

## **PROVISION: ITS UNCHANGING RELATIONSHIP TO THE CLINICIAN'S AMBIVALENCE**

### **Introduction**

The focus of this paper is on the clinician's ambivalence in regard to provision; a concept that has become more inclusive over time and no longer carries the narrow meaning, of something concrete, such as money, hospitalization or medication. The meaning of provision has varied along clinical disciplines, within settings and among practitioners. A current understanding is that provision encompasses whatever the clinician offers, if it is thoughtful and possibly beneficial for the patient. However, it does not imply that the therapist can just do whatever feels right, nor does provision always end in a benefit since we cannot predict a result beforehand. The therapist's intention and action must be for a therapeutic purpose, relating to that specific patient. Ambivalence of the therapist has been part of many case discussions but has not been conceptualized *vis a vis* provision. Although the meaning of provision has changed over time, the individual clinician's ambivalence about provision remains a constant.

The verb *to provide* means: to make available, to furnish, to supply means of support, to look after, from the Latin *video* - *I see* and from *pro*, meaning overseeing. The noun, *providence*, means divine care and direction, guidance and wise benevolence. It is interesting that HMO's refer to professionals on their panels as providers implying a benevolent care taking. In the context of current health care delivery it seems to be more of a double bind term, namely, while the company states that one will be looked after, which at times might be true, the actual experience is more often one of being deprived of enough of what one needs, perhaps not given to at all, or having a provision taken away. This can occur despite evidence of positive change and against the judgment of the service provider. This clearly represents ambivalence in the social contract. As with some of the large recently failed industrial corporations it may be the company and its

executives for whom provision is most beneficial. Greed, in our society, is expressed in an aggressive entitled mode and viewed as successful initiative, while asking out of need is shameful and represents failure. Aggression is a safer and more acceptable position with which to identify than is vulnerability. The therapist has a complicated task in dealing with provision.

There are two fuller clinical examples later in this paper but now I would like to offer a brief vignette to illustrate a point that may at first seem frivolous. Beth, who I had just begun to see with her husband in couple therapy was a highly contained, almost prim woman in her forties who was about to attend a family wedding. She commented that she had nothing to wear to the event since she'd had no new clothes in so long and that she couldn't shop in the stores she liked since their money was being spent on therapy. It felt hostile and envious, and as if she were a teenager seeking a mother's permission. What I *said* was that one of the dress stores she liked was having a sale and if they wished they could delay my payment of one session. What I *thought* was: Should I offer this or not? What would that mean to her, to her husband? Was I trying to change her from the outside in? Why did I want this so much? Was I being seductive? What were the unconscious cues I was picking up? Was she resisting being a sexually adult woman? etc. I decided to take the risk. Next session she reported that she felt she had been given permission to have something for herself, bought a wonderful dress, and looked great at the wedding.

She felt this was a good sign for beginning therapy. Her husband was overjoyed that she showed some interest in her appearance. This incident paved a swift way for Beth to express her feelings about a narcissistic un giving mother and her sexual fears based on an earlier trauma. It also allowed her husband to voice his frustrations with a withholding mother and their frustrating sexual life. We began unraveling each of their very complicated individual conflicts and how they interlock with each other. What I did could be considered controversial. There was no way that I might have known ahead of time what the outcome might be. At the time I was not fully conscious of my intent. I tend to

lean toward the risky edge (which has usually helped the treatment process) even though my training as a social worker and analytic therapist has been of a more traditional nature. This paper will explore some of these professional roots, how I have dealt with them over the years and some of the conflicts they have engendered.

### **Historical Perspectives on Provision in Social Work**

Social Work initially saw provision as concrete service from a funding source that felt entitled to set policy in accordance with certain values which predetermined what was appropriate for the client according to an economic class, a specific culture, or an age stage. The Latin term, *client*, originally referred to the dependents of Roman patrician families for whom protection and guidance were an obligation.

Social work agencies were derived from local charity organizations, propelled by social reformers who were primarily economists. They classified provision as food, clothing, shelter, emergency medical attention and burial. They made economic eligibility the condition of providing services. The earliest social workers carried out these policies but were not trained professionals. Eligibility in those days was stringent as was “watchdogging” for fraud, both expressions of ambivalence about provision. As with the HMO’s gate keeping of medical care now, decisions are determined by organizational policy, interpreted and carried out by employees, often clerks, not professionals, who express the company’s ambivalence by withholding benefits for economic gain. Profit becomes the negative side of the ambivalence and limiting healthcare becomes the positive. Ambivalence about provision is consistent with the lack of a universal health system that allows health care to compete in the market place as a business rather than as a response to a need.

Early casework practice and early mental health services did not yet conceive of treating the internal world as a valid provision. Psychoanalysis, especially was

considered an indulgence, a luxury accessible to those who could afford it but not for anyone in real need who was dependent on a public program.

Selma Fraiberg (Gottesfeld and Pharis, 1976), the child analyst, was an exception in applying psychoanalytic concepts of provision within public welfare agencies. She wanted to demonstrate that it could be just as useful for helping people on welfare, such as young unmarried mothers or those who were second and third generation welfare recipients in understanding their dynamics and making other choices. In her time, the 1950's, it was considered quite a novel idea. There was skepticism about offering such an abstract and internally focused provision to poor, often uneducated clients in a setting that dealt mostly with concrete services. Historically it is not uncommon that when a non-tangible and compassionate service is begun it is under the banner of research, as an experiment which, although proven to be worthwhile, (even known beforehand) somehow never becomes instituted as part of an ongoing service program.

