached about what themes could be inferred from the material. In the fourth step, all quotations connected to each theme were read to determine the inner homogeneity of that theme. After that, both primary authors read all of the transcripts to determine whether the themes truly reflected the collected material. The fifth step of the analysis was to definitively identify the main themes and subthemes. The thematic structure was then presented to the third author (supervisor) for quality assurance purposes. The sixth and final step involved writing a report of the results. Table 1 illustrates the steps from meaningful quotation to main theme.

Main theme	Sub-theme
1. Minority in relation to a majority	1.1 Solidarity in relation to the majority 1.2 Searching for similarities with the therapist 1.3 Addressing racism in the therapy room 1.4 Unspoken understanding and its limits
2. Too close: the therapist's role is compromised	2.1 Therapist emotionally impacted by patient 2.2 Approaches to preserving role as therapist
3. Provides instruction in multiple ways	3.1 Therapist instructs patient 3.2 Therapist at a Swedish workplace
4. Interplay of fixed and variable	4.1 Like any therapy 4.2 More social power dimensions have effect–intersectionality 4.3 Power in role of therapist

Table 2: Overview of main themes and sub-themes

Results

Four themes emerged from the data. Table 2 presents an overview of the main themes and associated sub-themes. The first theme, *minority in relation to a majority*, describes respondents' experience of being in dyads with similarity of nonprivilege, including in terms of alliance creation and perceived similarity. The second, *too close: the therapist's role is compromised,* comprises respondents' stories about more challenging and emotionally strenuous experiences of being in these dyads. The theme *provides instruction in multiple ways*

reflects respondents' finding themselves between the patient and work group, expected to translate culture in both directions. The last main theme, *interplay of fixed and variable,* describes the fixed conditions of therapy and factors beyond ethnicity that may affect the dyad. Thus, all four themes involve how the therapists navigate different parts of their work based on assumptions about their background.

1. Minority in relation to a majority

The fact that both therapist and patient belong to minority cultures was depicted as a contributing factor to mutual assumptions about how the other's experiences resemble one's own. This can be seen as creating a dynamic within the dyad in which together, patient and therapist form an inner sphere from which they look out at the world. The dyad becomes its own in-group, striving to some extent for internal homogeneity between members, whose inclusion criteria are defined by what excludes them from the norms of society: their ethnicities. The respondents explained how, within the dyad, they refer to "Swedes" and how space is made for their descriptions of daily and structural racism. Thus, the dyad contains two people who belong to minorities, but the dyad itself is also a minority relative to the majority, where closeness is sought out by highlighting similarities. The respondents describe these themes through four sub-themes.

1.1 Solidarity in relation to the majority

This sub-theme describes the initial components of treatment contact. Most of the respondents reported that a good alliance can emerge early based on perceived similarity between therapist and patient, described as both parties being of a different ethnicity than the Swedish majority. While several respondents identified this similarity as an advantage, one respondent (Amina) stated: "I kind of feel like I skate by on it, in a way. In other words, it's easier to establish an alliance, much of the time." Some respondents said a dyadic sense of community was created that increased the patient's trust, which enabled them to relate to the therapist like a close relative.

Some respondents said that a sense of "us against them" could easily arise in these dyads, where patient and therapist constituted the "us" relative to the Swedish majority. The quotation below is an example of this observation.

> It's kind of like, "Oh, but it's us against these other strangers." Who are, like, different. It's mainly that: they're different from us. We...and it doesn't matter, it doesn't have to be other Latin Americans, it's just being foreign that makes us more similar in some way than the others, who are different. And that influences trust, I think. (Ariela)

Another aspect of this sub-theme involves how respondents described social power conditions as a constant presence. Some reported that therapy concerned itself with social power conditions to varying extents; one emphasized that social power conditions must be set aside to work therapeutically. One respondent (Aleksija) expressed this as: "Our alliance exists in relation to those conditions."

1.2 Searching for similarities with the therapist

This sub-theme reflects the part of the respondents' stories in which their background ended up in focus during therapy. Therapists described this categorization as a process that had already begun when patients were called with the therapist's ethnically difficult-to-place name. Moreover, some respondents expressed how categorization also took place in the waiting room, when the patient first saw the therapist and coded her as non-white. Several respondents argued that this categorization served a function for the patient; one respondent (Agata) specifically described questions about background as: "it's a way to create an alliance. It's a way to get closer and feel kind of at home, in a way." However, several respondents emphasized that specific questions about country of origin were unusual.

