Reconsidering Graduate Training and Clinical Practice: The Importance of Psychodynamic Thinking

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ABSTRACT

Treatment can be powerfully informed by the exploration of psychodynamic concepts. Yet, many graduate social work programs struggle to adequately examine these ideas. Psychodynamic practice has transformed from a framework of long-term private practice, which requires multiple sessions a week, to a contemporary framework that can integrate into any modality, frequency, setting, and length of treatment. Literature on the psychodynamic approach has not been effectively incorporated into most current graduate programs. This article addresses this gap in social work education by advocating for graduate-school coursework focusing on—at a minimum—the concepts of (a) the unconscious, (b) transference, and (c) countertransference. In the following pages, we offer a synopsis of current graduate-level coursework, and an examination of psychodynamic thinking, including its base of evidence and value in contemporary treatment. This article explores an integrative approach to training and practice. We argue that understanding these fundamental psychodynamic concepts creates a more nuanced, deeper, and impactful treatment and that training in this area is beneficial to all social workers.

KEYWORDS

transference; countertransference; graduate school; unconscious; psychodynamic theory; social workers

Introduction

Psychodynamic thinking is critical to deepening treatment. This article conceptualizes such treatment as not only recognizing external, visible behavioral manifestations and symptoms, but also understanding how forces outside of awareness—the unseen and unspoken—drive one’s inner world and outward patterns. This approach values the exploration of the meaning behind problematic behaviors, symptoms, and presenting problems that a client manifestly brings to the work. Deepened treatment also values the impact of what the client and social worker bring to the interpersonal field.

These ideas of unconscious life, transference, and countertransference are ubiquitous to treatment regardless of one’s primary modality or practice setting. This article recommends a more integrative approach that
incorporates into training and practice the concepts of the unconscious, transference, and countertransference. Based on our contention that integrating psychodynamic concepts in one’s practice is clinically sound, whether one is working in a homeless shelter, a prison, in child welfare, in an adolescent group home, or in the multitude of other settings in which social workers practice, we argue for the inclusion of psychodynamic orientations in the standard curriculum of social work graduate training.

Current social work graduate programs (master’s and doctorate) have ample coursework to cover in order to prepare social workers for various challenges facing advanced practitioners. Nonetheless, many social workers assert that their training did not equip them to tackle the complex and deeply embedded psychological issues that clients bring.

The Council on Social Work Education (CSWE) currently determines through clinical guidelines the essential concepts that will be taught to social work students. The pressure to comply with accreditation standards and a fundamental misunderstanding of psychodynamic approaches make it difficult for graduate programs to offer training that addresses transference, countertransference, and unconscious life, which are universal to clinical practice. Despite common misconceptions, psychodynamic methods have a strong evidence base. Instructors do not need full analytic training to grasp why and how these concepts can add to their teaching. Simply introducing these three concepts will add to student experience, as students gain from learning about their subjective relationships with clients.

Managed care and short-term behaviorally based treatments have privileged symptom reduction and have undervalued in-depth approaches, sometimes resulting in clinical impasses. Not knowing about the power of unconscious life, nor the dynamics that occur relationally between client and social worker, can result in frustration and even treatment failure. Because this content is largely absent in graduate training of social work, social workers are then forced to get needed clinical training after their master’s programs. Not infrequently they turn to psychology and psychiatry to meet these needs, thus diluting their social work identities. Although there are many other psychodynamic concepts that would further strengthen one’s clinical approach, this focuses the role of the unconscious, transference, and countertransference as fundamental to any helping relationship.

Mainstream therapeutic approaches do not always adequately meet clients’ needs. Social workers might wrestle with not understanding their clients on an intrapsychic level and do not consider the following: what this behavior or defense serves, how this defense might have been adaptive at some time, what the client provokes in the social worker, how the social worker feels when sitting with this client and what that reveals about the client, whether the client allows the social worker to have a subjective
experience or uses the social worker as an object, and how these relational and interpersonal aspects impact the client’s functioning.

When social workers meet their clients, they inevitably want to understand why their clients behave as they do. They often know that the behavior may be the best a client can do. Some may know that while the behavior might have been adaptive at some time, now it is not. What beginning social workers are not trained to know is what the client provokes in them. Why do they feel deadness, or disorganized with some clients? How can a social worker understand her own helplessness and even despair when sitting with a client’s depression, or her client’s rage at her, when the source of which is not evident or on the surface? What do their own feelings and reactions tell them about the client’s experience, past and present? How might these relational and interpersonal issues between client and social worker impact the client’s functioning? Where do these relational configurations come from, and how are they being reenacted in the present? How can the social worker be helped to understand that while the client may want to change, she is also afraid of changing?

This article challenges the notion that in-depth and psychodynamic therapy only happens on the couch in an expensive, long-term treatment modality with an analyst, or that an instructor must have analytic training to teach psychodynamic concepts. Even if instructors lack formal insight-oriented psychological training, they can still teach related concepts, thereby equipping social workers to employ those concepts with diverse populations and in varied settings.

Understanding the concepts of an unconscious, transference, and countertransference also enables social workers to take an empathic stance toward their clients’ behaviors that otherwise might mystify them. When a client treats the social worker with suspicion, or derision, when the social worker dissociates in the face of a client’s story, when a social worker is left feeling helpless and hopeless, these are relational responses that have everything to do with the client’s history, as well as the social worker’s history. There is ample evidence, detailed in this article, illustrating the benefit of using these psychodynamic concepts. Social work students are eager to deepen the work that they do, including the provision of support and insight to clients. For these reasons, the inclusion of psychodynamic concepts in graduate school training is critical.

The value of incorporating psychodynamic concepts in practice and in social work graduate school

Before we begin a detailed examination, let us first present an introduction to the value of incorporating psychodynamic concepts in therapeutic
practice and social work graduate school. Brief definitions of the concepts will place our argument in context.

**Defining three fundamental psychodynamic concepts**

*Merriam-Webster Dictionary (2018)* defines the noun “unconscious” as “the part of mental life that does not ordinarily enter the individual’s awareness yet may influence behavior and perception or be revealed (as in slips of the tongue or in dreams).”

Transference, for the purposes of this article entails “the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood unconsciously displaced onto figures in the present” (Greenson, 1967, p. 155).

We think of countertransference as “entailing a jointly created reaction in the clinician that stems in part from contributions of the clinician’s past and in part from feelings induced by the patient’s behavior” (Gabbard, 1995, 2005, p. 21).

**The value of incorporating psychodynamic concepts in practice**

This article challenges readers who heavily rely on symptom-reduction approaches to learn about transference, countertransference, and the unconscious—even if those readers’ primary approaches remain unchanged. A psychodynamic approach offers *a way of thinking* about a client and the therapeutic relationship. This way of thinking could promote a more empathic understanding of the client, and provide insight beyond symptomology, even if the social worker does not employ psychodynamic psychotherapy per se. In addition to understanding treatment impasses and adding to one’s therapeutic toolbox, learning about psychodynamic concepts (particularly transference and countertransference) can minimize complaints to ethics committees and licensing boards.

Solution-focused approaches absolutely have an important place in social work training and practice, but social workers should have a variety of approaches from which to choose. Insight-oriented understanding of a client’s psychology can enrich treatment and minimize the social worker’s risk of clinical impasses. Learning to think more dynamically can fill gaps in formal training, education, and supervision—while strengthening and deepening work with clients.

