

Relational Social Work: A Model for the Future

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ABSTRACT

This article outlines and elaborates on the main features of the authors' relational model: a reconceptualization of transference and countertransference, the role of enactments in the clinical setting, the importance of the use of self, and the worker's participation as a change agent. Use of this model will enhance clinical services, reduce failed treatments and therapeutic impasses, and diminish the incidence of boundary violations. This conceptual framework has been used successfully by the authors in residential settings with homeless individuals, persons with chronic mental illness and substance abuse, and ex-offenders. Additionally, the authors have found it useful in child welfare settings as well as in teaching and supervising students and clinical staff. Clinical examples are provided to illustrate the model.

At a recent conference in Chicago, a panel of social work educators and professionals led a discussion on trends in social work education and raised concerns about the marginalization of psychodynamic viewpoints, particularly in graduate school curricula. Additionally, many social work textbooks include psychodynamic theory as a historical artifact without reference to current developments in relational psychoanalysis and its proliferation in social work training institutes and advanced certificate and continuing education programs.

The way opponents describe psychoanalytic theory gives the impression that the theory began and ended with Freud and was limited to drive theory; the structural model of id, ego, and superego; and the psychosexual stages. On a more positive note, clinically focused social work journals have featured a number of articles by clinicians who include a psychodynamic approach in their practice. In one of her editorials in *Clinical Social Work Journal*, Carolyn Saari

(2003) referred to a recent collaboration between social work professionals at New York University and their film department that produced a film using psychodynamic principles in teaching interviewing techniques and supervision. The Council on Social Work Education (CSWE) reviewed this film and proposed a series that could be disseminated to educators. The film is now available for purchase on the CSWE Web site. Saari also noted in her editorial that some of the resurgence in psychodynamic thinking appearing in social work education and practice may be due in part to the "growing edge of theory known as relational psychoanalysis" (p. 102). The relational movement originated in New York, but it has influenced psychoanalytic practice due to conferences and a variety of books and publications, most notably the journal *Psychoanalytic Dialogues*, initiated in 1990. Another influence on practice, Saari suspected, is that some social work educators "have become aware, perhaps not yet fully consciously, of how

little depth and individualization of the client there is in formulations of 'direct practice' ... without some of the old style psychodynamic formulations" (p. 102).

Although these trends have been slow to influence social work education, a handful of articles paved the way for the recent emergence of interest in the relational perspective. A decade ago, Jane Gorman (1993), writing from a psychodynamic perspective, investigated postmodernism and the conduct of inquiry in social work. She argued that narratives were "intensely personal, highly emotional" stories of lived experience by clients and presented a "reality" that is "fragmentary, interpretive, and limited" (p. 250) as well as contextualized and self-reflexive. She viewed the use of narrative as a method of inquiry that could be used to bridge the gaps between research and practice. More recently, William Borden's seminal essay in *Social Service Review* (2000) traced the emergence of the relational paradigm in psychoanalysis and investigated its relevance to social work theory and practice. Among the earliest articles to apply relational theory to practice was Ornstein and Ganzer's (1997) application of Stephen Mitchell's relational conflict model.

For nearly a decade we (Ganzer & Ornstein, 1999, 2002, 2004; Ornstein & Ganzer, 1997, 2000, 2003) have practiced from a relational psychodynamic perspective and have published articles about working in that perspective with vulnerable populations in community mental health, substance abuse, homeless, and child welfare settings; we have found these theories enrich our clinical work and inform our practice. Additionally, we have applied this perspective to field instruction and supervision. Our intention in this paper is to give an overview of the relational approach to treatment and to demonstrate how well it interfaces with social work principles, and, in fact, enhances our work with clients, reduces failed treatments and therapeutic impasses, and diminishes the risk of boundary violations.