Viennese born Berta Fantl, (1964), a social worker in northern California, applied psychoanalytic ideas to centralized school guidance services translating them into a successful program at Hunter's Point in San Francisco, known as one of the worst and most dangerous housing projects of the city. I made one of my first home visits there during the mid-fifties in a state of terror because of its justified reputation. Here again was an experiment with a fine outcome but no further application to any public program. Clinicians have not been notably successful and may not be the most effective persons for reforming public programs.

The underlying value system of eligibility states that the needs of people who cannot provide for themselves must be titrated because their dependency would increase if rewarded with "too much gratification". This rationalization defends against our fear that the person who is being given to will stay a "baby" forever and remain dependent on us in arrested development.

With the development of clinical skills in Social Work provision was focused on the individual, viewing each with care leading to the tailoring of treatment. However, even with the most skillful therapy and best treatment protocol, lack of provision in the form of social supports can impede a good outcome. Why are people who are dependent not offered more supportive structures in the external world and why are they often treated so harshly? Why is the external world ignored as a parallel to treatment of the internal in many of the mental health disciplines? Why are dependent people not considered a viable resource in the development of their own treatment plans?

### **Dependency - A Social Shame**

Since dependency is *a priori* considered a failure the burden is placed on the person, not the person in context. Michael Harrington's (1968) phrase, "blaming the victim" is apt. There is little tolerance for people who are economically needy or with physical limitations. Independence is overvalued and often results in unfairness and dysfunction. While other cultures value interdependence, autonomy remains *our* social ideal. Our mythic image is of overcoming all challenges by force of will. Christopher Reeves was the ideal Superman. The tacit myth is that even a paraplegic by enough will can succeed on his own toward repair and independence.

### **Internal Dependency and Regression in Relation to Provision**

Recent disasters resulted in an unambivalent outpouring of giving. Clearly such catastrophes are less conflictual situations than our therapeutic work where we are consistently ambivalent when deliberating about providing for those who are dependent upon us. Wherever there is need, there is both the wish to give and the reluctance to give, both the dilemma of what to give and the question of how much to give.

Within the circumscribed frame of a therapeutic relationship, the well-trained clinician is able to tolerate, with less judgmental involvement, the deficits expressed in dependency and the resurrection of regressive affect, the helplessness and past disappointments from significant earlier relationships. In fact early feelings are encouraged, and even evoked in treatment so they can be analyzed. Within the new object relationship there is the possibility of the patient receiving a different response and mitigating the deficit. Regressed behavior seems immature when acted out socially in adult life and may be harshly judged. The shame may spill over to initially inhibit exploration in treatment. But it offers an opportunity that Michael Balint calls, "the new beginning." (Balint, 1968). Clinicians believe that what Kris (1956) called regression in the service of the ego is clearly a pathway for further internal individual development and growth.

Regression in a close and loving relationship can lead to soothing and healing. When one's regressive vulnerabilities are exposed, there are feelings of shame and defensiveness, one cannot easily form either a loving or therapeutic relationship. Only when there is no danger of attack or punishment is intimacy achieved. If we are not afraid of identifying then empathy can allow us to cross a boundary and experience how it feels in some way, to be the other, without having to live there. But it can also trigger regressive feelings from the therapist's own past. The result can be either a defended response or an avenue to a better understanding of both the patient's and therapist's experiences. Defending against identifying with another's regression protects from our own regressive feelings and keeps them out of conscious experience. Our own unconscious narcissistic struggles can be touched off and lead to enactments that require us, by virtue of our professionalism, to try to understand them in order to recapture the analytic space. This complex process involves our own ambivalence and hostility along with those of our patient. It is also a process that involves both the heart and the head.

Theory can guide us but it can equally entomb us in an eternal and unchanging monument of allegiance to formulaic responses and ideas that survive beyond their time.

It is our human need to give as well as to receive. To gratify comes from the Latin root *gratificare*, to please, reward, satisfy. We see this in times of disaster such as 9/11 and tsunamis but every day needs raise ambivalence. Gratification took on another meaning in psychoanalysis.

### **Provision in Psychoanalysis**

An early concept in psychoanalysis is a paradoxical provision, namely, the rule of abstinence (Freud, 1915). It is a provision by an absence, not offering libidinal gratification, allowing transference to develop, which, I think, is the most important provision that can be given in analytic therapy. Ruth Oscheroff, in discussing this paper at the NMCOP in March, 2004, makes the point that the therapist must also provide the climate and a way for the patient to understand and work it through. Freud's instinctual drive theory stated that by not providing a response to those desires of instinctual gratification the patient would be offered the rare and safe opportunity of struggling with his own conflict to bring unconscious wishes to consciousness and explore their origins in his past in order to learn about himself. Freud wrote, "The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (Freud, 1912, p. 118).

The second and related provision offered by psychoanalysis is neutrality. Neutrality came to mean, from Freud's definition, evenly hovering attention, with lack of criticism, to the three structural parts of the patient's mind: that part of the mind that desires, wants gratification, called the id; the part that is critical of those desires, the

super-ego; and the third, the ego which tries to mediate them as well as manage reality. Providing neutrality creates a safe haven and uncritical atmosphere allowing the patient the opportunity for self- discovery, especially of his unconscious and its wishes. Once wishes become conscious, understood and worked through, the assumption is that the patient is no longer neurotically driven toward dysfunctional repetition or acting out, and will constructively sublimate. The patient's wish for a response from the idealized therapist would no longer be the issue. For example, the patient who is always asking for reassurance that she is not stupid or unattractive, which she believes are the reasons why she is not able to achieve a relationship would become conscious of the origin of this insecurity. She would come to understand its dynamics and work through to a more solid and authentic sense of self, with fewer unconscious compulsive and narcissistic needs, therefore enabling her to allow a real relationship of intimacy with another.