Many psychodynamic concepts can expand social workers’ thinking and improve therapeutic outcomes. These concepts encourage consideration of how unconscious communications manifest content and behavior, defenses
and their protective qualities, relationship-seeking patterns and repetitions, using an adaptive lens instead of a deficit model can help explain resistance, and treatment can benefit when moving beyond validation to interpretation and an understanding of enactments and blind spots. However, this article focuses on the concepts of the unconscious, transference, and countertransference. In addition, we are interested in awareness of oneself, and one’s feelings toward, and reactions to, clients. This awareness can inform diagnoses, and create insights into thoughts, feelings, and behaviors related to treatment.

Curiosity about the client’s way of being in the world can be therapeutically illuminating. By examining what the client projects onto the social worker, the social worker can access the client’s pain, relationship patterns, and defenses (both problematic and adaptive). Some questions the social worker might ask include (a) What do clients cast onto the social worker through transference?, (b) How does that inform the social worker about the client’s unconscious world?, and (c) What does the client communicate that he or she cannot express explicitly? Conversely, social workers can explore their own feelings during client encounters by accounting for what is getting triggered, how the social worker feels when with the client, what those feelings indicate about the social worker, and what all of this means about the client. These are just some of the questions that graduate social work students should be taught to ask about their clients and themselves.

One resource for such learning may be found in the second edition of the *Psychodynamic Diagnostic Manual* (PDM-2; Lingiardi & McWilliams, 2017). Here the student can learn about capacities for mental functioning, how to assess personality structure, and how to think about symptomology at the manifest and latent level. The *PDM-2* (2017) can therefore help graduate students understand the intersection of psychological development, diagnostic manuals, and transference and countertransference reactions. These capacities highlight the different developmental tasks that influence psychological development and promote a more in-depth understanding of the client and provide an avenue for interventions and outcomes in treatment (Table 1).

| Cognitive and Affective Processes | Identity and Relationships | Defense and Coping | Self-Awareness and Self-Direction |
|-----------------------------------|----------------------------|--------------------|-----------------------------------|
| Capacity for regulation, attention, and learning | Capacity for differentiation and integration (identity) | Capacity for impulse control and regulation | Self-observing capacities (psychological mindedness) |
| Capacity for affective range, communication, and understanding | Capacity for relationships and intimacy | Capacity for defensive functioning | Capacity to construct and use internal standards and ideals |
| Capacity for mentalization and reflective functioning | Capacity for self-esteem regulation and quality of internal experience | Capacity for adaptation, resiliency, and strength | Capacity for meaning and purpose |

Table 1. *PDM-2* capacities for mental functioning (Lingiardi & McWilliams, 2017).
Most social workers have a specific approach that resonates with them and on which they strongly rely. However, one should avoid being rigid, exclusive, or territorial. Berzoff (2012) advocates that psychodynamic concepts such as unconscious life, transference, and countertransference apply to all settings and with all populations, including those most vulnerable. She addresses oppressed populations including but not limited to the homeless, the racially marginalized, immigrants, prisoners, individuals with disabilities, and individuals who struggle with addictions. She and Altman (2010) further advocate that psychodynamic concepts be applied to community mental health and case management settings. Altman (2010) presents numerous examples of how psychodynamic concepts are applied in community agencies to not only understand transference and countertransference but how to think about client crises, missed appointments, and administrative matters.

More than 20 years ago, Reid (1997) stated that the variety of clinical approaches available is a “creative and constructive response to the great variety of client needs and problems and the great variety of talents and capacities of clinical social workers” (p. 201). Reid went on to say, “It is no longer necessary to force all clients and practitioners into the same therapeutic mold” (1997, p. 201).

The integration of different approaches has a rich history of interest. The Society for the Exploration of Psychotherapy Integration and the Journal of Psychotherapy Integration explore the strengths of various approaches (Pikecki, Thoma, & McKay, 2015). In their article “Cognitive Behavioral and Psychodynamic Therapies: Points of Intersection and Divergence,” Pikecki and colleagues (2015) offer a candid look at the benefits of both cognitive-behavioral and psychodynamic therapies.

Social workers of all orientations should work together to manage the mental health needs of those who suffer. This work should not be left to pharmaceutical and insurance companies. The commodification of treatment compromises the treatment itself. Most third-party payers (private, employer, and government insurance) are not interested in, nor do they fully understand, the requirements for meaningful psychological reintegration and stabilization—nor do they understand that this process is different for each client. Third-party payers focus on the fiscal bottom line and not human suffering. This leads to privileging the fastest and cheapest treatment option, even if that option is not best for the client.

The value of incorporating psychodynamic concepts in social work graduate school

Social workers are becoming more interested in deepening their treatment approach and broadening their perspectives. This is illustrated by increased
participation in the American Psychoanalytic Association (APsaA). Social
work candidates in psychoanalytic training increased from 71 to 108 in the
period 1998–2007, while other related professions, although still greater in
number than social workers, declined during the same time period (Lightbody,
2009, p. 29). The number of social workers who graduated from an APsaA or the International Psychoanalytic Association training
program increased from two before 1990 to 102 by March 2007 (Lightbody,
2009, p. 30), illuminating a need that was not being addressed in traditional social work training.

As documented by Duncan-Datson and Schneller (2016), positive outcomes
resulted from the teaching of psychodynamic psychotherapy in graduate-level
social work. Elsewhere, Rozas and Grady (2011) found that the “principles that
comprise psychodynamic theory provide a clinical foundation that requires
practitioners to think beyond a manual or protocol; to pay attention to the
dynamics rather than solely to the symptom or dysfunction” (p. 220). In add-
ition, Mishna, Van Wert, and Asakura (2013) argued the following:

Social work educators ... have a responsibility to advance approaches to research and
practice that embrace and reflect both the complexity and context of needs presented
by social work clients. We believe that, given its focus on the therapeutic relationship
and person-in-environment approach, contemporary psychodynamic theories and
practice should be incorporated back into social work education, along with research
on process and outcomes. Such integration is necessary in order to prepare future
practitioners to respond to the multiple intersecting needs of social work clients
more effectively. (p. 299)

Graduate training should include certain important treatment aspects,
including psychodynamic concepts of the unconscious, the use of the self
in the therapeutic relationship, transference, and countertransference.

Rozas and Grady (2011) warned that critical discussions might “be
absent in manualized treatment protocols because the techniques are per-
ceived to be an element of the treatment and divorced from the influences
of the individual practitioner” (p. 217). The two researchers further stated,

Students should be instructed in basic, foundation elements of psychodynamic theory
as a way to maintain consistent elements of practice that remain crucial to client-
centered practice. A foundation in psychodynamic theory equips students with a
developmental approach to understanding a person and the unconscious, to be keen
observers, to appreciate the complexity of a client’s situation, and to recognize the
effect that one element has on another. (p. 220)

Fuertes, Gelso, Owen, and Cheng (2015) stated that they and others con-
sider “the concept of countertransference (CT)... a key ingredient of the
therapeutic relationship in all psychotherapies” (p. 38), and that countertrans-
ference “although rooted in psychoanalysis, is meaningful and operative in all
psychotherapies and manifests itself of therapies of all durations” (p. 40).
Wheelock (2000) stated that with a psychodynamic approach, “even in a limited number of sessions, one may have a significant impact on patients’ lives while maintaining the basic principles of psychodynamic practice” (p. 214). Mills (2012) argued that during child-protection work, psychoanalytic thinking such as the concept of the unconscious “can provide a powerfully soothing function during the highly emotive sets of events that are unavoidable” (p. 310). Elsewhere, Fuertes, Gelso, Owen, and Cheng (2013) asserted the importance of nurturing “trainees’ ability to develop strong collaborative and positive relationships with clients… and effectively manage client transference and therapist countertransference,” and, “To do requires training in transference and countertransference management” (p. 309).