From Modern to Postmodern

One of the predominant themes of the late 20th century is the rise of postmodern thought in every discipline. As Stephen Mitchell (1993) observed:

All major intellectual disciplines, all knowledge, including scientific knowledge, is regarded as perspectival, not incremental; constructed not discovered; inevitably rooted in a particular cultural and historical setting, not singular and additive; thoroughly contextual, not universal and absolute. (p. 20)

Freud and his followers were products of the late 19th and early 20th centuries, the age of modernism, where the search for scientific truths, the quest for certainty, objectivity, and rationality were hallmarks of the age. Freud developed his metapsychology, the topographical and the

structural models based on archeological metaphors and ancient myths, and used them to examine intrapsychic experience. Psychic reality and the individuals' internal world became the focus of discovery. Therapeutic progress had to do with gaining knowledge about the self in the process of making the unconscious conscious through interpretation, thus enabling one to exercise restraint and control over thought and actions and to reduce tension. In this model, the therapist functions in the role of an expert who is able to discern the true meaning of the client's unconscious intrapsychic processes. Proponents of an ego psychological orientation furthered the development of psychodynamic theory by shifting from investigation of the id and its rich fantasy life and instinctual responses to the ego and its adaptation to reality. Although the move from exclusive emphasis on instinct, drives, and fantasy life to an exploration of autonomous ego functions and their adaptive capacities expanded upon and diverged from Freud's original theories, ego psychology, nonetheless, predominantly maintained an intrapsychic as opposed to an interpersonal focus and maintained the role of therapist as the final arbiter of truth. In the early decades of the 20th century, ego psychology played a significant role in social work practice, as it provided a "more optimistic and humanistic view of human functioning and potential than reflected in classical psychoanalytic theory and took into consideration the dynamic response to environmental, cultural, and social factors" (Goldstein, 1995, p. 35). Ego psychology's influence dominated practice until family systems and ecological theories became more influential in the 1960s.

Later psychodynamic theorists, such as Winnicott, Fairbairn, and Bion in Great Britain, and Loewald and Kohut in the United States, were precursors to the current paradigm shift to a relational model in psychoanalysis. This model, although rooted in psychoanalytic theory, is a reaction to the classical, ego psychology developed after Freud. The postmodern turn or paradigm shift that affects practice provides a fertile ground for the integration of various strands of relational theory. There is not one relational model but a variety of approaches, the most prominent of which are relational conflict (Mitchell, 1988), mutuality and reciprocal influence (Aron, 1996), dialectical constructivism (Hoffman, 1998), and intersubjectivity (Benjamin, 1998; Ehrenberg, 1992; Ogden, 1994; Stolorow, Brandchaft, & Atwood, 1983). Other prominent theorists whose work is allied with this model are Jodie Messler Davies and Mary Gail Frawley (Davies & Frawley, 1994), Steven Cooper (2000), and Karen Maroda (1991, 1999, 2002). The clinical implications of these approaches stand in stark contrast to the best practice and cost containment models currently dominant in contemporary practice and whose influence is felt in how we negotiate the insurance and managed care industry in an effort to ethically treat our clients.

The main features of this relational approach are the use of redefined concepts of transference and countertransfer-

ence, including paying attention to the use of projective identification, an increased emphasis on self-disclosure in treatment, and the identification and investigation of enactments as they unfold between therapist and client. This model also stresses the co-construction of meaning, a two-person rather than a one-person treatment approach, the acknowledgment of the therapist's participation, and the shift in location of therapeutic action from exclusive focus on insight and interpretation to an emphasis on the mutative potential of the client/therapist relationship. Although Freud and his followers (Mitchell, 1993) were aiming for "clarity, explanation, and insight," the contemporary relational theorists "stress ambiguity, enrichment, and meaning" (p. 32). The classically oriented therapist worked from a belief that experience corresponded to reality and could be known objectively and interpreted to the client, whereas the postmodern practitioner asks how do we know, what do we know, and what's going on around here. Rather than a one-to-one correspondence with reality, the relational therapist views her or his own experience and the client's experience of the therapeutic relationship from many perspectives and contextualizes those experiences, locating them in the historical, cultural, and social matrices in which both the therapist and the client are embedded. We have often pointed out that this particular aspect of the relational model makes it very congruent with the current emphasis of social work practice.

Rather than discussing each contributor's particular theory, we delineate our view of the overarching features of the relational model and what we feel are the individual theorists' approaches most relevant to social work practice. We situate our concerns primarily in social work education and agency practice where transference and countertransference and the other psychodynamic constructs mentioned above often are seen as outdated concepts. They may be touched on in treatment but usually do not represent the core concepts in work with vulnerable populations. Our experience with these populations has led us to reexamine how we work with students, beginning therapists, and staff therapists in conceptualizing cases, designing treatment plans, and carrying out the treatment in a way that weaves these contemporary relational concepts back into the very fabric of treatment process.