The rules of abstinence and neutrality in clinical practice as the late John Lindon (1994) states, "...infiltrated psychoanalytic technique of every psychoanalytic persuasion..." (P.2), and I would add, of related professions like clinical social work. As a result clinical practice, at times and with some practitioners, became rigid, mechanical and dogmatic, anti-individual, hiding what the clinician did not know through silence, passivity or withholding, which was sometimes sadistic, caricatured with much bitterness, hostile humor, and, unfortunately, sometimes truth. (Who listens?) Ferenczi, (1993) who was often referred to as the mother of psychoanalysis, with Freud, the father, called generalized abstinence a "professional hypocrisy" (p. 226). That was in 1933. Maroda, a contemporary therapist writes that the therapist's use of neutrality may be to hide from the patient, and perhaps from herself (1994). We have had decades of discussion about abstinence and neutrality in treatment, two *seemingly* opposite concepts of provision that are both abstract and can be either rigid or variable in their entwined application.

Khan (1969) states that Balint's work in object relations altered Freud's idea of analytic technique by ascribing a much more active, significant and profound role to the analyst. The difference focused on what the *analyst* provided the patient in the creation and process of treatment. Michael Balint, (Khan, p.237) believes that to understand provision in the treatment process one needs to understand the analyst's behavior.

"What the analyst must provide - and if this is at all possible - during regular sessions only - is sufficient time free from extrinsic temptations, stimuli, and demands, including those originating from himself (the analyst). The aim is that the patient should be able to find himself, to accept himself, and to get on with himself, knowing all the time that there is a scar in himself, his basic fault, which cannot be 'analyzed' out of existence, moreover, he must be allowed to discover *his* way to the world of objects - and not be shown the 'right' way by some profound and correct interpretation... Apart from being a 'need recognizing' and perhaps even a 'need satisfying' object, the analyst must be also a 'need understanding' object....(Balint in Khan p.238)

The inclusion of this new Object Relations concept had tremendous influence on the future development of psychoanalysis. It allowed for propelling countertransference into a positive aspect of treatment and foreshadowed Self Psychology, Attachment theory, and the Relational and Intersubjective viewpoints.

Bela Grunberger (in Etchegoyen, p.513) offered another view of *need understanding* in a split version of provision. He separated the desire for libidinal

instinctual gratification in the transference, from an Object Relations need which he called analytic rapport. This was a separate, parallel relationship in which the patient could feel currently attached to the therapist in the present and not be denied some narcissistic gratification, such as praise. Grunberger believed the analytic rapport actually strengthened the mobilization toward the regression into the analytic process and the transference. (Etchegoyen, 1999, pp. 513-515). Some therapies remain forever benignly within the analytic rapport, which may be appropriate and sufficient for some, but might deprive others of a deeper transference experience for greater change. A clinician who does not confront denial and resistance may be withholding a provision from a countertransference reaction, perhaps the therapist's fear of being attacked, or fear of awakening one's own dependency and aggression. The therapist, of course, needs to be aware of which patients are not appropriate to confront as well as how the therapist's own internal world enters the process.

The understanding of the therapeutic relationship and analytic rapport in psychoanalysis has changed over time. In the most recently published *Freud Encyclopedia* there is this quote.

"Contemporary analysts tend to agree that wishes that are derivatives of the libidinal and aggressive drives should not be gratified. Gratification of other motivational factors, however, such as the need for object relatedness, is not only permitted but regarded as essential to the therapeutic process" (Bonovitz, 200p.5).

Integration of Object Relations theory and Attachment theory has redefined provision in light of the need for new good internal objects and secure attachment. The withholding of gratification by the analyst was established within the provision of neutrality, which Freud viewed as a special *benevolent* provision of psychoanalysis, not available from other relationships. Such concepts as Winnicott's (1958) "holding

environment" expanded clinical provision and was even more benevolent. These innovations, useful as they are in treatment, still do not erase or resolve the ambivalence about provision that inevitably arises within each therapist.

Abstinence along with the neutrality were never intended to be expressions of passivity or withholding, nor punishment to deprive the patient of either a human response or an opportunity for healing past wounds in a new relationship. On the contrary, withholding gratification of certain wishes and providing neutrality were scaffolds to support the progression of the treatment as the patient worked on finding himself. It was one of several fundamental rules that Freud (1912) created in his experimental treatment called psychoanalysis, rules that included lying on the couch and free association. Interestingly, at various times, in his clinical practice, Freud broke his own rules, which demonstrates his own ambivalence about withholding gratification. He walked with patients outside of the office while analyzing them, invited some to join him on vacation, he gave gifts to patients, including food, as well as expressed his personal feelings. (Bonovitz, p.5).

Clinicians have not always diligently practiced abstinence and neutrality but these concepts were diligently preached. Their applications have been individual, often secret, and even entitled, but the issue of conflict about such provision remains.