In addition to expanding one’s therapeutic repertoire, professional liability presents another reason to understand psychodynamic concepts such as transference and countertransference. As stated by Gordon and colleagues (2016), “Many of the complaints to ethics committees and licensing boards, as well as many malpractice suits against mental health professionals, involve inaccurate or missed diagnoses, boundary violations and mismanaged countertransference” (p. 237). Thomas (2005) noted that most clinicians who received formal complaints were found in need of more insight around countertransference reactions. Pope and Tabachnick (1993) wrote about the effectiveness of graduate training in preparing for risk-management problems caused by countertransference issues; the researchers found that “A large percentage of participants rated their graduate training as inadequate (i.e., nonexistent or poor)” (p. 151). Gordon and colleagues (2016) stated that they “feel that even today many practitioners are not exposed to sufficient (countertransference) education to help treat high-risk patients and also help them be more proactive to possible ethical dilemmas” (p. 243).

Furthermore, the exam to become a Licensed Clinical Social Worker includes both solution-focused therapeutic strategies and psychodynamic concepts (Apgar & Association of Social Work Boards, 2015). Graduate programs have an obligation to prepare social workers to become licensed clinicians and should therefore cover all relevant material. Rozas and Grady (2011) stated, “Course content should be closely evaluated to ensure that one approach is not valued over the other; the two should fit seamlessly in the clinical curriculum, suggesting that use of both in the field is standard practice” (p. 220). By maintaining our core social work values and embedding other ways of thinking into our practice, we could enrich the therapeutic experience.

Psychodynamic theory is expansive and has a long history. This article focuses on the three psychodynamic concepts important to any healing relationship: the unconscious, transference, and countertransference. We
contend that these concepts are foundational and can be used by all social workers regardless of training.

We now present a synopsis of the historical context of the three concepts. Afterward, we explore the following topics: (a) the difference between transference/countertransference and therapeutic alliance, (b) current graduate social work programming, and (c) the marginalization of psychodynamic concepts, and the evidence that challenges that marginalization.

**Defining and providing historical context for the unconscious, transference, and countertransference**

As previously stated, this article adopts Greenson’s (1967) definition of transference:

Transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood unconsciously displaced onto figures in the present. (p. 155)

We argue, along with others in the literature, that transference can appear not only through repetition but also (a) projection, (b) displacement, and (c) enactments, which can occur unconsciously (Frosch, 2002; Grant & Crawley, 2002b; Sandler, Dare, & Holder, 1992b; Schaeffer, 2007b). This article adopts Gabbard’s (1995/2005) conception of countertransference as “entailing a jointly created reaction in the clinician that stems in part from contributions of the clinician’s past and in part from feelings induced by the patient’s behavior” p. 21).

To understand these definitions more fully, we first need to understand the historical evolution of the concepts of transference and countertransference. Theories about both psychodynamic treatment and general treatment grew out of adult psychoanalysis. In his lectures on transference, Freud affirmed that therapists\(^1\) can feel emotions placed onto them by their clients, and these emotions originate from the client’s past relationships and not from the current therapeutic relationship (Freud, 1966). Freud goes on to state that transference, whether positive or negative, is a threat to treatment and therefore must be addressed (Freud, 1912, 1966). Thus, Freud saw transference as a hindrance to the treatment to be analyzed away. Many thinkers followed Freud, and the contemporary understanding of transference came later. A more in-depth discussion of transference from the psychoanalytic perspective exceeds the scope of this article. For a more detailed discussion of the evolution of these concepts please refer to Orr’s (1954) article “Transference and Countertransference: A Historical Survey.”
The concept of transference evolved beyond Freud’s original perspective. Anna Freud believed that dealing with transference issues required a trusted relationship between therapist and patient (Altman, Briggs, Frankel, Gensler, & Pantone, 2002a; Freud, 1971). Melanie Klein thought transference is directly connected with the unconscious and should be immediately interpreted, regardless of the existence of a trusted relationship (Klein, 1932, 1952). Donald Winnicott’s view of the therapist differed from those of Anna Freud, whose view differed from Klein’s. However, all three scholars recognized the necessity of exploring transference and addressing it within treatment. Winnicott acknowledged the therapist as an active participant who influenced the play/process (Altman et al., 2002a). By the mid-20th century, the concept of transference started to shift from a one-person perspective to a two-person perspective, away from Freud’s understanding—known in the literature as the “classical definition”—toward the “totalistic definition.” Schaeffer (2007b) explained the latter as,

the client’s unconscious displacement of attitudes, feelings, sensations, and thoughts from another person in the client’s life, past or present, to the therapist in an attempt to reenact and resolve conflict; it presumes the therapist’s unconscious participation in these efforts. (p. 9)

The totalistic definition centers on the understanding that interpersonal dynamics seen in treatment are not a repetition, like Freud originally thought, but a reenactment that engages both people in the room: therapist and client (Schaeffer, 2007b). Thus, the social worker is an active participant in the process. The totalistic definition of transference foreshadowed how transference was later conceptualized by psychodynamic relational theorists. They emphasized that transference and countertransference were related to the here-and-now dynamics that occur in the therapy room (Goldstein & Goldberg, 2004b; Grant & Crawley, 2002a; Shaeffer, 2014).

The concept of countertransference has also evolved since Freud’s era. Freud believed that reactions related to both countertransference and transference merited immediate attention. Otherwise, those reactions might collude with a patient’s defenses, becoming countertherapeutic (Freud, 1912, 1966; Joseph, 1985; Rosenberger & Hayes, 2002). Winnicott’s conceptualization differed from Freud’s classical view. Winnicott described how therapists need to contain not only the client’s material but also their own countertransference, which they must resolve before sharing insights with the client (Winnicott, 1949).

Hayes, Gelso, and Hummel’s 2011 article “Managing Countertransference” identified four conceptions of countertransference: classical, totalistic, complementary, and relational. We have already defined the classical conception. Hayes and colleagues defined the totalistic conception by noting, “Countertransference represents all of the
therapist’s reactions to the patient. All reactions are important, all should be studied and understood, and all are placed under the broad umbrella of countertransference” (2011, pp. 88–89). In the same article, the authors defined complementary countertransference based on Racker’s work, which described how the patient “pulls” certain reactions out of the therapist due to interpersonal patterns of relating (Hayes et al., 2011). Finally, Hayes and colleagues (2011) defined relational countertransference by noting that “the needs, unresolved conflicts, and behaviors of both are believed to contribute to the manifestation of countertransference in session” (p. 89). The relational conception is based on relational theory’s core tenets (e.g., therapeutic experience is co-created by the therapist and patient; Aron, 1991; Goldstein & Goldberg, 2004b; Mitchell, 1988; Shaeffer, 2014). Aron (1991) stated that although the therapeutic process is a mutual endeavor undertaken by both parties, it is an asymmetrical mutual relationship because of the therapist’s training.