Most respondents named appearance as a tangible reminder of the similarities between the parties. Looking alike, either being racialized as non-white or looking non-Swedish, was described, as in the quotation below, as evoking assumptions in the patient about shared experiences and understanding.

> And that's also what can be a little dangerous, too. That you think I have a deeper understanding because I look the way I do. And that creates fantasies in the patient about what my experiences are. (Amara)

The assumptions mentioned above emerged as both helpful and slightly dangerous in the material. Some respondents said they used assumptions about perceived similarity to their advantage in therapy, for example by intentionally talking about their background or stating their own origins. Amina noted*:* "I might feel like I know this from experience, it's fairly helpful; I get a lot of points from saying this or that." Therapists' intentional

disclosures of their background were described as a way of validating patients' experiences and opening up the conversation. One respondent commented, however, that even if this "self-disclosure" was intended to benefit the patient, in some cases she told foreign patients more than she told patients with a Swedish background.

1.3 Addressing racism in the therapy room

All respondents described racism as a present theme in these therapeutic dyads, regardless of the workplace/context in which they occurred. Their stories included experiences of discrimination when in contact with government agencies, experiences of exclusion, and outright xenophobic comments. Below is Ariela's description of how racism as a theme permeates dyads with similarities in nonprivilege.

> Racism, on the other hand, is always a theme, absolutely. Always. I don't think I've ever met anyone in adult psychiatry, before or now, where we didn't talk about racism. Personal experience, what they see, what my classmates experienced and the teachers always excusing it...and then, what parents experience, what they experience themselves through their parents. So, it's always a topic.

Some respondents noted that in other contexts they were hesitant to discuss racism or religion, due to concern about how the addressee would react – a hesitation they did not experience in dyads with similarities in nonprivilege. A few therapists mentioned their experience of being positioned by the patient as "more Swedish." In other words, having more access and greater ease navigating Sweden. Swedishness is thus described as a continuum or a spectrum, on which the patient places the therapist.

1.4 Unspoken understanding and its limits

Respondents noted how the patient often presumes understanding based on the therapist's background. Several of them stated that a patient had told the therapist: "You know how it is." Ana described how the patient used that phrase in conjunction with mentioning a family member: "It might be something about the people around them, relatives, and they'll say, strictly culturally, 'Yeah, well you know how it is when you call an aunt."

Several therapists emphasized how patients can feel understood in these dyads. But some also pointed to the risk of both parties presupposing too much understanding based on background. As a result, patients might not talk about something they assumed the therapist already knew about. Several therapists reported clarifying, for both themselves, and the patient, that their understanding was not complete. They felt a not-knowing approach was particularly advantageous in these dyads. This involved asking open-ended questions about the patient's culture. Alekxija described how she sometimes conducted her own research and talked to friends to learn more about particular cultures.

> I mean it isn't my culture, where I come from. I can relate to it in part because there are a lot of similarities, but I have that humility, in that I don't really know what it's like to be in your place. Or, I'm not really in your shoes. So, I'm a little uncertain, and I compensate for it by asking quite a bit. So, I try to more actively work with... well, the fact that I don't know, that I don't know everything.

In summary, the first theme describes a strong dyadic effort to seek out similarity and communality, where the existence of similarities is relative to the dissimilarity of the world outside the therapy room. This perception is beneficial for trust and understanding, but the therapists were also aware of the limitation of perceived similarities.

2. Too close: the therapist's role is compromised

The second main theme involved respondents' difficulties in their role as therapist. Almost all mentioned identifying with patients' stories. This theme is presented in relation to the theme "minority relative to a majority," where seeking out similarity and community resulted in the experience of the patient getting "too close."

2.1 Therapist emotionally impacted by patient

Several respondents talked about how similarities to patients were most evident when the therapist identified with the patients' experiences. Most respondents described this as an emotional experience in which they felt dramatically touched, especially by stories about difficult immigration processes, experiences of exclusion, and structural racism.