No Place to Hide

Early classical psychoanalytic conceptualization of transference viewed it as a distortion, where the therapist functions as a blank screen on whom the client projects and displaces wishes and conflicts. This restrictive model of therapeutic action relies only on interpretation and places exclusive focus on the client's intrapsychic process. Gill (1982) redefined transference as not only the client's displacement and distortion from the past but also the reflection of the here-and-now experience of the client

with the therapist who has a role in eliciting and shaping the transference. In this formulation, transference is understood as both an intrapsychic and an interpersonal phenomenon. Gill has transformed the meaning of transference from being only the client's distorted projections onto the therapist to being, instead, a phenomenon of selective attention where the client insists on one explanation of a situation when, in fact, many different explanations might be possible. What is transformative, as Gill (1982) argued, is that the therapist must always view the client's perceptions as plausible given the client's history and lived experience. Hoffman (1998) more recently argued that the therapist's participation in the cocreation of transference is part and parcel of the treatment and inevitable. Furthermore, Hoffman (1998) extended Gill's argument by emphasizing that the therapist is not necessarily a more objective observer of his own participation in the therapeutic process than the client. From this point of view, the client's experience is subject to a number of narratives or explanations rather than one "true" interpretation. The therapist's task is to validate the client's complex and multifaceted experience and to collaborate with the client in co-constructing a broader array of possible explanations and understandings of the client's narrative. The shift we are describing primarily affects the therapist's role, which is a more interactive and participative one, and which centers on the relationship as a change agent. Although social work has long valued the importance of the relationship in practice, without these innovative relational concepts, the profession has lacked a sophisticated theoretical framework to more fully potentiate the use of the therapeutic relationship as a catalyst for change.

The essential contribution from contemporary relational theory is the inclusion and explicit valuing of the therapist's participation. The classical psychoanalytic view of transference, that the therapist would provide correct and accurate interpretations of the client's transference, suggests that therapy would unfold in much the same way with any therapist who could give the correct interpretation. The classical view that privileged abstinence, anonymity, neutrality, and silence may have made the therapeutic situation feel safe and comfortable for the therapist, but probably did little to actually help the client. The shift to include the therapist's participation is a shift from relying exclusively on the therapist's application of detached, precise, technical expertise to fully utilizing the therapeutic relationship with the therapist operating from a fully engaged and involved position in which he or she must take into account the quality and nature of his or her own participation in addition to focusing on the client's thoughts, feelings, and behavior. The therapist truly has no place to hide. Consequently, the therapist and client are better able to identify strengths, and share power. This reconceptualization of transference, that more fully acknowledges the quality

and nature of the client and therapist participation in the clinical encounter, provides a powerful way to differentiate between areas in the client's experience where distortion occurs and areas where the client's perceptions are accurate. This more complex and comprehensive understanding of interactions can assist the client in identifying and using strengths to more effectively negotiate the interpersonal world. This position encourages the therapist to resist pathologizing the client but rather to hold the client in high esteem, to create an atmosphere of increased mutual respect, and to value the client's cultural background and experiences. The additive effect of these revised conceptualizations of transference contribute to enhanced respect for the client due to the deemphasis on the therapist's role as expert on the nature of the therapeutic interaction. It elevates the importance of the client's experience of the relationship, as the therapist no longer has all the answers and must listen carefully to the client's perceptions and concerns, including the client's experience of the therapist's participation.

Countertransference

Unlike transference, which has been seen as a less relevant or an outmoded concept, even nonpsychodynamic clinicians realize the importance of countertransference. For example, family therapists pay attention to interface issues that include the therapist's reaction and feelings. Countertransference is phenomenologically a clinical reality and has utility and power. Nonetheless, social work practitioners do not appear to have a highly developed framework for talking about it, despite their awareness of its importance. Again, countertransference often has pejorative connotations. It is problematic, something to be avoided or worked through. The unconscious determinants are rarely given currency or acknowledged.

Historically, even in psychoanalytic theory, countertransference was considered undesirable. It represented an inappropriate intrusion of the therapist's unresolved conflicts and/or psychopathology. The maxim was the less the better, and therapists were encouraged to go back to their own therapy to work it out. Gradually, a sea change in understanding of countertransference (Heiman, 1950; Maroda, 1991; Ogden, 1994; Racker, 1968; Scharff, 1992; Tansey & Burke, 1989) resulted in a shift from the narrow pathologizing view of countertransference to a broader understanding of the therapist's emotional reaction.