**The great transference and countertransference divide**

The definitions of transference and countertransference in the psychoanalytic and non-psychoanalytic literature have evolved over time, but still spark debate. The literature identifies two distinct groups who differ as to whether treatment benefits from transference and countertransference reactions. The first group shares Freud’s belief that transference and countertransference reactions require immediate attention, so that treatment remains unimpeded (Freud, 1912, 1966; Joseph, 1985). The analyst’s thoughts and feelings are of the client’s making, and must immediately be addressed to allow treatment to continue.

The second group believes that the therapist’s experiences—including transference, reverie, and countertransference—are important aspects of treatment, and that its components can help the therapist understand the client’s experience (Altman, Briggs, Frankel, Gensler, & Pantone, 2002b, 2002c; Bonovitz, 2009; de Masi, 2012; Ogden, 1997a, 1997b). This conceptualization of transference and countertransference only began to take hold in the 1970s (Brandell, 1992).

Within this perspective, transference and countertransference issues need to be addressed because these issues can become obstacles to treatment; however, the therapist’s experience is not dismissed. Ogden (1997a) considered the therapist’s reverie and personal experience an intersubjective creation between the therapist and the client’s unconscious. Part of treatment consists of the therapist and client exploring this co-created intersubjective experience for a better understanding of the issues that brought the client to treatment.
Racker (2013) affirmed that the therapist’s countertransference reactions can help the therapist gauge the success of client interventions. Altman (2002) considered the therapeutic space to be influenced by a matrix including the therapist, client, parents, and each person’s representational worlds. Thus, one must consider many relationships when thinking about the therapeutic relationship. The social work field is starting to actively acknowledge this second group’s stance, from which most of the analytic field operates (Table 1).

**The difference between the concepts of transference/countertransference and therapeutic alliance**

Most therapeutic approaches view therapeutic alliance as a critical ingredient of treatment success. As Sandler, Dare, and Holder (1992a) wrote, “The treatment alliance can be regarded as being based on the patient’s conscious or unconscious wish to co-operate and his readiness to accept the therapist’s aid in overcoming internal difficulties” (p. 29). A relationship exists between transference/countertransference and therapeutic alliance, but these two concepts are different. Machado and colleagues (2015) explained that “The term therapeutic alliance (TA) designates the capacity to establish a working relationship between therapist and patient, in opposition to regressive and resistive transferenceal reactions” (p. 3).

Transference highlights the tendency for clients to repeat aspects of early relationships with the therapist. As stated by Pikecki and colleagues (2015), “The development of sufficient transference responses then allows for the therapeutic relationship to identify and then correct any early relational experiences that may be contributing to unconscious conflicts and symptoms in the patient,” and, “In contrast, the therapeutic alliance in CBT is more collaborative and at times similar to that of a teacher or coach” (pp. 472–473).

An expanding literature addresses the value placed by short-term treatment therapists on the concepts of transference and countertransference, both of which originated in the psychoanalytic community. In addition, therapeutic alliance, transference, and countertransference are essential components of treatment. As Curtis (1979) stated, “danger lies especially in the tendency to see the therapeutic alliance as an end in itself—to provide a new and corrective object relationship—rather than a means to the end of analyzing resistance and transference” (p. 190).

**Current graduate social work training and the marginalization of psychodynamic concepts**

The Council on Social Work Education (CSWE) determines the scope and sequence for most master’s programs in social work. Please refer to Table 2...
for the nine core competencies of the CSWE (2015). To anticipate the level of preparedness among social work practitioners, several researchers have shown interest in learning precisely what graduate social work students study.

Multiple studies have examined the interface between graduate programming and preparedness for practice (Deglau et al., 2015; Slovak, Joseph, & Broussard, 2006). Stone and Gambrill (2007) argued that certain textbooks in social work programs do not provide a sound guide for education and practice, although this was disputed by Constable and Massat (2007). Textbooks give an overview of the therapeutic process that includes (a) exploration of the problem, (b) implementation of solutions, and (c) termination with clients—with very little reference to work with the unconscious (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2006d). The bulk of these textbooks refer to basic elements of social work practice, with a strong emphasis on assessments of problems and strengths, as well as understanding interpersonal and environmental factors that affect the client’s current predicament (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2006a, 2006b). Within these texts, the social worker’s experience and the client’s experience of the social worker are mentioned in passing during a discussion of potential barriers to change.

Graduate-school texts about child clients are not much better at acknowledging the importance of managing the social worker’s experience or the child’s experience of the social worker. The text by Kronenberger and Meyer (2001) used in child social work classes focuses specifically on what diagnoses look like in children and how to use different assessment tools to identify a diagnosis without any mention of the social worker’s experience. Without guidance on how to navigate these pitfalls, this gap in training can lead the social worker to be either over-involved or under-involved (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2006c). Some graduate programs address this gap with articles that discuss (a) the use of self and others, (b) critical self-reflection, and (c) reflective and reflexive self-awareness (Cartwright, 2011; Kondrat, 1999).

| Table 2. Council on Social Work Education’s nine core competencies (Council on Social Work Education, 2015). |
|---|
| **Nine Core Competencies in Social Work Education** |
| 1. Demonstrate ethical and professional behavior. |
| 2. Engage diversity and difference in practice. |
| 3. Advance human rights and social, economic, and environmental justice. |
| 4. Engage in practice-informed research and research-informed practice. |
| 5. Engage in policy practice. |
| 6. Engage with individuals, families, groups, organizations and communities. |
| 7. Assess individuals, families, groups, organizations, and communities. |
| 8. Intervene with individuals, families, groups, organizations, and communities. |
| 9. Evaluate practice with individuals, families, groups, organizations, and communities. |
Although outdated, Wodarski, Feit, and Green’s (1995) study provides valuable information from a review of two decades of empirical research of graduate social work education. The researchers looked at “research, practice skills, human behavior, and social environment, policy, values, and field instruction” (p. 108), and described practice and interpersonal skills as “attending, reflecting, supporting, [and] confronting” (p. 110). It does not appear that the authors considered addressing in-depth psychological approaches such as exploration of the unconscious, examination of defenses, recognition of enactments, and exploration of transference and countertransference reactions.

Lacasse and Gomory (2003) studied 71 psychopathology course syllabi from 58 different social work graduate schools. The researchers concluded that “There is little evidence that graduate psychopathology courses cover viewpoints other than the most conventional and institutional—that of biomedical psychiatry” (p. 383).

Weissman and colleagues (2006) conducted a study of all United States accredited training programs in the fields of: psychiatry (73 programs in all), PhD in clinical psychology (63), PsyD in psychology (21), and master’s in social work (64) (p. 925). Seventy percent of Master of Social Work (MSW) programs required coursework on behavioral therapy, and 80% of MSW programs required coursework on cognitive-behavioral therapy. Meanwhile, only 56% of MSW programs required coursework on psychoanalytic/psychodynamic psychotherapy (Weissman et al., 2006, p. 927).