> In other words, this experience of, "Okay, I've experienced that myself," and then the emotion is not just the patient's emotion; it's mine, too... and I often think it's in relation to discrimination. And to how the journey, you know... when

> your identity or personality have been questioned. In other words, the entire impact of changing cultures, what it does to you. (Aleksija)

> "It really got under my skin, and I kind of lost my focus on my role, that it was... I was both a psychologist but also identifying with the patient" (Ana)."

Respondents usually described identification with patients as difficult to handle, though some said if fostered trust when patient and therapist could relate over shared experiences.

One respondent said that humor was an important element in these encounters: to be able to laugh at their shared experiences together.

Finally, several respondents said that patient vulnerability in the Swedish system could evoke a strong emotional response, even if that was not something they had personally experienced.

2.2 Methods for preserving the role as therapist

Based on the emotional experiences described above, several respondents in dyads with similarities in nonprivilege described the impact on therapeutic neutrality. They described this as the momentary disappearance of therapeutic neutrality. Several, however, also questioned the ideal of neutrality itself, pointing out that for some patient groups, an intentionally non-neutral approach is both desirable and necessary.

Several therapists mentioned the potential risks of identification and related emotional reactivity; some stressed the need to differentiate between their own experiences and those of the patient. They talked about not letting their own desire for communality lead them to overidentify with the patient's stories. One who described her own immigration process as traumatic made an active effort to keep that experience out of her work with patients. Several therapists also said that they had developed ways to deal with to their emotional reactivity, but that this took time and was significantly more difficult when they were new to the profession. Ana's observation illustrates this process:

> And it was difficult, and it's been a process. I think it's going better now. Now that I've been able to practice and reflect on it myself a little. And for a while it was almost like, "God this is so hard, I don't want patients from there because it doesn't go well. I don't do a good job."

In summary, this main theme includes respondents' efforts to rise to challenges in their role as therapist. Identifying with the patient narratives is described as a powerful affective experience. This emotionality contrasts with the next theme, where the focus is on relating to factors outside of the dyad.

3. Provides instruction in multiple ways

A third theme concerns the therapists' intermediate position between their patients and their workplace. Two sub-themes emerged: (1) socializing their patients into Swedish culture and society, and (2) having to help Swedish colleagues understand and navigate non-Swedish culture.

3.1 Therapist instructs patient

Interview data consistently revealed that the therapists took on a more didactic role when working with patients with a foreign background. Several noted some patients' lack of knowledge about the Swedish medical system. They also mentioned patients whose understanding of government agencies, based on their countries of origin, was more authoritarian. Respondents stated that in such cases of patients who assume oppression or lack of freedom, they needed to relate with extra sensitivity. Several described addressing this by providing instruction in how the Swedish medical system works and informing patients about their rights and entitlement to self-determination. One explained that she incorporated her acquired Swedish values into the conversation with certain patients, and that this allowed her to become a representative of Sweden and the democratic world. Some interviewees discussed the challenge of finding a balance between patients' original values and Swedish values.

> In other words, the people we encounter are–and it's far from everyone, of course... but maybe a bigger majority has a different view of what medical care looks like. How they relate to medical staff. I think it can be clear that they see an imbalance in power there as well. (Amara)

Several therapists noted that therapy in these dyads has more educative elements. For example, some patients expressed feelings that were understood by them but not by their Swedish colleagues. In these situations, they became seen as both part

of the Swedish medical system and a person who understands. Amara described this as follows: “Even if I work in medical care and I’m a psychologist, they still often say, ‘Well, you know how it is’.”

One respondent described how she helped guide the patients to find new, nuanced ways of interpreting interactions with Swedish doctors. Several respondents talked about therapists “becoming a go-between,” which could involve needing to be responsible for patients’ dissatisfaction with the Swedish medical system. Ana described this as follows:

> If someone is new to Sweden or not very familiar with the country, to be able to add some nuance when someone says, for example, ‘Well, you know how Swedish doctors can be,’ and they interpret this in a particular way. ‘Yeah, but could you... you think this is because that doctor doesn’t care about you, but it might also be the case that...’

3.2 Therapists at a Swedish workplace

Several therapists described having an instructive role in more than one sense: they had to help Swedish colleagues interpret the cultures of patients. A few respondents described becoming ambassadors for non-Swedish cultures at their workplaces. Annelie remarks: *“*Pretty quickly, I had a lot of colleagues begin to approach me with questions themselves*.* They had patients from other countries and didn’t know what to do.”