Contemporary relational theory views countertransference as central to treatment and inevitable and unavoidable in every therapeutic situation. Even among the best contemporary analytic writers, there is sometimes the sense that countertransference is dichotomously divided into objective and subjective, positive and negative. It has to do with the therapist's vulnerabilities and unresolved issues, or it provides important information about the

therapy. In our approach to relational theory, the situation is more nuanced and complex. In actual clinical practice, countertransference often involves the simultaneous triggering of both the therapist's subjectivity and personal vulnerabilities *and* a repetition of the client's dysfunctional relational configurations. Consequently, therapists need to struggle to be aware of and reflect on both of these aspects of countertransference in order to have a full view of their own participation and the client's dynamics in any given clinical situation.

Contemporary relational writers routinely give examples of this kind of reflective practice. It is in instances where they are stuck or puzzled that they look for clues in the countertransference to begin to sort out what is going on. Rather than seeking to reduce ambiguity and uncertainty, they immerse themselves in it. They avoid premature closure in looking for definite answers and are able to enter the complex world of the client to participate in the experience and to work with the client to emerge from it. With the earlier view of countertransference, therapists often felt a sense of paralysis and mortification because their own personal issues and vulnerabilities were stirred up in an uncomfortable manner. The therapist who feels stuck in this way may withdraw, act out, or shift to a superficial protective stance with the client.

Sometimes there is a sense of shame and a feeling of inadequacy on the part of the therapist. But in any case, the potential to create therapeutic space is foreclosed, and the therapist's capacity for empathy, attunement, and reflection can be diminished. This dilemma is even more problematic for beginning therapists. For example, when students first experience sexual feelings for a client, they often question their ability to maintain appropriate boundaries or their suitability for the profession. In other words, the earlier dichotomous view of countertransference as useful if originating in the client or destructive if emanating from the therapist needlessly heightens therapists' sense of vulnerability, feeling of inadequacy, and fear of catastrophic failure. These situations often result in therapeutic impasses, boundary crossings and violations, and, ultimately, failed treatments.

It is in this area of more effectively managing countertransference that contemporary relational theorists make one of their most important contributions. Contemporary relational theory allows for a *both-and* rather than an *either-or* focus, and encourages therapists to nonjudgmentally struggle to be aware of their affective states, internal processes, and visceral bodily experiences. They can then reflect on the possible meanings and attempt to identify connections to the client's history, issues, and dynamics as well as being aware of the same connections to their own history, issues, and dynamics. Although feelings may be painful, the connections might be difficult to discern, and the realizations about oneself and the client could be disturbing, nonetheless, this process opens the

potential therapeutic space and creates interpretive possibilities that lead to less rigid, more flexible kinds of interactions between therapists and clients and hold the possibility for the kind of reparative, compensatory object relational experiences that we have already described in our discussion of transference.

Projective Identification

An important aspect of a relational understanding of transference and countertransference involves the defense mechanism of projective identification. This complex defense mechanism takes on increased importance from a relational perspective because it is the only defense mechanism that has an interpersonal component as part of its operation. There is much ferment and controversy about projective identification, which is beyond the scope of this paper to address. We will restrict our focus to a brief summary of our view of the crucial role this defense often plays in relational social work with vulnerable populations, illustrating its use in the first clinical vignette.

Projective identification frequently provides the stage on which transference and countertransference processes between therapist and client are played out. In projective identification, the client or therapist unconsciously attributes some aspect of himself or herself to the other person. Usually this occurs because the part of the self—which could be an affect, self-representation, or object image—is experienced by the person as being intolerable. In other words, the person rids himself or herself of an objectionable part of the self by placing that part into another person. Next, the person finds himself or herself compelled to stay involved with the projected part. This continued involvement is what differentiates this process from simple projection and has important implications for the therapeutic process. As part of this continuing involvement, the projector unconsciously relates to the other person in a way that brings forth in that person feelings and behaviors that resemble the part of the self that was projected into them. The initiator of the projective identification then feels it is necessary and justifiable to control or even attack the other person in order to protect himself or herself from a part of the self that is now experienced as residing in the other person and threatening their well-being.