A more recent study obtained syllabi from 58 MSW school social work courses (Berzin & O’Connor, 2010). Data drove the study; the researchers coded syllabi content, as opposed to looking for preconceived categories and concepts. Table 3 illustrates the results. The number following the subcategory reflects the number of schools out of 58 that covered the stated content. The only subcategories that are explicitly psychodynamic—transference and countertransference—are categorized under “Clinical Practice,” and only one school covered this content (p. 242). (See Table 3 for the

| Clinical Interventions | Mental Health and Learning Disability | Clinical Practice |
|------------------------|---------------------------------------|-------------------|
| Clinical Groups (36)   | Substance Abuse (25)                  | Resiliency (10)   |
| Crisis Intervention (27)| Attention-Deficit/Hyperactivity Disorder (18)| Termination (4) |
| Meditation (17)        | Self-Harm/Suicide (18)               |  Self-Care (3)   |
| Case Management (16)   | Learning Disabilities (15)           | Transference/     |
| Home Visits (16)       | Pervasive Developmental Disorders (12)| Countertransference (1) |
| Solution-Focused Therapy (15) | Depression (10)              |                   |
| Social Skills Training (15)| Oppositional Defiant/Conduct Disorder (10) |                   |
| Grief Work (10)        | Anxiety (7)                         |                   |
| Play Therapy (7)       | Eating Disorders (4)                |                   |
| Cognitive-Behavioral Therapy (6)| Mental Illness (2)         |                   |
| Bibliotherapy (2)      |                                       |                   |
| Psychoeducation (1)    |                                       |                   |

Weissman and colleagues (2006) conducted a study of all United States accredited training programs in the fields of: psychiatry (73 programs in all), PhD in clinical psychology (63), PsyD in psychology (21), and master’s in social work (64) (p. 925). Seventy percent of Master of Social Work (MSW) programs required coursework on behavioral therapy, and 80% of MSW programs required coursework on cognitive-behavioral therapy. Meanwhile, only 56% of MSW programs required coursework on psychoanalytic/psychodynamic psychotherapy (Weissman et al., 2006, p. 927).

A more recent study obtained syllabi from 58 MSW school social work courses (Berzin & O’Connor, 2010). Data drove the study; the researchers coded syllabi content, as opposed to looking for preconceived categories and concepts. Table 3 illustrates the results. The number following the subcategory reflects the number of schools out of 58 that covered the stated content. The only subcategories that are explicitly psychodynamic—transference and countertransference—are categorized under “Clinical Practice,” and only one school covered this content (p. 242). (See Table 3 for the

| Clinical Interventions | Mental Health and Learning Disability | Clinical Practice |
|------------------------|---------------------------------------|-------------------|
| Clinical Groups (36)   | Substance Abuse (25)                  | Resiliency (10)   |
| Crisis Intervention (27)| Attention-Deficit/Hyperactivity Disorder (18)| Termination (4) |
| Meditation (17)        | Self-Harm/Suicide (18)               |  Self-Care (3)   |
| Case Management (16)   | Learning Disabilities (15)           | Transference/     |
| Home Visits (16)       | Pervasive Developmental Disorders (12)| Countertransference (1) |
| Solution-Focused Therapy (15) | Depression (10)              |                   |
| Social Skills Training (15)| Oppositional Defiant/Conduct Disorder (10) |                   |
| Grief Work (10)        | Anxiety (7)                         |                   |
| Play Therapy (7)       | Eating Disorders (4)                |                   |
| Cognitive-Behavioral Therapy (6)| Mental Illness (2)         |                   |
| Bibliotherapy (2)      |                                       |                   |
| Psychoeducation (1)    |                                       |                   |
other subcategories under “Clinical Practice.”) Out of 104 codes reflecting coursework content, only two were cited, each by a single school. All other 102 codes were cited by multiple schools. This illustrates the lack of visibility for psychodynamic concepts (Berzin & O’Connor, 2010). The concept of the unconscious was never named.

A recent mixed-methods study conducted by Turner, Strand, Bliss, and Sacristan (2018) explored curriculum priorities and perceived preparedness levels among MSW programs in terms of clinical competencies. The study found a “great variability in student competency in specific clinical competencies” (Turner et al., 2018, p. 9). These results prompted the researchers to argue for more consistent training in graduate programs, and now prompt us to appeal for more clinical options. Social workers do not feel clinically prepared (Gordon et al., 2016; Pope & Tabachnick, 1993; Turner et al., 2018). They do not receive consistent instruction about psychodynamic concepts (Berzin & O’Connor, 2010; Lacasse & Gomory, 2003; Weissman et al., 2006; Wodarski, Feit, & Green, 1995). Thus, it makes sense to integrate these concepts into graduate-level studies.

Brandell (2002) noted many factors that have contributed to the marginalization of psychoanalytic content in academic social work, including “The influence of managed care, efforts within the academy to accommodate to a narrow definition of empirical science, and the domination of biological models of causality” (p. 41). Wheelock (2000) argued managed care has a “general hostility toward psychodynamic theory and practice” (p. 204). Elsewhere, Wheelock made two other important observations: first, that the “typical managed care ‘behavioral treatment plan’ places little or no importance on such ‘invisible’ aspects of a person” (p. 205), and that there exists “institutional discrimination against this theoretical orientation” (p. 214).

Nancy McWilliams, a prominent psychodynamic thinker, implicated the analytic community’s responsibility in this marginalization, writing that “the disdainful attitude of many 20th century American analysts arguably set the stage for the backlash against psychoanalysis and the psychodynamic therapies that has crippled the analytic tradition” (McWilliams, 2013, p. 920). McWilliams (2013) noted a “disappearance of psycho-analytic ideas from most clinical psychology training programs” (p. 920).

Brandell (2002) observed that the CSWE policy and accreditation includes nothing about the unconscious (p. 47). Abbott (2003) seemed to agree, writing, “The abandonment of psychoanalytic theory was coupled with the growing emphasis by CSWE on the teaching of generalist social work practice. In the process, a disservice has been done to both clinicians and to the clients that they serve” (p. 31). The CSWE does not take a stand against teaching psychodynamic concepts, and does not prevent a social work program from incorporating psychodynamic concepts. In fact, the
CSWE states that advanced social workers should “synthesize and apply a broad range of interdisciplinary and multidisciplinary knowledge and skills” (CSWE, 2015, p. 8).

According to the “Social Work ASWB Clinical Exam Guide: A Comprehensive Study Guide for Success,” candidates should prepare for assessments regarding the following psychodynamic concepts: the history of psychoanalytic theory, Freud’s psychosexual stages of development, self-psychology, ego psychology, Erikson, object relations theory, defenses, the unconscious, and transference and countertransference (Apgar, 2015).

Some social work schools do an exceptional job of teaching psychodynamic content, including the unconscious, transference, and countertransference. However, multiple studies pose serious questions about the overall well-roundedness of social work training. Additional research in this area would be beneficial.

