

Authenticity, Mutuality, Self-Disclosure, and the Creation of Meaning: A Shift in Models of Therapeutic Action

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Abstract

The shift in models of therapeutic action follows the evolution of psychoanalytic theory and changes in society and values. This paper reviews three models of therapeutic action as conceptualized by Donnel Stern. After a discussion of the historical context, major theorists, and primary features of each model, the social model of therapeutic action is presented and explored in depth. The work of Donnel Stern and Irwin Hoffman guide much of the discussion presented throughout the article. The second half of the piece is dedicated to contrasting the developmental model and the social model, the latter representing a shift toward a two-person psychology featuring the constructivist ideals of authenticity and mutuality. In many ways, the field of social work has been ahead of its time with its view of clinical treatment as a democratic process focusing on the importance of the environment and the value it places on client self-determination. Implications of the social model for clinical social work practice are provided.

Three Shifts in Models of Therapeutic Action

The study of the human mind, particularly as embodied in psychoanalytic theory, is a relatively new discipline. Until the late 1800s mental pathology was neither formally understood nor investigated, and the term “mental health” did not yet exist. Throughout the twentieth century, psychoanalytic theory expanded dramatically, giving theorists and clinicians numerous options for understanding the human psyche and human behavior. Consequently, the repertoire of clinical tools and choices in therapeutic action available for use by therapists has also widened. The evolution of psychoanalytic theory and practice can be summarized in a discussion of three major shifts in models of therapeutic action, as articulated by Donnel Stern. While each model has offered something new and valuable to the practicing clinician, earlier theories are far from absent in clinical work today. “Each set of values [in the three models] have been especially influential during a particular era. As successive models of change have arisen, earlier models have not disappeared, only lost some of their influence, so that today there are adherents of all three” (Stern, 1996, p. 267). The

discussion presented here will begin with a brief overview of the three shifts in models of therapeutic action. Understanding the historical context and general principles of each model is necessary for a thorough exploration of current values and practice.

The Interpretive Model

In the early part of the twentieth century, Europeans and Americans viewed the rest of the world’s culture as primitive and in need of Western religion, morals, and industrialization. The ontology of the western world assumed individuals were self-contained units and that, in any situation, there existed a single, knowable truth. From a European and American perspective, the West was in possession of that truth. It was within this historical context that the study of mind and human behavior was born, forming “the pad from which psychoanalysis was launched” (Stern, 1996, p. 267). The education of the third world peoples can be compared to the analyst’s *provision of insight* to the analysand in the interpretive model in which a benevolent authority attempts to impress truth on those who seem not to know it (Stern, p. 268). Early analysts held that “because reality was self-evident, any evidence of selection in one’s picture of reality was also evidence of psychopathology.... For analysts, reality was a given; it was simply and solely what they believed it to be” (Stern, p. 269).

The most influential theorist in the interpretive model was Sigmund Freud. Freud was born at the height of the Victorian era, when Vienna was rampant with anti-Semitism and there existed a facade of control and repression of sexuality within a largely Catholic culture. He came to believe repressed sexuality and aggression were central forces in human and national development (Berzoff, Flanagan, and Hertz, 1996). To treat neurosis and hysteria, Freud used the *talking cure* or his patient’s free association to discover and interpret aggressive and sexual conflict, eventually conceiving of a structural model (id, ego, superego) from which that conflict stemmed. Anna Freud later expanded her father’s understanding of the structural system of the ego and began to illustrate its unconscious defenses while maintaining the clinical goal of psychoanalysis: to release trapped, unconscious energies to increase healthy mature ego

functioning (Mitchell and Black, 1995). Heinz Hartman contributed to the theory of ego psychology with the argument that a baby is born with built-in ego capacities which awaited proper “average expectable environmental conditions” to spark their growth (Mitchell and Black, pp. 36–37). Hartmann’s theory of the ego’s autonomous functioning shifted psychoanalytic theory and clinical practice to the exploration of the adaptive abilities of humans. Although Hartmann maintained the traditional tenets of the interpretive model with regard to therapeutic action, he opened the door for future theorists to investigate the developmental sequence of infancy and childhood as related to environmental factors.