Lindon (1993, p.15) refers to "optimal provision" which he defines as "any provision which, by meeting a mobilized developmental longing facilitates the uncovering, illuminating and transforming of the subjective experiences of the patient." Lindon (p.36) also quotes Winnicott, who makes a much less opaque statement, "If the patient does not need analysis than I do something else." With his patient Margaret Little, (1990) the analyst who dealt with psychotic regression, provision meant holding her hand, home visits and hospitalizing her when he left for vacation. Little (1996) wrote from her own practice that there are areas and times when words are insufficient and the patient must be given direct physical contact.

This is a touchy subject, an advisedly double entendre on my part. In Berkeley in 1982 Heinz Kohut, appeared at a Self Psychology Meeting devoted to the idea of empathy. He expressed his own ambivalence as he described his offering to hold the two fingers of a patient, doubtful that it would help but desperately not knowing what else to do about her deep depression. We practitioners are often confronted by helplessness which may lead to our wanting to give something, anything, to the patient to alleviate both the patient's suffering and our own.

In an issue of *Psychoanalytic Inquiry* of 2000, devoted to the problem of touch, Patrick Casement, (2000) a social work analyst, writes about a patient who, at 11 months of age was scalded and operated on, with the mother holding her hand until mother fainted. The child was left alone with the surgeon. The patient wanted Casement to hold her hand during intolerable anxiety. Given his knowledge of the patient he chose not to touch because he felt that was in the best interest of the patient's analysis. Casement writes:

Analytic work of any real value cannot, in my opinion be done on a basis that is bound by rules. That is why I have taken the trouble to outline as carefully as I can how we need to follow patients, not only at the manifest level of what is said but with a fuller context, also taking into account the unconscious meaning of the interactions taking place between analyst and patient. But when we do follow the patient at a deeper level, we sometimes arrive at a position that is far less comfortable than anything we might personally have chosen (p.171).

Although Casement does not use the word ambivalence, he clearly implies the ongoing struggle between our feelings as persons and what we do as professionals, specifically about touch. Withholding can be a provision in the best interest of the patient while our very human souls want to provide a more active demonstration of caring.

Whether to give, what to give, and how much to give are clearly our professional struggles.

### **The Clinician's Regressive Feelings**

Providing for others is problematic. It raises many regressive internal issues that we might want to avoid. Our own earlier deprivations are still alive in the timeless unconscious. It raises many internal issues: How helpless we felt and continue to feel, how disappointed, how angry at not being given to, and how narcissistically injured, feeling we were not worth being considered. If a parent withholds it may be for the child's best interest but that may feel no better than it does to a patient when we don't provide what the patient wishes. How vulnerable we were to this as children, and are as adults, in our most intimate relationships. Nor do we want to rouse our hidden envy of those who have more or of those who have the power to give to us. Neither do we want to rouse our inner anxiety.

For some people giving is experienced as a giving up of what is needed for oneself leaving one feeling impoverished. The conflict may be intense. A three-year-old struggles with sharing a toy he wants, in a relationship he also wants. We may not wish to give to another what we did not get, and we may not even be aware of our feelings about the deficit until it is triggered while working with a patient when we try to defend against feeling it. Aggressive feelings lie in wait, leftovers from the frustrations of failed nurturing. To give and to deny giving evokes our earlier fears of not getting and feeling angry. The rage and anger of our clients arouse our own repressed rage and anger. We wanted to be provided for and loved unconditionally as do our clients in the dependent relationship they have with us.

In therapeutic work we always question ourselves: do I want to give out of concern for the client or to make myself feel better? The clinician asks endless questions

during each working moment. It is important not to be self-critical clinically if we see things differ-gently at a later time since decisions are made only of a moment.

Ambivalence within the therapist about provision has not been something easily discussed or questioned. Clinicians have been fearful that they might be shown in a less analytic stance. Theoretical devotion to abstinence and neutrality kept psychoanalysis in America from providing even practical and needed solutions in mental health. The theoretical devotion with which abstinence was taught often inhibited practitioners from speaking *at all* to their clients that resulted in much client frustration and brought many a treatment to a premature end. Linden (1993) states:

The rule of abstinence did not accomplish what it was prescribed for in the first place, i.e. to be the motivating force impelling the patient to work analytically. Not only was it unnecessary, but it was often detrimental. The rule of abstinence has skewed, disrupted and needlessly prolonged analysis. In addition, much does not get analyzed that could have except for the rule of abstinence and essentially, unwittingly, closes off whole areas from analysis(p.2)

### **Changes in Provision in Social Work**

By contrast Social Work became more professionalized as a treatment method when humanistic considerations were introduced into philanthropy through people like Mary Richmond, (1917), whose concepts of "social diagnosis" and individualization of the client came as early as 1899.

As Social Work searched for new techniques to help both individuals and groups the profession explored knowledge from other fields, especially psychoanalysis. Psychoanalytic theory was particularly welcomed by Social Work for its non-judgmental understanding of dependency and regression. Psychoanalysis became the compass for

understanding and determining internal diagnosis and treatment of person in situation. The hope in the social work profession was that the psychoanalytic perspective could partner with our experience in social provisions and relationships to help our clients more fully.