Another respondent described helping Swedish colleagues keep up with what was going on in the room during patient visits; for example, by interpreting nonverbal communication. She did not know whether she had ended up in this position because of her role as a therapist or her non-normative ethnicity. Ariela said she was often the one in the workgroup who ended up treating patients with foreign backgrounds:

> As I said, it’s a very Swedish workplace. So, whatever it may be, it’s kind of hard to put my finger on exactly what it is. All of these things are little pieces, I think, but it ends with… well, ‘foreign expertise; Ariela will take the patient’, kind of like that.

Several respondents described witnessing or hearing about patients suffering discrimination in public organizations or about patients who did not feel comfortable or well-treated in the Swedish medical system. One presented an example of unequal treatment, namely that patients who wished to see a clinician of a certain gender or nationality were treated differently within the workgroup depending on whether the patient was Swedish or of another background.

Other reported examples of discrimination included foreign children being deprioritized and receiving less support at school, and parents of foreign descent feeling that social services were suspicious of them.

> Yes, I think these are the differences that come in... from how referrals are received to how the family is received. How the treatment… well, how patient you are with the fact that it can take longer at first, because you don’t understand where you are, I mean the concept. (Ariela)

Several respondents noted that the experiences and values of foreign patients, risk being pathologized when they deviate from a Swedish norm. For example, it was brought up that spiritual experiences can be misinterpreted as hallucinations.

> I think it’s very dangerous to pathologize culture. That there’s a bias. I think that foreign people are explained in pathological terms more often and treated as if they were sicker than they are. And it’s very easy to interpret things they say and experiences as sickness. (Aleksija)

Another respondent (Angela) said she had met patients who had previously felt that their cultural values were not met with understanding in the Swedish medical care context: “Either they’ve explored things completely unreasonably or a great deal, even though they aren’t actually problematic in general. Or rather, they just avoided the subject and didn’t dare to address it in general.”

In summary, this third main theme involved respondents’ experiences of finding themselves in an instructive, interpretive role, both translating Swedishness and Sweden to patients, and translating cultures to colleagues. They felt they had made themselves into go-betweens or had been made so by others.

4. Interplay of fixed and variable

The fourth theme concerned how the therapists experienced the interplay of fixed and variable aspects of the therapeutic relationship. Fixed aspects include the realities of therapy, such as the unavoidable power imbalance they saw as built into the therapeutic relationship. Variable aspects include gender, class, and other dimensions of social power. Respondents emphasized that the uniqueness of each dyad is more complex than what is contained within a shared ethnicity.

4.1 Like any therapy

Most respondents emphasized that they did not find the content of therapy to be impacted by patient non-normative ethnicity. Several elaborated that while these interactions can initially consist of more instructive elements, making the path to therapeutic work more complicated, the subsequent content is not remarkable. Annelie commented: "We're going to talk about the same things–thoughts, feelings, experiences. We're going to have more or less the same process. But we might need to take on the role of instructor a bit more sometimes."

Another respondent (Agata) emphasized that similarities among people are more important than their dissimilarities: "The closer you get to someone, regardless of privilege, we become more similar than dissimilar, I think." None of the respondents felt they used a particular, special technique in these therapies. Rather, they chose techniques based on individual patients and their challenges.

> But otherwise, I think you work as usual, because we aren't so different. I mean when it comes to existential issues, where you might feel anxious, maybe sad, maybe you've lost a child, maybe you've lost your husband. (Agata)

4.2 More social power dimensions have effect – intersectionality

It emerged in the interviews that the therapists feel the dyads are affected more by social power dynamics rather than just ethnicity. They emphasized that every patient brings much more than just their ethnicity to therapy, and what they bring will impact the power dynamics of the dyad. Agata described this as follows: "So it's like… as always with people, it's a bit more complicated than just ethnicity; there's so much more to it, of course."