Historically, the primary features of therapeutic action in the interpretive model were the therapist’s power, authority, complete neutrality and use of interpretation. The analyst “mastered a technique that was supposed to make it possible to exert less direct influence on the shape of the patient’s experience than other people do; he subtracts himself from the social equation” (Stern, 1996, p. 269). He maintained a position of neutrality so the transference would be protected from contamination and the analyst could accurately interpret the interaction as a function of the patient’s psyche. Essentially, the goal of such neutrality was to interpret “the truth” or “reality” underlying the client’s transference. Today, even conservative analysts do not believe they are in the position to define reality for their patients, nor would they want to exert such influence. Rather, interpretation of transference material ideally enables the client to acknowledge his or her own internal world (Stern, p. 270). Yet, analysts continue to judge whether the patient’s psychoanalytically relevant knowledge and understanding correspond to predetermined criteria.

The Developmental Model

According to Stern (1996), “The twentieth century is often described as the era of the self.... because it has drawn attention to the legitimacy of individual misery” (p. 272). In the 1940s and 50s, the focus on the individual self and the alleviation of its suffering became important in both psychoanalysis and the surrounding culture. At that time, a growing interest in psychological development was evidenced in the psychoanalytic literature of the years after WWII. “After the senselessness and brutality of the war years, people longed to immerse themselves in family matters...A reaction formation rooted in perfect nurturance and rational authority was the

order of the day in America” (Stern, p. 274). The study of how the self was formed and influenced during development became the focus of psychoanalytic theory. The goal of therapeutic action shifted to the exploration of deficiencies in the development of the self and the growth enhancing potential of the therapeutic relationship.

While a number of theories were born during the middle of the twentieth century, object relations theories and theories of the self were among the most prominent. The self was regarded as the core of personality, with its own developmental sequence. Many psychoanalysts took to the perspective that if development were not disrupted during the early years, the individual would naturally develop psychological health. Psychopathology was conceptualized not only as the result of conflict, “but also as the outcome of deprivations and derailments, especially social in nature... suffered in the course of development” (Stern, 1996, p. 269). Through the influences of object relation theorists (such as D. W. Winnicott) and self psychologists, clinical practice shifted to emulating the nurturing aspects of the parent-child bond. Winnicott’s (1958) commitment to the centrality of maturation and direct environmental participation in development and in psychoanalysis is particularly well known but Loewald (1960) also viewed the parent-child relationship as a model for psychoanalysis. Heinz Kohut developed his theory of self psychology after turning away from the traditional tenets of the psychoanalytic society (Kohut, 1979). Kohut’s theory greatly influenced the shift toward a developmental focus in clinical practice with his concept of a selfobject as “a person who is sufficiently responsive in just the ways parents were not” (Stern, 1996, 279). Self psychology positioned the patient’s self-object transference to the analyst at the center of therapeutic action.

Application of theory to practice in the developmental model included use of the transference relationship and empathy in fulfilling developmental relational voids. Developmental themes and current problems were directly acknowledged in theory and “there began to appear an explicit concern with tact and sensitivity and with providing the analysis with an atmosphere of emotional safety and the experience of being understood” (Stern, 1996, p. 275). The analyst was thought to have the opportunity, if the transference was properly managed, to offer the patient growth-promoting experiences in the here-and-now. “Generally speaking, the analytic situation became ‘softer’ and more intentionally

indulgent and nurturing” (Stern, p. 277–278). Psychoanalysis became a process of maturation that aimed to allow the patient to resume normal development through attachment to a benign parental figure who could offer a corrective emotional experience. For the first time, psychoanalytic literature acknowledged that the quality of the patient-analyst relationship was an important determinant of the treatment outcome. “In terms of therapeutic action, we can say that while the patient’s *feeling* of being understood becomes more important in the developmental model, the content of that understanding remains predictable to the analyst, just as it was in the interpretive model. Theory, that is, still allows the analyst to know the truth” (Stern, p. 277). Despite a novel approach, the developmental model accommodated pre-existing psychoanalytic theory without challenging its central tenets.