Often psychoanalytic theory was used rigidly, without examination and with little confidence in evaluating what we had already learned from our own practice experience. Social workers often have considered theirs a lesser profession, implying we were not as helpful to patients, had less knowledge about practice and were involved with people of less value. That was in part our own sense of self-esteem and well as disrespect from others. I will not explore this issue here. For many years our only consultants were psychiatrists; there was also a time when I recall being told that working with dreams was not appropriate for social workers. Idealization of psychoanalytic theory and the personal experiences of many social workers that went into psychoanalysis led them to reproduce with their clients, copies of their own treatment experiences, for better or worse. Clinicians were often ashamed and guilty when they did not strictly abide by the narrow interpretation of the abstinence concept and did not report in supervision or recording what they actually did in practice I now find that consultees have the most reluctance and anxiety about reporting their active responses rather than their silences.

Balint's concept of "need understanding" did not exist in our historical roots, or in our professional settings with their implied judgmental attitude. In England Object Relations theory developed internal worlds more fully and is less a battlefield theory even in Kleinian terms. The struggle of giving up the paranoid schizoid position for the more vulnerable depressive position does allow for the evolvment of a new beginning in which an object can be experienced not only as less dangerous and more benevolent, but also idolized. Perhaps the reason that Ego Psychology was so readily accepted as the major theory used by Social Work in America was not only that it was a psychology of the ego but that it also focused on the power of, and battleground with, the superego

which was closer to the historical social milieu in which the profession was rooted as well as the causes for which it fought.

Social work education and practice in the 40's and 50's united with Ego Psychology theory. In that framework ambivalence in treatment was considered a client's problem. It was our job to "objectively observe" the client. Countertransference was seen as an impediment to treatment. While not attending to the unconscious sources of our own ambivalence we tried not to blame the client for what was touched off in us. This was the era of my social work clinical training. Clinical practice has changed with the development of Object Relations theory, Attachment theory, Self Psychology, Intersubjectivity and Relational Psychology. In all of these models the person is seen as needing relationships with others to provide for emotional survival and development. The therapist is not only the objective observer but is also a participant, a caring co-creator of the relationship. For me, these ideas opened up my authenticity as a person-professional and removed an artifact that I think, in many instances, was a barrier in my work

In primitive states and regressed states patients cannot sustain themselves without real object relationships, they need to be given to just to survive. People in economic trouble, the ill and the homeless, also need to be given to in order to survive because they cannot sustain themselves, sometimes because of psychological deficits. Many people who need help also shun it, feeling shame based on social values that have formed our views on dependency. Whose fault is being needy? Fault has two meanings. It is a vulnerable place in the structure, a fault line, which is potentially susceptible to a breaking up, like in an earthquake. The other meaning of fault is blame. Balint's term, the basic fault, does not refer to blame as if need and dependency were the patient's fault, but it is used as a way of locating an historical and psychological reality, a fault line, in which an object relationship failed to provide for further development, something got broken up. There are similar "basic faults," that produce breaks in the social fabric, failures to provide

for individual survival, development and opportunity for those who cannot do this for themselves.

Social Work uniquely deals with the person in the social system as well as with the individual's inner object relationships. People need other real objects for survival, individually and in a community that can then provide good inner objects. In our professional formulations we have not melded the simultaneous lives of both internal objects and real objects into a seamless theory from which to practice. Neither has any other mental health profession. The whole person is an interaction of real objects with inner objects, both good and bad. However, our terms for areas of the profession: case-work, group and community organization illustrate that we have not found a way to make it seamless. At times these areas are competitive and often remarkably ignorant of each other's provisions and skills. How can we ever explain to others what social work is when we have not made it clear for ourselves. How can we say what mental health or mental illness is using only one dimension of experience? This area remains virtually unexplored, unresolved and unintegrated into our identity as one profession. Can clinical and community include both real and inner object connections describable in theory and provided in practice? Fraiberg and Fantl operated as if it could. The Community Mental Health Movement of the sixties also came closer to a rapprochement. Perhaps it will no longer be the social work profession that completes this task or will be required to deal with it since other disciplines are taking over championing social connections. Even Freud enjoined the two by requiring that analysts spend time each week in a "free clinic" in order to allow those economically deprived to benefit from psychoanalytic skills.

Isn't it interesting that contemporary psychoanalysis in Jill Horowitz' (1998) words is "finally commensurate enough with our own traditions that psychoanalysis has become a natural, rather than a dislocating discourse in which to participate. We have one hundred years of clinical thought and experience behind us; we had arrived at much of the current theory many years ago" (p.382). The significance of this statement reflects

how much of contemporary psychoanalysis offers ideas considered new but were already the base of professional social work practice, although perhaps neither fully conceptualized nor valued enough. Whereas in earlier years we incorporated and acknowledged ideas from psychoanalysis we have not expected psychoanalysis to appreciate our focus on the internal-external dynamic. The favor is usually not returned, in fact it is totally ignored. The focus we have had on understanding the various cultures of our clients has recently come into psychoanalysis, even to the development of a journal called *Culture and Psychoanalysis*. But one must wonder if all the social workers that have entered psychoanalytic institutes haven't in some way been influential in this trend toward more of an assemblage of inner and outer psychoanalysis.

### **EMPATHY – A CORNERSTONE OF SOCIAL WORK**

I first heard the word empathy in social work school long before it was so much a focus in psychoanalysis. When I was a young and beginning social worker in the 1950's I attended a talk by Bertha Capen Reynolds. She was a small, somewhat fragile looking, white-haired lady, with a firm and quiet strength, who looked like some of my early schoolteachers. Unlikely as it seemed, this delicate, spinsterish lady had been asked to develop a new social agency for The National Maritime Union, namely the United Seamen's Service, to serve the Merchant Marine during WWII. What I remembered her saying was, "Until someone is given to he cannot give." In her book, *Social Work and Social Living* (1951,p.4.) she wrote: "There is no doubt that the trend in social work, as it has become more professional, has been away from kindness as such to activities that accomplish something that the agency regards as its function."