**Psychodynamic psychotherapy is supported by evidence**

The marginalization of psychodynamic approaches partially stems from the belief that these approaches are not evidence-based. This is a misconception. All social workers (whether employing solution-focused or insight-oriented approaches) owe it to their clients to engage in a practice that improves clients’ well-being. According to Bender, Altschul, Yoder, Parrish, and Nickels (2013), the Evidence-Based Process (EBP) includes the following characteristics:

- reflective; is self-critical; uses evidence to discern what is most likely to work;
- evaluates practice decisions to ensure client needs are met, resources are not wasted, and harm is not inflicted; and considers clients [sic] values/preferences and one’s own professional abilities. (p. 340)

There appears to be a view in the social work field that EBP is synonymous with short-term treatment based on symptom reduction. This view has been shaped by extensive research into EBP. However, we should not confuse the “amount of research with strength of empirical support” (McWilliams, 2013, p. 926). Researchers have frequently studied short-term manualized approaches, but questions remain as to the intensity and sustainment of improvement (McWilliams, 2013; Shedler, 2010a). Many of these studies have not reflected the reality that therapists often face with clients. Although random controlled trials are the gold standard in research, they often require (a) concepts to be operationalized in simple ways, (b) interventions to be short term, and (c) disorders to be discreet and without comorbidity (McWilliams, 2013). Such presentation rarely occurs in real-life treatment experiences.
Contemporary psychodynamic thinking offers a powerful, meaningful, and valuable way of thinking about the therapeutic process. However, the term “psychodynamic therapy” often conjures up thoughts of Freud, couches, and outdated approaches. This leads to a misguided belief that psychodynamic clinicians are not interested in evidence of effective treatment. However, evidence (perhaps from lesser-known research) supports psychodynamic therapy (Lingiardi & McWilliams, 2017; Mishna et al., 2013; Shedler, 2010a).

de Maat (2009) and colleagues published a study review that noted long-term positive outcomes of psychodynamic theory. Town et al., (2012) echoed this conclusion via meta-analysis. Taken together, these two studies call to mind Shedler’s (2010a) assertions that “Empirical evidence supports the efficacy of psychodynamic psychotherapy,” and “patients who receive psychodynamic therapy maintain therapeutic gains and appear to continue to improve after treatment ends” (p. 98). In addition, Mishna and colleagues (2013) noted, “Several authors have conducted systematic reviews and meta-analyses to assess the efficacy of psychodynamic psychotherapy with adults” (p. 294).

Mishna and colleagues (2013) stated, “Transference-focused therapy was specifically predictive of symptom improvement in the areas of impulsivity, irritability and aggression” (p. 295). In addition, Driessen and colleagues (2013) demonstrated the efficacy of psychodynamic therapy for the treatment of depression through a random controlled trial. In 2015, Fonagy mentioned that “evidence supports the use of PDT in treatment of depression … However, there are too few large-scale trials to fully establish equivalence” (p. 140). Driessen et al. (2007, 2015) led to random controlled trials that supported the effectiveness of psychodynamic therapy and its equivalence to CBT results. Please see Tables 4 and 5 for evidence supporting psychodynamic therapy with various other diagnostic classifications.

In terms of anorexia nervosa, Fonagy (2015) cited an “exceptionally high-quality study” that showed psychodynamic treatment resulting in more positive results than the control group. Wild and colleagues (2009) referred to this original study as “the first study to show superiority to CBT” in this area (p. 141). The reader is referred to “The ANTOP study: focal psychodynamic psychotherapy, cognitive-behavioural therapy, and treatment-as-usual in outpatients with anorexia nervosa—a randomized controlled trial” (Wild et al., 2009) for specific findings. Furthermore, health care cost reductions were illustrated in a study by Abbass, Kisely, Rasic, Town, and Johansson (2015). Most of these studies were controlled trials.

In 1954, the Menninger Foundation Psychotherapy Research Project began following 42 adults who suffered from severe disorders. The project lasted more than 30 years (Appelbaum, 1977; Kernberg et al., 1972; Wallerstein,
| Mental Health and Social Adjustment | Post-Traumatic Stress | Borderline Personality Disorder | Eating Disorders and Bulimia | Substance Disorders | Depression |
|-----------------------------------|----------------------|--------------------------------|-----------------------------|---------------------|------------|
| Panic Disorder, Social Phobia, and Anxiety | Milrod, Busch, Cooper, and Shapiro (1997) Leichsenring, Hiller, Weissberg, and Leibing (2006) | Abbass, Hancock, Henderson, and Kisely (2006) | Schottenbauer, Glass, Amkoff, and Gray (2008) | Bateman and Fonagy (2004) Clarkin, Yeomans, and Kemberg (2006) Clarkin, Levy, Lenzenweger, and Kemberg (2007) Gibbons, Crits-Christoph, and Hearon (2008) Levy et al. (2006) Meares (2012) | Levine and Mishna (2007) Leichsenring et al. (2006) | Leichsenring et al. (2006) Driessen et al. (2013) |
McWilliams (2013) noted that “the study reported substantial improvement in general functioning for patients in both psychoanalysis and analytically oriented psychotherapy” (p. 924). The Columbia University Department of Psychiatry Center for Psychoanalytic Training and Research found similar outcomes with more than 250 less-troubled patients (Bachrach, Weber, & Solomon, 1985; Weber, Bachrach, & Solomon, 1985a, 1985b). There is also ample empirical research on the usefulness of countertransference in therapeutic outcomes (Fuertes et al., 2013, 2015; Hayes & Gelso, 2001; Hayes et al., 2011; Hayes, Nelson, & Fauth, 2015).

Research on psychodynamic psychotherapy has demonstrated that patients maintain improvement after treatment concludes. Although using a small sample size of 25 patients undergoing analysis and psychodynamic therapy, Vaughan and colleagues (2000) found “statistically significant therapeutic effects on a variety of measures after one year” (McWilliams, 2013, p. 924). A long-term follow-up study 10 years later showed that patients maintained their progress (Kantrowitz, Katz, & Paolitto, 1990a, 1990b, 1990c).

The literature provides abundant evidence that patients improve in proportion to the frequency and duration of treatment. We find this evidence via multiple studies, including (a) two meta-analytic data analyses (Leichsenring et al., 2008, 2011), (b) a study of 450 patients (Sandell et al., 2000), and (c) various other research (Freedman, Hoffenberg, Vorus, & Frosch, 1999; Shedler, 2010a). As McWilliams (2013) stated, “All these ambitious empirical studies of psychotherapy provide cumulative evidence that long-term psychodynamic treatment, including psychoanalysis, is effective” (p. 925).

Even short-term psychodynamic therapy results in improved functioning. Town, Abbass, and Bernier (2013) demonstrated that improved treatment outcomes were achieved through Davanloo’s Intensive Short-Term Dynamic Psychotherapy (ISTDP) method. Abbass, Town, and Drissen (2013) located 21 studies and conducted a meta-analysis on ISTDP and found statistically significant results supporting the maintenance of gains. Furthermore, they found that data show ISTDP was effective with various populations (Abbass et al., 2013).

Table 5. Evidence that indicates efficacy of psychodynamic psychotherapy for somatoform disorders.

| Irritable Bowel Syndrome | Dyspepsia | Chronic Pain | Unexplained Symptoms |
|--------------------------|-----------|--------------|----------------------|
| Creed et al. (2003)      | Faramarzi et al. (2013) | Mosen and Monsen (2000) | Schaefer et al. (2013) |
| Guthrie, Creed, Dawson, and Tomenson, (1993) | Hamilton et al. (2000) | | |
| Syedlund, Sjodin, Ottosson, and Dotevall (1983) | | | |

1986).
Growing evidence supports the use of psychodynamic practice with clients who are children. Midgley and Kennedy (2011) examined 34 empirical studies, including eight randomized control trials. Mishna and colleagues (2013) illustrated the effectiveness of psychodynamic treatment and its sustaining effect, compared to other models such as CBT, particularly for younger children with internalizing symptoms. Play-therapy interventions have also proven helpful (Draper, Siegel, White, Solis, & Mishna, 2009; Mishna, 2007; Mishna, Morrison, Basarke, & Cook, 2012).