The Social Model of Mutual Influence

Though it would not have been articulated as such at the time, the beginnings of the social model sprang forth during the reconceptualizations of countertransference that arose in the early 1950s in England, South America, and the United States (Stern, 1996). Interest in countertransference grew in the 1960s, and by the 1970s and 1980s the belief that it contained important information was common. The postmodern group essentially amended the “modern” ideas of self psychology, which seemed as outdated to this group of analysts as classical drive theory and ego psychology were to Kohut only a few decades earlier. Irwin Hoffman articulated the shift to a social model in 1983, dubbing those who accepted social reciprocity as “radical critics of the blank screen model” (Stern, 1996, p. 281). He believed that he was proposing a paradigm shift analogous to the developmental model’s departure from the emphasis on drives, defenses, and conflict to an emphasis on development and integration of the self. He delineated this position as either a “social-constructivist view” or a “dialectical-constructivist view,” both of which emphasize how the personal participation of the analyst strongly and continually affects and shapes both his and the patient’s experience.

Influential theories within the social model fall under a postmodern or contemporary umbrella. “Collectively, a broad movement seems to be emerging in psychoanalysis with contributions from various schools under various headings: intersubjectivity, relational-conflict theory, constructivism, feminist critical theory. This overarching movement...

seems to be running parallel to related developments in other fields under the broad banner of ‘postmodern thought’” (Hoffman, 1998, p. xiii). Sullivan, although generally not considered to be a postmodern theorist, held that the analyst had no choice but to be a real person in the treatment situation and in the patient’s experience and that absolute neutrality and an “uncontaminated” transference, therefore, made no sense. Constructivism is the predominant ideology within the postmodern paradigm of psychoanalytic theory, but theorists vary in the degree to which they conceptualize a partially independent reality versus the creation of reality by human participants. Irwin Hoffman and Donnel Stern, the theorists featured in this article, consider themselves “social constructivists” and focus on the creation of meaning or reality in the therapeutic relationship.

In applying the postmodern or constructivist theory to practice, one will find the articulation of guidelines and techniques few and far between. The mutuality, spontaneity, and authenticity of the therapeutic relationship are highly valued in the social model and the reliance on predetermined, defined techniques is opposed. “In the social model of therapeutic action, because of existence of continuous mutual influence, much of which is unconscious, ...both analysts and patients are understood to be continuously embedded in certain social aspects of their own experience.... Like every other act, interpretation is part of a complex and only partially knowable interchange” (Stern, 1996, p. 282). While discussion of therapeutic action in the social model will be the focus of the remainder of the article, it should be emphasized that the reliance on the use of technique was discarded for the primacy of the genuine therapeutic relationship. Hoffman (1998) embodies this shift in his belief that the spontaneity of enactment in the therapeutic relationship may be what is curative, and can be destroyed by traditional analysis.

Despite differences between the developmental and social models in technique, language, and history, many believe that the social model simply expanded the use of the therapeutic relationship and empathy already present in the developmental model. The ideas presented here suggest that the changes within psychoanalytic theory in the past quarter century from a positivist, one-person psychology to a constructionist, two-person psychology represent a drastic shift in models of therapeutic action. The differences between these two models will be illustrated by contrasting the psychodynamic

theories of the self with the social constructivist paradigm. First, let us turn to a deeper exploration of two influential theorists in the social model of therapeutic action.

The Social Model

An extensive history of Donnel Stern and Irwin Hoffman is neither possible nor necessary in this discussion. Like most other postmodern theorists, they studied classical psychoanalytic theory before drifting from its primary tenets due to clinical experience of limitations in the therapeutic use of any predetermined technique including interpretation, empathy, or neutrality. Though language used by each theorist differs, the stance is the same. "It is probably adherents of the social model of therapeutic action, based as it is in the idea of continuous, reciprocal, and not necessarily knowable influence between analyst and analysand, who will find it easiest to consider social constructivism" (Stern, 1996, p. 268).

Donnel Stern

Stern's theory kept the focus on the self as the center of experience and meaning. "We are moving toward a conception of the self as manifold, as a collection of characteristic ways of dealing with the certain kinds of interpersonal situations - the self, that is, as a set of socially defined roles experienced under the single umbrella of personal being" (Stern, 1996, p. 286). According to constructivist theory, the individual self is not a lone producer of his or her own experience but a co-constructor of personal realities "with the prefix co- emphasizing an interactive interdependence with their social and physical environments" (Hoffman, 1998, p. 21). The meaning of experience defines one's reality and is constructed through interactions and relationships with others in the social world. Because meaning and reality are constructed, interpretation is insufficient as the lone therapeutic tool because the analyst has no better access to "the truth" than the patient does.