This statement can easily be misinterpreted as *carte blanche* for providing anything at all without careful consideration for individual differences. It is highly confusing to the beginner trying to learn to be professional! The need to appear more

"professional" was stronger than our desire to respond authentically. Rigidly adhering to agency eligibility, blindly adhering to a theory and speaking "professionalese" all interfere with establishing a close intimate relationship with the client, as well as constrict one's individual thinking. In the attempt to become "more professional," meaning, more like psychoanalysts of yore, the pressure was on the side of withholding, using the idea of abstinence or agency function as reasons. Clients were considered resistant if they did not keep appointments when they may have had the motivation but in the reality of the external world they may not have had carfare. In earlier years there were few clinical social workers in private practice so that the clinician was not only in battle with her own ambivalence but often with the agency setting as well. Withholding became a misinterpretation of abstinence within psychoanalysis and was an equally misused cultural and professional rationalization in social work.

It was Charlotte Towle (1969) who commented on the issue of neutrality as withholding in the form of silence **when it became a mechanical response**. She saw that silence and avoidant response were neither neutral nor harmless but were being processed by the client as much as what was spoken, and often not processed correctly. She was aware of the need for responsiveness as a provision reflecting both Object Relations and therapeutic rapport. She wrote:

...Even with a relative degree of skill, however, in the control of this type of therapeutic relationship, it is our conviction that many clients cannot use it. Our present concern is one of affording the client a relationship which he can use to some advantage. This implies laying aside any rigid ideal as to the kind of therapeutic role a social worker should play. It implies a flexible meeting of the client's needs at his particular level of personality organization, which in turn makes imperative a supportive relationship in many instances (p.66).

## Clinical Illustrations

Towle echoes Balint's idea of being "need understanding". The following case illustrations might also explain some of the points about ambivalence related to provision and why I have been thinking about this for such a long time.

In my first year of practice in an agency that was geared to crisis I saw a young veteran in his early thirties who was desperate, hungry and was new to the city. He needed a small amount of money to tide him over for a few days until he started a job he already had. My supervisor refused to allow me to offer any agency help using her rigid interpretation of agency policy regarding his eligibility. Her passionately punishing attitude was expressed by her saying he **should** have been prepared for this, a super-ego verb. How much, I now wonder, did this relate to her need for power in her authority role? To a desire of not to be giving? To a punitive projection onto me, as a not-good-enough professional because I couldn't help him figure out a way of his not being dependent? I argued with her because it seemed so irrational and frightening to me. I felt the ambivalence in wanting to help but also wanting to be considered a good professional. I felt my client's despair. I was distraught. My supervisor said that I was someone who was not accepting of agency limits. This statement was one of a repertoire of superego-ish jargon that was used in social work agencies to provoke guilt, adherence, and a non-questioning attitude. Such abuses of professional power have also been used as threats in evaluations as a way of intimidating someone from leaving, not daring to try another position. What is created is a fearful, hostile, dependent staff of lifers.

The next day I received a call from County Hospital that my client had made a serious suicide attempt, and asked to see me. My supervisor was shaken. I said that I intended to visit him. At this point she did not bring up agency policy, which was actually more flexible and less punitive than she was. I didn't know how to deal with a

first suicide attempt by a client, nor did she offer any help, but I felt I needed to give him something, reassurance, a word, a touch, something that showed that someone cared. I felt some guilt about not having been more assertive, of depriving him of a provision that was not unreasonable. Could I have done more? How far could I have gone then in putting myself on the line?

I wondered what I would want if I were in the hospital so in my inexperience I packed a small box with chocolates, sardines, crackers, cigarettes etc. I think on some level I understood and was responding to his internal hunger. I made my very first visit to a psychiatric ward. I literally had to walk across this grim room on top of mostly empty beds stacked next to each other in order to get to him. I won't forget the smile he gave me when I arrived. When he came out of the hospital he returned to see me and we worked through a number of issues over the next few months. He was someone who did not think through his plans, so that inevitably he would bring himself to a crisis, needing to become dependent on others, which is the only way he could allow dependency. He would then feel angry when they would not go along with him, proof of no one being there which reinforced his inability to trust. He acted this out with me. This was a repeat of impulsive earlier behavior in his family. He roamed from one place to another, which contributed to his avoiding intimacy, which he then could rationalize by saying he was not in any place long enough. The military was a good venue to act this out. My understanding of his dependency needs seemed healing and allowed him to get closer to me. He was able to get in touch with his internal yearnings and to put into words his great sense of deprivation.

Quoting Bertha Reynolds, (1951) "The scientific answer, then, to this old popular notion about spoiling people is that it is not the amount of aid or service that matters, so much as the way it is given in conjunction with the casework process of helping people to be active for themselves" (p.84). That is a heartening general statement but does not guide us in how to go about it. The profession has not been as helpful in mapping a route

as it has been in defining the problem area. In the situation of my client, whatever I gave provided a new object experience for him, in Balint's words, "a new beginning" and in being "need understanding" allowed him to trust and engage in growth which he had been unable to do on his own.

Shortly thereafter I left the agency. I decided that my feelings and beliefs could still be compatible with professionalism and that rules could be humanely applied to incorporate helping those of our clients with early and severe deprivation. I was a professional in search of theory as well as a kinder climate in which to practice.