McWilliams (2013) provided an extensive compilation of evidence supporting psychodynamic approaches, many of which are cited in this section. For a more comprehensive list of studies, please refer to McWilliams’s (2013) article, “Psychoanalysis and Research: Some Reflections and Opinions.” However, Pignotti and Albright (2011) challenged some studies supporting psychodynamic therapy.

Discussion

Graduate training tends to focus on short-term, solution-focused approaches. Social workers could benefit from the study of diverse therapeutic methodologies. An exploration of the significance and integration of the concepts of the unconscious, transference, and countertransference would benefit all social workers, not only those actively practicing the psychodynamic approach.

Significance of unconscious, transference, and countertransference in contemporary treatment

Mishna and colleagues (2013) stated that many psychodynamic perspectives “emphasize the use of the therapeutic relationship as a vehicle for change” (p. 291), and that “contemporary psychodynamic approaches hence provide social work practitioners with a theoretical framework that stresses the centrality of the therapeutic relationship in clinical practice” (pp. 291–292). Bonner (2002) wrote that “students must be taught about the central psychoanalytic concepts of transference and countertransference to fully understand the process of healing and change” (p. 66). In addition, Abbott (2003) explained,

By having greater understanding of transference and countertransference, the clinician can begin to understand the source of the client’s feeling toward him/her and can help the client understand how his/her distorted perceptions are influencing his/her relationships with others.... In terms of identifying the impact of countertransference, the worker, in noting lack of progress on the part of the client, may try to see if he/she (the worker) has blind spots, is overreacting, over-involved, over-identifying, overindulging. Is he/she behaving in a way that is primarily driven
by his/her distortions from the past, or on the basis of the reality presented by the client before him/her? (p. 38)

Abbott (2003) asserted that “even though social work has moved away from psychoanalytically-based psychotherapy, the need for psychodynamic understanding of transference and countertransference remains high” (p. 31). Abbot (2003) included “teaching key psychoanalytic concepts” under his “strategies for minimizing risk,” specifically as it relates to boundary violations (p. 36). This is particularly important when considering the vulnerability of clients and managing risk in one’s therapeutic work.

The unconscious
Psychodynamic and psychoanalytic therapies began with Freud’s work. However, those therapies are not stuck in time. Freud originally conceptualized the unconscious and consciousness more generally through the topographic model. This model consisted of three parts: (a) the conscious, where the individual is aware of thoughts, feelings, and ideas, (b) the preconscious, where acceptable thoughts, ideas, and feelings that are acceptable reside and have the capacity to be conscious but are not yet, and (c) the unconscious, where unacceptable thoughts, ideas, and feelings reside out of awareness (Freud, 1923; Mitchell & Black, 1995). Mitchell and Black (1995) stressed the following:

What we experience as our minds, Freud suggests, is merely a small portion of it; the rest is by no means transparent to our feeble consciousness. The real meaning of much of what we think, feel, and do is determined unconsciously, outside of our awareness. (p. 16)

Freud’s work continued to evolve over the course of his life. His understanding of psychic conflict changed from seeing it as occurring between the levels of consciousness to psychic conflict being inside the unconscious mind (Freud, 1923; Mitchell & Black, 1995). It was this change in thinking that created the structural model that includes the id, ego, and superego. An in-depth discussion of the structural model is outside the scope of this article.

Psychodynamic psychotherapy views symptoms as expressions of “[unconscious] conflict that typically occurs outside of an individual’s awareness, and therapy is therefore aimed at allowing this conflict to be expressed and bringing aspects of the unconscious into awareness” (Pikecki et al., 2015, p. 464). The contemporary use of the unconscious is increasingly being used by a variety of therapeutic approaches. Stoycheva, Weinberger, and Singer (2014) noted,

The study of unconscious processes has always been central to psychoanalytically oriented psychologists. Within the past 3 decades, social and cognitive psychologists
also have begun investigating unconscious processes. These investigators have focused on nonconflictual and unmotivated unconscious processes, which they termed *implicit* and which we call the “normative” unconscious. (p. 100)

How does the unconscious pertain to transference and countertransference? Both processes occur in the conscious and unconscious of both the client and social worker (Colli & Ferri, 2015; Goldstein & Goldberg, 2004a; Grant & Crawley, 2002b; Levy & Scala, 2012; Schaeffer, 2007a, 2007b; Shaeffer, 2014).

Grant and Crawley (2002b) stated that “transference is largely an unconscious process. That is, individuals are unaware that they are projecting past experience and understandings onto the current situation” (p. 5). Schaeffer (2007a) stated “unless it is detected and processed by the therapist’s conscious mind, countertransference undermines positive therapeutic outcomes” (p. 19).

Freud was a neurologist before becoming a psychoanalyst. During his lifetime, Freud (1895/1950) abandoned what he called “the project” to find the brain apparatuses he saw in treatment. The technology in the late 19th century and early 20th century was not sophisticated enough to detect what Freud wanted to find. However, current technology does have the sophistication to provide brain-related scientific data that support the unconscious, transference, and countertransference phenomena. Neuroscience and brain research have helped further Freud’s “project.” Schaeffer (2007c) stated that most conscious processes use the neocortical circuits of the left hemisphere, and that unconscious processes use subcortical circuits in the right hemisphere. These assertions are supported by and elaborated on in “The Neuropsychology of the Unconscious: Integrating Brain and Mind in Psychotherapy” (Ginot, 2015a, 2015b).

**Transference**

Strean (1978) noted,

> everyone’s attitudes toward intimate relationships in the present are continually colored by these past transactions…. This invariably reactivates mixed feelings and ideas about the social worker that the client experienced with those on whom he depended in the past. (p. 195)

The social worker is “loved, hated, demeaned, or adored by his clients not only because of what he says and does but because of how they experience him” (Strean, 1978, p. 196). Strean (1975) also pointed out that “Clients do not perceive the social worker exactly as he or she is, but in addition to perceptions based on reality, clients also relate to the worker in terms of how they wish him to be or fear that he is” (p. 26).

Examining how the client experiences the social worker is key to understanding, and perhaps alleviating, the client’s pain. McWilliams (2013) cited
several empirically based works that illustrated how “a focus on transference and resistance enhances outcome in any type of therapy” (p. 931). The literature supporting the significance of transference can be found in the work of Silberschatz (2005), Ablon and Jones (1998), Jones and Pulos (1993), Anderson and Berk (1998), and Luborsky and Crits-Christoph (1990).

**Countertransference**

Much like the client, the social worker can be unconsciously triggered by his or her own past experiences, such as biases, anxieties, and feelings. These experiences need to be examined for their influence on the therapeutic relationship (Strean, 1978). Social workers must strive to be aware of how their psychological makeup affects clients. Although it may make some social workers uncomfortable to admit, feelings toward clients can include anger, rage, and even hate. This is harmful when the social worker is unaware and does not understand his or her feelings.