What is important in the therapeutic situation, according to Stern, is the relationship between and the mutual influence of the therapist and patient. "While the analyst is still the expert in the room, it is no longer because they know exactly how to relate or exactly what to look for in the patient's experience - or in their own. Rather they know how to look.... Disembedding themselves helps their patients to do the same" (Stern, 1996, p. 283). There is a freedom of choice for both the therapist and the patient. "The analyst's values, like countertransference and the

analyst's own history, become not merely passive objects of investigation but inexhaustible sources of meaning" (Stern, p. 266). In his critique of positivist models of therapeutic action (such as the developmental model) Stern writes, "As long as humans are understood to be self-contained units imposing the shape of life on the external world, and as long as it is conceivable for one party of a relationship to observe the other without being routinely affected or influenced by that other, therapeutic action must remain a matter of omniscient analysts imposing knowledge on benighted patients" (p. 271).

For Stern, mutual influence in the therapeutic relationship is only possible through spontaneity, which tends to include both therapeutic and non-therapeutic factors.

So much of what is going on falls in the realm of what Donnel Stern (1983) has called "unformulated experience." The analyst is likely to be an unwitting accomplice to the patient's repetitive neurotic patterns at the same time that he may be promoting something new and healthier... This perspective on the analyst's participation encourages an element of personal spontaneity which lies outside the realm of technique and... is probably a necessary ingredient in any successful analysis. (Hoffman, 1987, pp. 212-213)

According to Stern (1989), "the spontaneous, unconsidered reactions of the analyst and patient to one another may be the sole evidence, the footprints, so to speak, of the very influences which cannot be articulated by either participant, but which most need to be known" (p. 1). This spontaneous interaction exists unconsciously until the patient or the analyst becomes able to observe the interaction and question it.

Irwin Hoffman

Hoffman (1998) describes how, early in his career, he realized that the prevailing psychoanalytic models minimized much of what was really important, giving insufficient attention to "a place for the analyst's personal, subjective involvement, for particularly blinding emotional entanglement, for uniqueness of each interaction, for uncertainty and ambiguity, for cultural bias, for chance, for the analyst's creativity, for the moral dimensions of choice, for existential anxiety in the face of freedom and morality" (p. xiii). He emphasizes as the central role of the relationship in contributing to therapeutic action "combining technical expertise with the special quality of love and affirmation" (p. xix). Through the relationship,

the therapist participates in not just the *discovery* of the patient's psychic reality, but in the actual *construction* of it.

The analytic situation is a unique setup – a ritual, in which the analyst is invested by society and by the patient with a special kind of power, one that the analyst accepts as part of his or her role. “The idea of the analyst as one who is systematically implementing a certain treatment strategy or method detracts from the patient's sense of the analyst's interpersonal authenticity.... for those who see the quality of the relationship as at the core of therapeutic action, considerations of authenticity become implicitly, if not explicitly critical” (Hoffman, 1998, p. 5). In constructivist theory, there is an “ongoing dialect between the patient's perception of the analyst as a person like himself or herself and the patient's perception of the analyst as a person with superior knowledge, wisdom, judgment, and power” (Hoffman, p. 203). The balance between asymmetry and mutuality for any particular therapeutic relationship must emerge from an authentic kind of participation by the analyst rather than adherence to a technical formula. “To effect the patient's representation of self and other, what is necessary is that the analyst's authority be sufficiently authentic, on the one hand, and that his or her authenticity be sufficiently authoritative, on the other” (Hoffman, p. 204). The analyst's navigation of the balance of authenticity and authority is marked by a willingness to struggle with uncertainty and consider the unconscious meanings of a course of action for both patient and analyst.