For me, as for many people, provision is an eternal dilemma. Do we take a patient to the hospital ourselves? When not? When do we respond and how? Provision for one person may be intrusion for another. One of my patients had a highly intrusive mother. Her best times in my office have been compatible silences, which allow her experience in a good new object relation the "going on being" that Winnicott's describes.

I have a twinge of ambivalence even when I think something is the right thing to do. Sometimes provision becomes a permanent commitment. When I first saw an 11-year-old patient who didn't speak it was an agonizing experience for both of us. When a breakthrough finally came after a year it was a testimony of trust. After a few years when I moved to another city she would not see anyone else and we continued to talk via telephone. She was eventually able to marry and successfully raise children despite a real ego deficit. I think I provided continuity for her and indirectly for her children. Recently I received a letter from her in which she wrote. "I met you when I was 11 and now I am 54. You have known me the longest of anyone in my life since my mother died. I think you have been my structure."

There were times when I wondered if I were really providing help for her, at times I resented the additional dependency and phone calls at night. But in the long view I feel that I was significant in helping an individual deal with life and reality and she in turn helped her children so there are waves that emanated from my provision that I can

only imagine. There is the desire to be part of an ongoing human process that may live beyond us.

With Frances, a more recent case illustration, my ambivalence about provision helped me understand her, on a deeper level through a countertransference experience, which eventually led to a better treatment outcome for her. This example demonstrates our daily struggle on a level that may seem, at first, neither weighty nor significant, but may have extended and prolonged effects. The rich breakthrough that occurred could, of course, have possibly turned out badly.

Frances was a professional unhappy in her work with a prominent mental health organization and was searching for another position. By chance, at a meeting, I heard about a job that sounded completely suitable for her. I thought about what to do. Her treatment had become a repetitive compulsive outpouring of frustrations with her job, the lack of empathy from administrators and her own impotence to change things. Her concerns were based in reality even though her inability to move was rooted within her own obsessive dynamics. She negated any attempt to explore the psychological problem and blocked attempts to talk about her transference toward me, which was passively dependent and distant, as she had been toward her parents. She rarely if ever made eye contact. Perhaps some of my unconscious motive for offering the information had to do with my being bored and impatient with the repetitiousness in the sessions but by using a suggestion I also consciously hoped to move the treatment along. I mentioned that I had heard of a suitable position for which I thought she might apply. She did and was offered the job, which she took, and it remained a successful match.

After she was offered the job Frances barely acknowledged my contribution and went on to deal with other issues. I felt somewhat slighted by such an offhand response, which made me feel quite unimportant. If it had been me I would have warmly thanked my therapist and would have talked about what it meant to me, how special and attached I felt, how given to, how narcissistically gratified in Gruenberger's ( Etchegoyen, pp.

513-515, 1999), sense, and then I would have gone on to offer my associations. The slighted feelings of my countertransference and my narcissistic association led me to recall her comments that her husband so many times said to her that he felt she did not connect to him with intimacy or give a response in the way he wanted. She just tried to fix everything. When next I posed why he might feel as he did I did not mention my own feelings to her but it led me to probe more. A resistance cracked and she was able to connect to earlier experiences. She felt that allowing herself to accept and acknowledge taking something from someone was tantamount to selling herself into slavery. It was dependency. It was unreliable. In her projective identification I would become the master, the all-powerful parent, who could give or take away. By not acknowledging that I had helped her she could defend herself from feelings of inadequacy about her needs and the earlier disappointments of their been unmet. What had occurred between us opened these narcissistic defenses for our work.

## **Conclusion**

Provision in treatment is an interaction between two persons influenced by the social milieu. I am again grateful to Ruth Oscharoff for making the point that in analytic work the therapist and patient give to each other and there needs to be a reciprocal receptivity from both to set a process in motion. In our own time social relationships with institutions have become more impersonal and provision is less clearly defined in all arenas, including civic and religious structures. The relationship of the person to the state has also become increasingly remote; one either benefits or suffers from regulations, but always at a distance from any real influence on policies shaped within the crucible of states' rights and federalism, our two major political philosophies. A special appeal to a congressman may be the closest one may come to a relationship

with the State. It will be interesting to see if the Internet, which has, becomes a powerful connecting tool that may alter this phenomenon.

Taking time to show concern and offer support to someone is sometimes the role given to volunteers, split off from the professional tasks and the bureaucratic powers, existing in a separate but parallel world. I don't want to split off that part of me and practice as if the external world has no impact on us. Patients often communicate their feelings and concerns more freely with volunteers because they find a receptive ear and time. I do not mean to exclude volunteers but to employ them far more consciously. To fold into the treatment process what we determine is an appropriate volunteer function. Can we take a retrospective look at our professional roots and reevaluate external provisions in relation to individual internal meanings. Agencies and mental health clinics usually partition the relationship with the client by splitting functions of service among several people, which spreads into an organizational culture that infiltrates the privacy of the treatment process that can make the therapist-patient relationship disjunctive. It also leaves many client experiences unavailable, unintegrated and therefore unusable in the treatment process. It isn't only HMO's that invade the privacy of the therapy and the consulting room.

Rigidity around economic provision resulted in many tragedies. Rigidity in health care provision demonstrated by the HMOs may also result in tragedy, serious illness, even death, when needed provider services are not allowed. Provision from earlier welfare organizations and current HMOs have in common that those in need are disenfranchised from participating in their own treatment plan and individual evaluation. The patient's ideas of what could help him best are usually not considered nor valued. Unfortunately such interactions take place when a person is already vulnerable and not in a strong position to question how he is being treated.