The therapeutic potential of projective identification can be actualized if the person who receives the original projection is able to *contain* the part of the other person's self that has been placed in them. This containment involves holding and detoxifying what has been put into oneself without allowing oneself to be provoked into attacking, retaliating against, or persecuting the original projector. In response to effective containment, the original projector has an opportunity to take back the part of the self from

the other person, which can then be integrated into the personality in a healthier way.

Our view is that therapists who understand and utilize this relational perspective and who have struggled to develop their reflective capacity and tolerance for ambiguity will be more likely to be able to effectively contain their clients' projective identifications and enable their clients to integrate these previously intolerable parts of themselves in healthier, more constructive ways.

First Clinical Vignette

A notable example of the expanded possibilities for the therapeutic use of transference and countertransference we are describing is found in Davies and Frawley (1994). In *Treating the Adult Survivor of Childhood Sexual Abuse*, which recounts a relational approach to treatment, the authors describe a situation where a female, young adult client, who was a survivor of severe and persistent childhood sexual abuse, comes to her session angry over the fact that the therapist had not returned an emergency call the client made the previous evening. Rather than expressing anger or depressive feelings, the client informs the therapist that she has a gun in her purse and intends to shoot herself before the session ends. She has concluded that her relationship with the therapist is like her other relationships, callous and uncaring.

Initially, the therapist attempts to de-escalate the client by acknowledging the times when she had failed but also pointing out when she was caring and concerned. The client, however, becomes more energized and agitated. The therapist goes through a range of emotions, her heart begins to race; she feels "frightened ... helpless ... stupid and unfit to the task," unsure of what to do (p. 140). At one point, she finds herself curiously sexually stimulated by the experience and is both horrified and mortified by her realization. The therapist courageously resists the temptation to withdraw from the client or to retaliate; instead, she uses her understanding of relational theory to help her stay attuned to the client and to focus on the process that is unfolding between them. The therapist begins to identify an enactment in the transference/countertransference transaction. With this dawning realization of what might be happening between her and the client, the therapist finds the courage to verbally share some of her countertransference experience directly with the client. She says, "If only I can say the right thing to you ... if only I can be good enough and smart enough and clever enough, then maybe I can say something ... maybe I can say or do exactly the right things and you won't do these terrible deeds" (p. 140). This initial self-disclosure of her countertransference catches the client off guard and effectively interrupts her escalation. The therapist then moves explicitly into a mode of transference interpretation where she reflects to the client that the client seems to be doing to the therapist what

the client's mother did to her, showing her "in the most powerful way ... what it was like ... when [her] mother teased and tormented her" as she teased and tormented the therapist (p. 140). The client gradually accepts the interpretation and seems to feel contained, and by the end of the exchange is no longer threatening suicide.

This vignette evocatively captures the *both-and* approach to countertransference that we endorse as relational practitioners, as well as the effective containment and therapeutic use of a client's projective identification. The therapist has the wherewithal to allow herself to be aware of her personal vulnerabilities and issues that have been stirred up by the client and to acknowledge to herself in the moment of crisis feeling sexually aroused and paralyzed. She, however, transcends the paralysis by using her own countertransference feeling of sexual arousal to identify the possible enactment that is occurring between herself and the client. In other words, her countertransference feelings alert her to the likelihood that the client has projected the intolerable feelings of sexual arousal and terror associated with her original sexual abuse into the therapist, and therefore feels justified in coercing and controlling the therapist through her provocative and threatening behavior. The therapist, in turn, is able to contain and detoxify the client's projective identification by internally processing and reflecting upon the disturbing feelings the patient has stimulated in her, without attacking the client. The therapist is then able to use her deepened understanding to formulate an effective response. Having caught the client's attention and having begun helping her to de-escalate, the therapist then has the presence of mind to use an explicitly interpretive intervention to develop the narrative that gives meaning to this volatile situation and facilitates the therapeutic work. One might notice that the therapist's initial inclination was to work in a conventional way to interpret the client's tendency toward splitting (when she commented that sometimes she failed the client, while other times she cared about her), but when she was unsuccessful, her next focus was to examine her countertransference for clues to what was going on. This example illustrates how a therapist can use a relational approach to effectively resolve impasses by increasing the range of alternative interventions available in a difficult situation.