Hoffman's (1998) focus on the balance between asymmetry and mutuality in the analytic situation is the essence of his thesis on dialectical constructivism, which rests on his belief that in psychoanalytic therapy, there exists “a dialect between non-interpretive and interpretive interactions” (p. xiii). The rich dialect between these two elements of interaction and the struggle to maintain a balance between them defines psychoanalysis according to Hoffman. In his writing, Hoffman (1994) defines a dialect as “a process in which each of two opposing concepts creates, informs, preserves, and negates the other, each standing in a dynamic, ever changing relationship with the other” (p. 195). Hoffman (1998) provides examples of dialectical tensions: transference and countertransference, repetition versus new experience, enactments versus verbal interpretation, analytic discipline versus personal responsiveness, and intrapsychic versus interpersonal components. “Loving, mutual relationships always entail a dialectic of use of the other as a need-satisfying object and

appreciation of the other as a separate subject. In some measure, each participant tolerates, forgives, and even caters to the narcissistic and autoerotic tendencies of the other” (p. 12).

One topic to which Hoffman gives particular attention in the analytic situation is the analyst's use of self-disclosure as a therapeutic tool. Rather than viewing patient curiosity as a forbidden transference wish, he argues that such curiosity is a healthy search for meaningful contact with the analyst. “Aspects of the analyst's identity must not only be overcome but transformed into a wellspring of therapeutic action. Such a transformation is made possible by attention to the dialect of... psychoanalytic ritual, which raises the analyst to a special level of power and authority, and... the analyst's spontaneous personal participation, which reveals him or her to be a person like the patient: merely mortal, potentially caring, creative, generous and wise, but also, just as surely, narcissistic, vulnerable, affirmation-seeking, and partially blind” (Hoffman, 1998, p. xix). The patient may come to terms with the fact that the therapist is a poor substitute for all-powerful, loving parents and with the particularities and absurdities of the psychoanalytic situation. This parallels the patient's coming to terms with such issues and disappointments in real life. “When the patient asks a direct question, there can be much honest self-disclosure, paradoxically, in the process of struggling out loud with one's conflict about answering it... However the analyst responds, such exchanges should be explored retrospectively to understand better the nature of the patient's need or wish and feelings about the analyst's response” (Hoffman, 1998, p. 148).

Contrasting Models of Therapeutic Action

Early in this discussion, the point was made that the shift in models of therapeutic action followed changes within psychoanalytic theory in the past quarter century from a positivist, one-person psychology to a constructionist, two-person psychology. After providing an overview of the interpretive, developmental, and social models of therapeutic action and highlighting two key theorists from the social model, the discussion now turns to the specific differences in each model that represent this drastic shift.

From a Positivist to a Constructivist Paradigm

The hallmark of the positivist or objectivist paradigm is the belief that the analyst can effectively remove him or herself from the interpersonal field, whether to formulate judgments, interpretations, empathic responses, or other interventions. While

Winnicott (1974) acknowledged the countertransference reaction of the analyst, he stated that the analyst must determine whether experiences such as “hate” in the countertransference experience are *objective* or not. Only when the countertransference is objective is it legitimate for the analyst to express it (Winnicott, p. 196). This perspective posits the analyst in the position to determine *reality* or *objectivity*. Thus, Winnicott continued to value interpretation and neutrality over authenticity. Kohut’s empathic stance toward his patients also followed the positivist paradigm. He believed the essential transference “is defined by pre-analytically established internal factors in the analysand’s personality structure, and the analyst’s influence on the course of the analysis is therefore important insofar as he – through interpretations made on the basis of correct or incorrect empathic closures – either promotes or impedes the patient’s progress on his predetermined path” (1977, p. 217). It should be noted that in the developmental model the analyst continues to be the knower of both correct empathic closures and the patient’s predetermined path.

From a social constructivist viewpoint, what is missing from the positivist (or objectivist) viewpoint is the recognition that analyst’s involvement and theoretical choices are often “underdetermined by the data” (Hoffman, 1998, pp. xxv–xxvi). In his discussion, Stern (1996) reflects on the major tenets of the positivist model: “Cure is contingent on the patient’s acceptance of the truth about himself. The analysts must be skilled not only in knowing and telling this truth, but in identifying for the patient the complex ways in which he resists it” (p. 269). The social model of therapeutic action, with its beliefs about the constructed realities shared between the therapist and the client, clearly departs from the positivist paradigm that has dominated the field for so long.