Winnicott (1949) explored hate in countertransference, and suggested that a crucial way to keep hate unexpressed with a client is to be totally aware of it. Countertransference can lead “therapists to view clients and sessions inaccurately, feel unduly anxious, and behave in ways that primarily meet their own needs at the expense of clients” (Hayes et al., 2015, p. 127). Buechler (2002) highlighted how treatment is affected by what the therapist brings to it:

> We prefer to think of the patient as finding himself, with us as helpful instruments. But we are not mere vehicles on a patient-guided journey. What we believe life is about will make a difference in how the journey’s destination is understood by both patient and analyst. (p. 277)

Elsewhere, Hayes and Gelso (2001) stated, “Research from the past 50 years has underscored the necessity for therapists to attend to their own unresolved conflicts to minimize the likelihood of having countertherapeutic reactions to clients” (p. 1050).

Clients project onto social workers through transference, and this impacts the social worker. Social workers project onto clients through countertransference, and this impacts clients. Social workers have a powerful tool in the conscious and fearless examination of feelings toward clients, as well as the use of self. These tools often help break through impasses in treatment. It is only appropriate that social workers explore and examine their feelings, much like they expect clients to do.

**Integration of the unconscious, transference, and countertransference into one’s practice**

Psychodynamic concepts help social workers understand the therapeutic relationship at a deeper level and can prompt change (Mishna et al., 2013).
By understanding transference and countertransference reactions, the therapist can assist clients to explore and understand distorted perceptions that influence their relationships, while also exploring themselves for blind spots when progress stalls (Abbott, 2003; Bonner, 2002). The therapist’s understanding and use of transference and countertransference are tools for shaping effective interventions to create potential long-lasting awareness and change in clients (Shedler, 2010b).

Understanding how the social worker experiences transference and countertransference can provide insight into the client’s attachments and relationships, such as how the social worker might impact others and how they might experience people, including their parents and others with whom they share significant relationships. It also sheds light on the client’s experiences of the self, regulation of emotions, and innate abilities. By using the self and their interactions and reactions, clients and social workers make meaning and create vehicles for therapeutic change (Ablon, 2015).

“Play” is an avenue to unlocking the clients’ internal worlds and understanding how they communicate pain and suffering, regardless of their age. Barrett (2012) stated that play is a form of displacement in which the therapeutic dyad creates new understandings of (a) one’s feelings, (b) internal and external conflicts, and (c) fantasies. It is paramount to understand that play gives the social worker a grasp of the client’s often unspoken difficulties. Children’s egos and capacities are not fully developed, so they resort to play and fantasy. Mastery of effective communication comes only with time and maturation (Berman-Oelsner, 2013). This is also true for adults with derailed psychosocial development.

“Play” is also used for typically-developing children and adults because it provides access to the unconscious. Play occurs between social worker and client via the use of cultural objects such as music, art, poetry, movies, and other shared experiences. Therefore, social workers should pay attention to the therapeutic relationship in terms of (a) how clients use the social worker, (b) how clients communicate verbally and nonverbally, and (c) what arises for the therapist in countertransference. How social workers use themselves in play and how they understand transference-countertransference reactions will help determine (a) the delicate balance of when to stay quiet and when to comment, (b) how to show empathy to the client, and (c) how to navigate the individuation process (Sarles, 1994). Therefore, the social worker’s attention to transference-countertransference reactions provides a tool in all forms of psychological treatment.

Social workers can apply psychodynamic concepts in any setting to better understand and manage clients overall, with specific attention paid to how stress, loss, and trauma impact how clients use services (Altman, 2010).
Altman (2010) presented numerous examples of how psychodynamic concepts can help those working in community agencies.

The following examples illustrate how an examination of transference and countertransference can alter the course of treatment.

An interpretation of Kernberg’s (1992) commodification of treatment and the case of Lucia

Lucia, a grandiose, oppositional patient, fired her psychiatrist and demanded a new one. Hospital administrators assigned Kernberg to the case. When Kernberg was lenient and accommodating, Lucia and her family were pleased, as were hospital administrators. However, Kernberg’s colleagues were upset with him and the administration for not holding Lucia to the same standards as other patients. Initially, Kernberg found himself feeling proud of being the psychiatrist who “fixed” the situation. He identified with the patient and administration and was rewarded. Everyone was “happy” and the case could have ended there.

However, Kernberg examined his countertransference. He discovered that underneath his pride of an apparent success, he had a nagging suspicion of being manipulated. He also eventually found himself identifying with hospital staff. In treatment, Kernberg started to challenge Lucia therapeutically and she became oppositional. She complained to hospital administrators, who assigned a new psychiatrist.

After bringing what was initially unconscious to awareness, Kernberg realized that hospital administration set him up to be the “good doctor” who would accommodate Lucia, possibly due to her wealth and influence. Lucia initially demonstrated a positive transference toward Kernberg. When Kernberg’s countertransference was elucidated, he became aware that he was colluding with hospital administrators to commodify Lucia’s treatment. Neither the hospital system nor Kernberg focused on Lucia’s mental health. The system made money and Kernberg received praise.

Had Kernberg failed to examine Lucia’s conditional positive transference and his own countertransference, he would have continued to unconsciously collude against Lucia’s therapeutic progress. Lucia would have continued to suffer and hospital administrators would have continued to capitalize on the patient’s status.

“Missed appointments” (based loosely from Altman, 2010)

When a client “no shows” at an inner-city public clinic, a social worker might consider external factors, such as poverty, as a possible explanation. For example, having to take two buses and pay for childcare might influence
attendance. A social worker can attempt to problem-solve and minimize stressors that affect a given client’s attendance. However, when these attempts are unsuccessful, the client is likely to be dropped from the social worker’s caseload—unless the social worker employs psychodynamic thinking.

Altman exhorts us to examine transference and countertransference reactions to “no shows.” Perhaps the client resists the social worker’s unpleasant feelings, like hate and anger, toward the client. Perhaps the social worker rejects the client out of unconscious hate and anger. Perhaps the client’s anxiety over becoming dependent causes the client to reject the social worker. One could examine this from an intersubjective perspective. Perhaps the social worker represents another authority that has exploited the client and that anger has been unconsciously enacted. Perhaps the social worker is pressured by the institution to bring in more money or shorten the waiting list and is angry at this client for potentially undermining the social worker’s performance. Or maybe the missed appointments activate the insecurity the social worker already brings to the relationship.

Failing to integrate a psychodynamic approach of transference and countertransference dynamics keeps the understanding of the missed appointments at only the manifest level. Thinking psychodynamically challenges the social worker to explore other layers of meaning for the missed appointments. These could have been explored in treatment and might have resulted in not closing the case, avoiding replication of past rejections and abandonment.

Social workers need training, however, to move the work from understanding what is manifest, visible, and spoken to that which is unseen and unspoken. This way of thinking informs the social worker how he or she is being used, perceived, and experienced and may lead to an improved understanding of the client’s internal and interpersonal world and patterns of relating to others. Only then can effective interventions occur.

**Conclusion**

Social work graduates are being tested on and expect to be proficient in psychodynamic theory and practice. However, social workers cannot be properly prepared for licensing and this clinical work if they are not trained in schools of social work. Social workers are hungry for an opportunity to deepen their understanding of their clients and graduate programs have a duty to prepare them for this work. This approach is supported by evidence and integrating it into practice is a crucial and enriching addition to traditional therapeutic methods. We implore social work graduate schools to include the three fundamental psychodynamic concepts of the unconscious, transference, and countertransference into their training.
programs so that all those who suffer, and the social workers who serve them, can benefit.

**Note**

1. We use the terms “social worker” and “therapist” interchangeably to maintain their usage in the literature by the cited author.

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