Several respondents described class as a social power dimension discernible in these therapies. One therapist explained that patient class affiliation and lack of wealth become evident in some patient encounters: "And class is something I encounter that becomes evident. That they talk about it. Not being able to afford rent or not having some kind of secure hourly employment. And unbearable employers." (Ana) Another respondent raised the patient's class affiliation as an aspect that can affect therapy. She also pointed out that similarity and dissimilarity can be derived from aspects other than ethnicity, noting that the experience of similarity can be reduced by class differences between patient and therapist.

Several respondents noted power dynamics related to being women. For example, these female therapists reported that challenges could arise with male patients from more patriarchal societies. Amara observed: "At those times, maybe I thought, why am I sensing some skepticism targeted at me right now? In some cases, maybe it was indeed an older man." Another perspective that emerged involved specific oppressive behaviors toward women in a nonprivileged position. One noted the value of talking about the particular oppression connected to being a woman of a non-normative ethnicity.

It emerged during the interviews that the therapists saw themselves in different ways as more privileged than their patients. They observed that they had more education and were better off financially. Other perspectives included being born in a European country and the extent to which one was coded as white. One respondent depicted it as challenging to be in a much more privileged position than her patients.
Aleksija described the difficulty of being Swedified, yet simultaneously foreign:

> So, I'm fairly Swedified, but I'm also foreign. [. . .] And I maybe feel a bit like… I don't know, false, like an imposter, on both sides. I'm not exactly like the patient, but I'm not entirely different either.

4.3 Power in role of therapist

All respondents emphasized that there is always a power imbalance in the therapeutic dyad, that through her role, the therapist occupies a position of power relative to the patient regardless of social status. Angela described her view of this power imbalance as follows: "Of course I do still have power as the therapist. I have power in my role, and it's there the entire time, of course, that is, it's inescapable." One respondent connected power to language, noting how the power imbalance is even greater in dyads in which the patient does not speak

Swedish and an interpreter is needed. Most respondents described strategies for evening out power. To minimize their own status as expert and boost their patients' autonomy, some were careful to note that therapy is a collaboration. One therapist explained that she uses herself in examples for this reason and is always careful to ask the patient's permission before doing so. Another felt the power imbalance was not as prominent in the room if a good alliance was formed early on. One respondent reasoned:

> The fact that as a psychologist, I'm often called doctor, and there might be a clear thought that I'm the one who knows best or that I need... yes, exactly, that I get to guide the conversation a little more [. . .] That's really independent of the fact that we share, that we are similar in our nonprivilege. I experience that anyway.

The therapists also stressed the importance of a self-reflective style, including attentiveness to their own power in the role of therapist. Several emphasized the value of helping patients talk about their difficulties in their own words, noting the risk that patients may begin describing themselves in the therapist's psychological terms. One respondent observed that in the therapeutic relationship, power need not harmonize with power in society and pointed out that a patient in a position of dependence relative to the therapist in the therapy room may have much more social power than the therapist.

In conclusion, this theme centers on how therapists navigate fixed and variable aspects of therapy. Fixed aspects can be found in respondents' awareness of an inherent power imbalance and emphasis on the universality of existential questions. In addition to ethnicity, which affects the degree of the power imbalance, variable aspects include class and gender.

Discussion

The Minority Matrix

The study results can be illustrated as four different positions that the therapists occupy and navigate in their work (see Figure 2). The overall picture is that through time and experience, respondents have defined internal and external approaches for handling matters pertaining to background and culture. They developed these various approaches on their own as professionals. The positions that illustrate the results do not appear to be static; rather, they vary depending on the contexts in which the therapists find themselves. This variability means that all positions can be found over the course of a therapy – or in a single session.

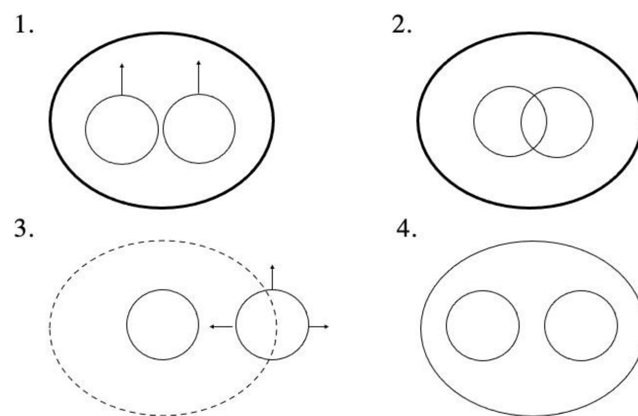

Figure 2 - The Minority Matrix: 1. Minority in relation to a majority, 2. Too close: the therapist's role is compromised, 3. Provides instruction in multiple ways, 4. Interplay of fixed and variable.