From a One-Person Psychology to a Two-Person Psychology

Because of its emphasis on the therapeutic stance of authority and neutrality, the developmental model – like the interpretive model – sustained the features of a one-person psychology, with influence flowing unilaterally from the therapist to the patient. According to Winnicott’s (1974) description of the analytic situation, the goal of the analyst was to create a holding environment to allow the patient’s “true self” to flourish. “The analyst must be prepared to bear strain without expecting the patient to know anything about what he is doing, perhaps over

a long period of time” (p. 198). Kohut believed that “analytic neutrality” should be defined as “the responsiveness to be expected, on average, from persons who have devoted their life to helping others with the aid of insights via the empathic immersion into their inner life” (1977, p. 252). Neither of these perspectives takes into consideration the influence the patient has on the analyst nor the mutual influence of both participants on the material that unfolds in the therapeutic relationship.

In contrast, the social model, with its focus on the mutual influence of the therapist and patient, is a two-person psychology. According to Stern (1996), there are infinite possibilities for the construction of meaning in each analytic moment. This implies that one can never tell for sure which elements in the relationship are coming from the analyst and which are coming from the patient, since the relationship is always open to an infinite variety of interpretations. While the developmental model is in theory a one-person psychology, some writers (such as Ghent, 1989) argue that psychoanalysis shifted from a one-person psychology in the first half of the century to the two-person psychology introduced by the relational/interpersonal model (Sullivan) and object relations theory (Winnicott). It then shifted back to a one-person psychology with the emergence of Kohut’s self psychology. Given Guntrip’s (1975) account of analysis with Winnicott, which will be explored in the following section, it seems that there is legitimacy to the belief that some object relations and interpersonal theorists were ahead of their time and, indeed, shifting to a two-person psychology decades before this shift was articulated. Indeed, early social workers shared in the relational techniques and values of the social model.

From Technique to Spontaneity and Playfulness

While adherents of the developmental model may appear to deviate from the strict techniques and “blank screen” ideal of the interpretive model, this deviation is somewhat superficial. In Kohut’s analytic situation, the analyst, like the adequate parent, “fails the patient slowly and incrementally, allowing the narcissistic transference to become transformed through transmuting internalizations, to a more realistic but still vital and robust, sense of self and other” (Mitchell & Black, 1995, p. 162). Interestingly, Winnicott may have been ahead of his time in his use of play and spontaneity with his patients. Guntrip (1975) said, when reflecting on his analysis with Winnicott, that psychoanalysis “is a process of interaction, a function of two variables,

the personalities of two people working together toward free, spontaneous growth” (Guntrip, p. 155). This begins to sound more like the social model than otherwise. Winnicott (1971) writes that playing is more than simply helpful, but essential to the analytic experience. “Playing has to be spontaneous and not compliant or acquiescent if psychotherapy is to be done” (p. 75). By Winnicott’s account, play is the actual medium of self-discovery. However, it is much more defined by analytic technique than in social models of therapeutic action.

According to Stern and Hoffman, the essence of a two-person psychology and the social model of therapeutic action is the spontaneous nature of the therapeutic relationship. Social constructivist theorists believe that it is neither possible nor good practice to rely on pre-determined techniques such as interpretation or empathy, to *cure* patients. Besides allowing the therapist to be a *real person* in the relationship, spontaneity or playfulness allows important interactions and material to unfold that may not be initially recognized or easily communicated through an authoritative, neutral stance. “Playfulness’ emphasizes mutual experience of fun and pleasure and includes the use of humor, irony, affectionate kinds of teasing, banter, joint fantasy. It can cut through barriers of distance and communication” (Ehrenberg, 1990, p. 77). Ehrenberg advises that the clinician must carefully monitor the effects of interaction and trust one’s intuitive clinical sensibility in order to be both playful and therapeutically effective. Stern (1996) mirrors this belief: “New freedom has been claimed simply by allowing into the consulting room, more of the interaction of everyday life, while maintaining an analytic attitude and a commitment to thoughtful discipline” (p. 289).