Enactments, such as the one Davies and Frawley (1994) described can be a source of potential therapeutic leverage only with the different, more nuanced relational understanding of countertransference we have described. From this point of view, enactments provide therapeutic data and are not seen as evidence of personal failing or unbridled acting out on the part of the therapist or client. Enactment involves the unavoidable reality that the client's relationship with the therapist is inevitably structured along the lines of the client's preexisting relational configurations. In other words, the clients not only verbally relate their problems to us, they also show us. What happens

between the client and the therapist during the session is emblematic of the client's behaviors outside the session. These interactions often have roots in earlier familial experiences as well as in current personal relationships. Just as was true in our discussion of the narrower concept of countertransference, our view of enactments always involves more than the source of the enactment coming from either the therapist or the client. Like our discussion of countertransference, the enactment always involves both the recreation of the client's past relational configurations and present lived experience, as well as the therapist's inevitable participation. Once again, the therapist's personal vulnerabilities and issues are always implicated to some extent in an enactment and similarly are examined in terms of how they are being stimulated by the client's recreation of her or his preexisting relational patterns.

In the older classical view, the occurrence of an enactment in the therapeutic situation was a stain on the therapist's competence, and such occurrences were to be avoided at all costs because the inevitable outcome would be uncontrollable transference escalation by the client and potential boundary violations by the therapist. The contemporary view of enactment that we endorse considers enactment to be an inevitable and essential aspect of all therapeutic interaction, which, if acknowledged and explored, can promote therapeutic action. Mitchell (1988) described this process as follows: The therapist

discovers himself a coactor in a passionate drama involving love and hate, sexuality and murder, intrusion and abandonment, victims and executioners. Whichever path he chooses, he falls into one of the patient's predesigned categories and is experienced by the patient in that way. The struggle is toward a new way of experiencing both himself and the patient ... to find an authentic voice in which to speak to the patient, a voice more fully one's own, less shaped by the configurations and limited options of the [patient's] relational matrix, in so doing offer the [patient] a chance to broaden and expand that matrix. (p. 295)

Now we turn to a previously published case conducted by the second author of this paper to illustrate how she identified and used an enactment between the client and herself. Previously, we (Ganzer & Ornstein, 2002) described her work with Arthur more fully in regard to issues of cultural diversity. Here, however, we focus on one segment of the case occurring about 4 months into a 2-year treatment.

Second Clinical Vignette

Arthur is an African American male in his mid-40s, who was resident of a facility for the homeless. He had been incarcerated in federal institutions for over a decade. He was a

survivor of childhood sexual abuse and had significant abandonment issues. Arthur's tendency to split happened frequently, often in the course of a session. He alternated between very intense idealization and vicious devaluation of my skills, ethnic background, and position in the social service agency with which I was affiliated. The enactment involved physical boundaries between Arthur and myself. For several sessions, Arthur had been demanding that I give him a "blueprint" for his life that would ensure success. Much as I tried to convince Arthur that I did not have a specific "blueprint" for him, I found him unrelenting in his request. During one of these sessions, Arthur jumped up and grabbed my head in his hands in order to accentuate the point he was making. He released my head and then repeated the action as he continued his demand. I was startled by his intensity and by the third move toward me, I put up my hands and told Arthur to stop. Arthur was aware that he could not have any aggressive physical contact with staff members, but it appeared that he was overcome with emotion and had acted spontaneously and impulsively to make his point. I was shocked more than frightened by his actions and before I could recover my composure, Arthur began a barrage of verbal abuse that included his assertion that "the only reason I stopped him was because he was Black and I was White" (p. 137). As personal boundaries were reestablished, I began to try to reflect on what happened. I began to wonder what was going on around here. Although I did not feel in immediate physical danger, I thought, "Am I safe?" I had not taken seriously the fact that he might escalate beyond threatening verbal comments.

Arthur interrupted my reverie by bringing up the feelings of rejection that he experienced with his previous counselor, who had referred him to me because she felt hurt by his critical remarks and exasperated by her inability to help him stabilize his behaviors in the residential program. At this point, I tried to engage Arthur in a mutual effort to understand what had happened between us. I disclosed to Arthur that I was confused and somewhat angered by his attacks, since I perceived all of my actions as attempts to be helpful and understanding. I interpreted to Arthur that I felt his exaggerated behaviors and verbally abusive language tended to drive me away from him as it had his previous counselor. Arthur "asked me if I knew why he wanted to hurt others. I told him I didn't know. 'Yes, you do,' he replied, 'I want them to know how I feel'" (p. 173). It occurred to me that in his rages, Arthur was showing me what it felt like to be him, how he experienced the loss of his mother when he was 5 years old, or the sexual abuse by his uncle as a child, or the physical abuse he encountered while in prison. The enactment underscored his ambivalent feelings about safety and trust. Whenever anyone got close to him, he would behave in such a way that the individual would reach limits of tolerance and reenact the abandonment and rejection. My countertransference feeling of being shocked but not