The first position (Minority in relation to a majority) is illustrated in box 1 of the figure, where the two smaller spheres represent the therapist and patient. The respondents described a sense of solidarity arising within the dyad. They find the fact that both therapist and patient belong to a minority culture to be a contributing factor to mutual assumptions about the other's experiences being similar to their own. Both therapist and patient are looking for similarities in the dyad, and together, they look out at society and "the Swedes." This position is characterized by clearly prominent boundaries with society; the sense of community within the dyad is based on the exclusion of its parties from the norm. This is illustrated in the figure by the clearly marked outer circle, the outer limit of the dyad. Assumptions of perceived similarity are described by respondents as both helpful and dangerous. Such assumptions can be connected to Racker's (1968) observation that "it takes one to know one," referring to similarities in internal experiences rather than external circumstances. He would consider it a mistake to equate external circumstances with internal experiences. Respondents correspondingly described the imagined similarity as dangerous when perceived external similarity created assumptions in the patient about shared experiences and mutual understanding. The respondents' stories support to some degree the idea of ethnic matching (Cabral & Smith, 2011), which rests partly on an assumption that similarity creates an alliance; that literature, however, tends to mention the advantages without the associated risks.

The second position (Too close: the therapist's role is compromised) is illustrated in the second box of the figure. The respondents talked about challenges that can arise in the role of therapist and described their identification with patients' stories as emotionally challenging. In this position, searching for similarity and solidarity resulted in the therapist experiencing the patient as getting "too close." The boundary between the dyad and society is clear, while the boundary between what is the therapist's story, and what is the patient's, has become fuzzy. The spheres inside the box overlap, while the external line is distinct.

Several respondents described how recognizing themselves in patients' stories could lead to identifying with patients in a way that could affect their role as a therapist. Fors (2018) describes the tension between identification with the patient and the fear of overidentification. The therapist may tend to overemphasize neutrality out of concern about being accused by self or other of overidentifying with the patient. Respondents' stories of getting too close can be interpreted as descriptions of overidentification, where fear of overidentification is one of the challenges they describe. Interestingly, the therapists described having developed ways to handle this dynamic, despite how challenging it could be. A few respondents said it could be helpful for trust in the dyad when patient and therapist could relate over common experiences. Again, the literature on ethnic matching has focused primarily on the advantages of the method, but the respondents' stories illustrate another dimension, which includes serious challenges.

The third position (Provides instruction in multiple ways) is illustrated in the third box. Respondents described experiences of being interpreters and instructors, in both directions, between their patients and their workplace. This is illustrated by a drawing in which the lines between the dyad and the outside–the workplace and society–are blurred. In this position, the dyad is in its context; the therapist has one foot in the dyad and the other foot outside it, with responsibility for interpreting in multiple directions, as illustrated by the arrows. She translates Swedishness and Sweden to patients, while being asked by colleagues to translate the patients' culture.

Several of the respondents' stories included having to instruct colleagues in patients' culture. These stories exemplify how ideas about cultural competence are expressed at health and medical care workplaces. Culture is viewed within this paradigm as possible to operationalize and translate into capabilities that can be taught to others (Kirmayer, 2012). This position, which involves informing colleagues and being the person emblematic of "culture" at their workplace, can be burdensome and frustrating in ways reminiscent of Pon's (2009) critique of the cultural competence paradigm: the majority can decline to take responsibility for meeting the minority by pleading lack of knowledge. In this vein, one respondent explained how in her workgroup, she is often the one who ends up treating patients with foreign backgrounds. Fors (2017, 2018) writes about a "mythical magnetism" that results in gay therapists usually getting LGBTQ patients on their patient roster. This magnetism describes unspoken structures and assumptions about "it takes one to know one," about how minorities should be able to understand one another. Respondents' experience of being the ones to treat patients with foreign backgrounds can be seen in light of Fors's (ibid) argument.