The Use of Self-Disclosure

The spontaneous use of therapist self-disclosure is also a point of disagreement between the two models. “A variety of theorists, including Sullivan, Winnicott, and Kohut, continue to suggest that analysts can somehow manage to keep their own subjective experience from contaminating their patient’s transferences. A corollary of this view is that analysts are in a position to assess accurately what they and their patients are doing and experiencing” (Hoffman, 1998, p. 143). Hoffman and Stern believe that such management of subjective experience and influence is not possible and, more importantly, not desirable as self-disclosure may actually be used to promote growth and reduce isolation while enhancing the therapeutic relationship. Hoffman (1994) states, “on

the one hand, psychoanalytic discipline can be self-expressive and, on the other hand, the analyst’s self-expression may reflect a complex, intuitive kind of psychoanalytic discipline” (p. 196).

From Empathy to Authenticity

This leads to another key distinction made among social constructivist theorists between the therapeutic tools or concepts of empathy and authenticity. Kohut was the first to articulate the use of empathy in treatment and “conveys the impression that a friendly, natural responsive attitude on the part of the analyst will promote the unfolding of the transference, whether classical or narcissistic, without specific reference to other aspects of the analyst’s personality” (Hoffman, 1998, p. 111). In the analytic situation, the analyst as a real person is limited to his or her use of empathy to facilitate the selfobject tie that the patient’s development requires. Kohut (1984) articulated the three essential selfobject transferences - mirroring, idealizing, and twinship - that the analyst must fulfill through his use of empathy. The sequential uses of empathy, minor failures in empathy, and the rectification of such failures promote “transmuting internalizations” that serve to repair ruptures to development of the self (Kohut, 1977).

Social constructivists advocate for a far more full and authentic use of the analyst’s personality. Hoffman (1998) is consistent throughout his book in his rejection of all theories and techniques when they are utilized automatically. He does not reject Kohut’s concept of empathy, but rather accords it the same status as self-disclosure and a variety of other analytic tools. “If we are there as empathic selfobjects (Kohut), or as responders to spontaneous gestures of our patients’ germinal or half-buried true selves (Winnicott), then we ourselves, as people with our own individual dispositions and values, can disappear just as effectively as we could behind a mantle of scientific objectivity in the classical model” (Hoffman, p. 85). The analyst cannot rely on taking any particular attitude toward the patient. He further articulates this point: “The analyst’s personal, emotional response to the patient, when expressed, may or may not entail some form of gratification of the patient’s needs or wishes.... Kohut and Winnicott have legitimized certain kinds of gratification as an intrinsic part of the psychoanalytic process. At the same time they have introduced a new kind of institutionalized disguise for personal, countertransference tendencies” (Hoffman, p. 201).

Practice Implications

Finally, we turn toward the ways in which the shifts in the social model of therapeutic action promote the commonly held value among social workers of symmetry and democracy in the therapeutic relationship. In earlier models, “the analyst had to decide what part of it was ‘real,’ and he had to correct the patient’s errors of perception and understanding” (Stern, 1996, p. 269). By rejecting a knowable reality for a view of reality and meaning that is created between the persons of the therapist and the patient, the social model endorses equity in the relationship. “Democracy in the consulting room becomes not only supportable, but inescapable. The patient’s view can no longer be understood as distortion, but must be respected as perspectives on the truth” (Stern, p. 287). In many ways, social workers have been far ahead of their time in the field of mental health by utilizing a democratic, authentic, and relational stance with clients. Early social workers such as Mary Richmond and Jane Addams practiced with a person-in-environment approach and believed client self-determination was an essential tenet of treatment. By literally joining individuals in the desperate environments they faced, social workers have historically offered their clients the type of democratic, authentic, and mutual treatment environment that is promoted within the social model. These professionals directly challenged the imposition of morals, values, or known “reality” on those they strove to help. These early values remain central in the field of social work as professionals strive to meet their clients where they are at, both literally and clinically. This type of thinking, although far ahead of the ideas of Hoffman and Stern, parallels the shifts in models of psychodynamic theories to a social model.

Social workers today often receive training in clinical theory that is on par with, or even exceeds, that of other mental health professionals. In the face of so many contrasting ideas about human development, pathology, and clinical treatment, it is easy to lose sight of the values and beliefs that have always set social workers apart from other professionals in our field. Regardless of the theory that drives therapeutic action, social workers have been able to offer others a unique and growth enhancing relationship that is the essence of good practice. In an era where theory drives so much of what happens in the treatment environment, the social model of therapeutic action offers useable and well-articulated treatment guidelines that are truly fitting with clinical social work that has historically been intuitively driven.