What we provide a patient may often give access to an area that has been defended against. I have not mentioned my negative experiences, which actually have

been few. As Casement (2002) writes, even our mistakes force us to achieve a deeper understanding that we might have missed in a smoother course. Frustrating a patient can be a valuable provision, if it is a meaningful action. When it is an accident we hope we learn from it. When it is punishment it is damaging. It takes courage not to act but it also takes courage to act outside of rigidity. What is required is our continuous self reflection, our checking, re-checking, looking at different reactions in ourselves, trying to understand if we are acting or acting out, also trying to accept that we cannot predict what will be the outcome of our decisions. In the act of providing our peers may see us as acting out and we try to avoid actions that would make us feel vulnerable within our professional community. Without risk there is no creativity and with too much risk there can be irresponsibility.

Practitioners need latitude to explore ambivalence around provision. Administrations could become more open to the dialogue, and encourage this in the supervisory relationship, ensure that it is addressed in consultation, and included in staff development. I wish that it would be discussed in the depth it deserves, theoretically and clinically, in the schools of social work. A more accepting attitude of the existence of ambivalence could help the clinician feel more comfortable internally and toward the setting, enabling her to use herself and her mentors more effectively in the process of treatment. This is one argument for having teachers who are also in practice. Newly trained professionals often think that we have all the answers. They also believe that "real treatment" deals only with deep internal meanings and theoretical interpretations. They would be helped to hear from more seasoned clinicians that our patients' inner worlds, as well as ours, are melded to the external ether. We also struggle with ambivalence. No one escapes. But to wrestle with it is the essence of growth, both personal and clinical. Neither one theory, nor one rule, nor one provision can be for everybody or for all moments. The issue of ambivalence in regard to provision belongs to all professionals. It is part of an ongoing internal process, organizationally and individually, needing to be

examined in an open atmosphere, devoid of shame and without penalty, with neither an omniscient fantasy nor a predetermined outcome. Ironically, a process that is free to consider, accept and process ambivalence can serve as an anchor to ground us while we hover over our therapeutic decisions.

## REFERENCES

- Aron, L. and Harris, A. (1993), *The Legacy of Sandor Ferenczi*. Hillsdale, N.J.: The Analytic Press.
- Balint, M. (1968), *The Basic Fault*. N.Y.: Bruner Mazel.
- Bonovitz, J. (2002), *The Rule of Abstinence*. *The Freud Encyclopedia: Theory, Therapy and Culture*. ed. E. Erwin. New York: Routledge.
- Casement, P. (2000). *The Issue of Touch: A Retrospective Overview*.  
N Y: The Analytic Press. ed. Ruderman and Shane, Psychoanalytic Inquiry  
Vol.20, No. 1
- \_\_\_\_\_. (2002). *Learning from Our Mistakes: Beyond Dogma in Psychoanalysis and Psychotherapy*. N.Y.: The Guilford Press.
- Etchegoyen, H. (1999). The Fundamentals of Psychoanalytic Technique.  
revised edition. London: Karnac Books.
- Fantl, B. (1964). *The Work of Berta Fantl*. Northampton, Mass: Smith College Studies in Social Work Vol. 34, No. 3. pp 178-241.
- Mary L. Gottesfeld and Mary Pharis ( 1976) Profiles in Social Work.  
New York: Behavioral Publications.
- Freud, S. (1915). *Observations on Transference Love*. Standard Edition  
14:163-17
- Harrington, M. (1970) *The Other America: Poverty in the United States*. rev. ed. N.Y. : Macmillian
- Horowitz, J. (2000) *Contemporary Psychoanalysis and Social Work Theory*. Clinical Social Work Journal Vol.27, No.4. pp. 369-83.
- Kasius, C. ed. (1950). Principles and Techniques in Social Casework. New York:  
Family Service Association of America.
- Khan, M. M. (1969). *On the Clinical Provision of Frustrations, Recogn-*

- nitions, and Failures in the Analytic Situation. International Journal of Psychoanalysis, 50: 237-248.
- Kris, E. (1956). On Some Vicissitudes on Insight in Psychoanalysis. International Journal of Psychoanalysis, 37:445-455.
- Lindon, J. (1994). Gratification and Provision in Psychoanalysis: Should We Get Rid of the "Rule of Abstinence"? Psychoanalytic Dialogues 4 (4) 549-582.
- Little, M. (1966) Transference in Borderline States. International Journal of Psychoanalysis, 47: 476-485.
- \_\_\_\_\_. (1990) Psychotic Anxieties and Containment: A Personal Analysis with Winnicott. Northvale, NJ: Jason Aronson. Record of an
- Maroda, K. (1994) The Power of Countertransference. Northvale, NJ: Jason Aronson.
- Reynolds, B.C. (1951). Social Work and Social Living: Explorations in Philosophy and Practice. New York: NASW.
- Richmond, M. (1917). Social Diagnosis. New York: The Free Press
- Towle, C. (1969). Helping. ed. by H.H. Perlman, Chicago: University of Chicago Press.
- \_\_\_\_\_. (1952). Common Human Needs. New York: American Association of Social Workers.
- Winnicott, D.W. (1958, 1991). Through Pediatrics to Psycho-Analysis. London: Karnac Books.