The fourth position (Interplay of fixed and variable) is reflected in the fourth box of the figure. Respondents noted fixed aspects of therapy, such as inherent power imbalance and universality of some psychological themes. Invariable elements that they identified included how other categories of social power, such as class and gender, impact therapy. According to respondents, other factors besides ethnicity and degree of Swedishness affect therapy.

The respondents emphasized the importance of selfreflection. They took multiple power dimensions into consideration, including class, age, education level, gender, and ethnicity. Several respondents said that class can play a greater role than ethnicity in dyads with similarities in nonprivilege. This assertion implies a technical dimension to be discerned by the therapist. Fors (2021a, 2021b) argues that although the social power dimensions in therapy tend to be considered primarily as an ethical matter, they also involve questions of psychotherapeutic technique. Holmes (1992, 1999) earlier noted that race is visible in the transference. Respondents' descriptions and emphases within this theme suggest that they have developed skills in discerning when ethnicity is specifically relevant. The feminist scholar and psychoanalyst Gentile (2013) has pointed out that social power is always present in encounters, including therapy. Further, Layton (2006) has emphasized unconscious aspects of racial encounters in psychotherapy. Here, respondents are describing a co-created reality which they have learned to navigate technically, by intuitively moving in and out of four different situations.

In conclusion, four clinically relevant positions emerge from therapists' descriptions of working with patients who share their status as nonprivileged. The respondents provide a nuanced picture of both the positive and the more challenging aspects of their work. Their experiences of challenges stand in contrast to the literature about the advantages of ethnic matching. Moreover, it appears impossible to explain what happens among the therapist, patient, and workgroup based solely on the therapists' cultural competence. By talking about their experiences as employees in different contexts, the respondents have successfully tackled the challenge of illuminating subtle aspects and putting the unspoken into words.

Limitations of the study and future research

We chose Fors's (2018) concept of *similarities in nonprivilege* based largely on the desire to include a wide sample. When recruiting participants, we used the wording *"non-normative ethnicity"* to include the widest sample possible, as the purpose of the study was to investigate therapeutic dyads in which both parties have experience of deviating from the Swedish norm.

Recruiting via terms such as "immigrants," "foreign-born," or "non-Swedish" would have included only some of the respondents we wanted to reach. Furthermore, such terms are somewhat charged, and we wanted to avoid provoking any potential participant. Our informational text led to follow-up questions in the Facebook group where it was published. The majority of people who commented on the term *nonnormative ethnicity* were male. None of the men who participated in the discussion about terminology showed interest in participating in the study, even though some of them did seem to meet its inclusion criteria. It was exclusively women who showed interest in participating. This disparity may be connected to our using the term "non-normative ethnicity," as the term "non-normative" is more often associated with feminist and/or intersectional contexts. The uneven gender distribution may also reflect the division within the Swedish psychology corps, in which women are dominant (Swedish National Board of Health and Welfare, 2018).

Another aspect of the framework on which the study was based is Mattsson's (2005) principles of *degrees of Swedishness*. These degrees of Swedishness are open for discussion and problematizing, such as whether the principles should be weighted. It is conceivable that some of the principles have more influence on classification of Swedishness than others. For example, a strong accent when speaking Swedish arguably has a greater impact than being born outside Sweden on whether one is perceived as Swedish. In our case, the study is based on the fact that there is a difference in social power between groups and people in the form of relative privilege. Racism springs from the same reality, which is itself unobservable but is evident in the form and effects of racist actions, rendering them visible.

Conclusions

This study indicates that therapists' non-normative ethnicities impact their professional roles and working situation in various ways. They have developed skills in assessing when ethnicity is specifically relevant and how they navigate sameness, difference, and closeness. As are illustrated through the proposed minority matrix, four different situations that are negotiated in therapy: minority in relation to a majority; too close: the therapist's role is compromised; provides instruction in multiple ways; and interplay of fixed and variable. These reach beyond the established paradigm of cultural competence and ethnic matching, clarifying a more complex picture of clinical practice than mainstream research has yet examined. Our respondents demonstrate how the therapist is always part of a larger context – an important lesson, regardless of ethnicity. Among psychologists, the respondents represent a rarely heard group, one that grapples with both internal and external experiences entailed by life outside the norm. We suggest a dimension that incorporates technical psychotherapeutic questions on closeness and distance.

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