Critiques of the interpretive and developmental models of therapeutic action have been presented throughout this paper, but the social model has its critics as well. The most common critique is that by promoting democracy, spontaneity, authenticity, and mutual influence, social constructivism gives the therapist free reign in his actions and responses in the consulting room and reduces the therapeutic relationship to a friendship. Hoffman (1998) warns against personal involvement with patients.

We would then simply be entering personal relationships with our patients with the arrogant claim, masked as egalitarianism, that to spend time with us will somehow be therapeutic... Clearly, there is much wisdom in the requirement that the analyst abstain from the kind of personal involvement with patients that might develop in an ordinary social situation... The analyst must try...in a relatively consistent way, to subordinate their own personal responsivity and immediate desires to the long-term interests of their patients. Such consistent subordination can be optimized only in the context of the analyst’s ongoing critical scrutiny. (pp. 193-194)

This reinforces the need for clinical understanding and practice discipline on the part of the therapist despite the authenticity and democracy that the social model promotes. For social workers, this stance can be accomplished by following the guidelines set forth by the *NASW Code of Ethics* (1999) and by maintaining the primacy of our clients’ experiences over our own in a clinical setting.

Models of therapeutic action continue to shift as society, values, and knowledge grow and change. Like the interpretive and developmental models, the social model of therapeutic action may soon be replaced by a more contemporary model. If anything can be concluded from the examination of the social model and the shifts in models of therapeutic action, it should be that there is no one correct technique or stance that a therapist takes with his or her patients. Responses to our clients should be as unique as our clients, themselves, are. Influences from past theorists do and will remain in current clinical social work practice in obvious and less-obvious ways, but it is up to each clinician to decide how we can most effectively relate to and care for our clients.

References

- Aron, L. (1996). *A meeting of minds: mutuality in psychoanalysis*. London: The Analytic Press.
- Berzoff, J., Flanagan, L. M., and Hertz, P. (1996). *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts*. New Jersey: Jason Aronson Inc.
- Ehrenberg, D. B. (1990). Playfulness in the psychoanalytic relationship. *Contemporary Psychoanalysis*, 26, 74–95.
- Ghent, E. (1989). Credo: The dialects of one-person and two-person psychologies. *Contemporary Psychoanalysis*, 25, 169–205.
- Guntrip, H. (1975). My experience of analysis with Fairbairn and Winnicott. *International Review of Psychoanalysis*, 2, 145–156.
- Hoffman, I. Z. (1987). The value of uncertainty in psychoanalytic practice. *Contemporary Psychoanalysis*, 23, 205–215.
- Hoffman, I. Z. (1994). Dialectical thinking and therapeutic action in the psychoanalytic process. *Psychoanalytic Quarterly*, 63, 187–218.
- Hoffman, I. Z. (1998). *Ritual and spontaneity in the psychoanalytic process*. London: The Analytic Press.
- Kohut, H. (1977). *The restoration of the self*. Madison, WI: International University Press, Inc.
- Kohut, H. (1979). The two analyses of Mr. Z. *International Review of Psycho-Analysis*, 60, 3–27.
- Kohut, H. (1984). *How does analysis cure?* Chicago: The University of Chicago Press.
- Loewald, H. W. (1960). On the therapeutic action of psycho-analysis. *International Journal of Psycho-Analysis*, 41, 16–33.
- Mitchell, S. A. and Black, M. J. (1995). *Freud and beyond*. New York: Basic Books.
- National Association of Social Workers. (1999). *Code of Ethics*. Washington, DC: Author.
- Stern, D. B. (1989). The analyst's unformulated experience of the patient. *Contemporary Psychoanalysis*, 25, 1–31.
- Stern, D. B. (1996). The social construction of therapeutic action. *Psychoanalytic Inquiry*, 16, 265–293.
- Winnicott, D. W. (1958). *Collected papers: Through paediatrics to psycho-analysis*. Oxford, England: Basic Books.
- Winnicott, D. W. (1975). *Through pediatrics to psychoanalysis*. New York: Basic Books.

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