frightened allowed me to contain him, to stay in the room with him, and to process what had happened as opposed to calling security and carrying out the abandonment he seemed to be unconsciously trying to provoke. As a result of our struggling to fully process what was for both of us a painful and difficult interaction, I was able to contain his affect and transform his mode of relating to me from a violent, action-oriented stance to a more modulated verbal expression of feelings. Arthur, for a time, was able to use this interpretation and this co-constructed narrative "to regulate his affect, retain employment, and improve interactions with others in the agency" (p. 173).

Discussion

The foregoing vignettes illustrate the movement from a one-person to a two-person approach to handling enactments in treatment. In a one-person approach, the client expresses his intrapsychic processes in the form of behavior and emotions and the therapist, as a detached, objective, expert observer, explains what it means, thereby making the unconscious conscious through carefully crafted interpretations. The thoughts, feelings, and behaviors of the therapist are not implicated or involved in this model. Any self-disclosure in these areas would be viewed as a technical error and an indication of the therapist's unresolved issues and psychopathology.

In a two-person relational approach, the therapist's thoughts, feelings, and behavior are inevitably part of the data that need to be considered in understanding any given therapeutic situation, as are the client's contributions. The therapist's participation gives shape, texture, and meaning to how the client's experience unfolds. In a parallel way, the understanding of the therapeutic data emerges with the full participation of the both the therapist and the client. This is what we mean by the co-creation of meaning.

One way these ideas of co-construction of meaning and the two-person approach are operationalized is in a different understanding of the components of therapeutic action in a relational approach. The source of therapeutic action is in the described continuous cycle of the therapist and client mutually participating and getting caught up in enactments that represent both the therapist's and the patient's transference and countertransference configurations. Specifically, the therapist's role in promoting therapeutic action is multifaceted. One important aspect of this approach is that the therapist who no longer views himself as a detached expert, and who has developed an increased tolerance for ambiguity and uncertainty, is able to more fully allow himself or herself to be caught up in the unfolding interaction in the therapeutic relationship. A key component in this process is the therapist, as in the case of Arthur, using her skill, tact, and empathy to elicit and engage the client's interest in mutually understanding and reflecting upon what has happened between them. As this

process of shared reflection and exploration unfolds, the therapeutic space between the two of them enlarges, and mostly for the client there is a loosening of their commitment and investment in the old relational patterns because they are now more aware of them. In other words, patterns of interaction and behavior that were formerly unconscious, automatic and inevitable now become a matter of conscious reflection and choice. In this way, there is an opening of an opportunity for the client to both develop and enact new patterns and ways of relating in the relationship with the therapist and in relationships outside of therapy. It is important to note that this conceptualization of therapeutic action emphasizes the mutative action of interpretation *and* interpersonal influence and experience.

Why are we advocating the use of this model for social work education and practice? As social workers, we believe we have an obligation to have a repertoire of knowledge and skills that we can bring to bear on situations where we have reached an impasse with the clients and are stuck, or where we are attempting to define boundaries in the unfolding therapeutic relationship. More importantly, it seems to us that having a conceptual framework that attends to activated, unconscious relational patterns at play in every treatment, and a well-defined relational theory as an underpinning to practice, are essential to providing structure while allowing for flexibility and creativity in practice. To paraphrase Irwin Hoffman (1998), it is important to have the therapeutic ritual in place in order to allow for spontaneous participation in the therapeutic process.

In our experience, a good deal of agency social work focuses on providing concrete services, immediate problem solving, and client advocacy, but dynamic issues often are of secondary importance. Although we acknowledge that any approach that calls itself social work must address these needs and provide these services, we argue that these traditional social work activities need to be integrated with the various components of the relational model described here.

Because social workers primarily treat vulnerable, oppressed populations where issues of diversity and social justice prevail, a model that emphasizes the client's uniqueness, increases and encourages client's narrative competence, and provides tools to understand complex experiences of self and others is needed. This relational model responds to the authentic in-depth needs of the whole person, thereby creating increased agency, empowerment, and the possibility of enduring change.

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