There's No Couch Here: Introducing Psychoanalytic Concepts to Non-clinical Staff

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In my experience of providing clinical supervision and clinical consultation to case managers and other agency line staff (e.g., front desk staff, money managers, benefit advocates, and rental subsidy coordinators) who don't have advanced degrees and/or have not been trained in clinical work, I have found that explicitly introducing psychoanalytic concepts into our meetings has consistently proved invaluable. I have observed that applying these concepts to work with non-clinical staff increases worker self-efficacy, enlivens the experience of work, mitigates against problematic exchanges with clients and may decrease burnout and demoralization among staff.

Role of Consultant/Holding the Supervisee

When consulting, I find that providing holding (Winicott 1960) and containment (Bion 1963) is greatly appreciated by the staff as they begin to acknowledge and metabolize the intense countertransference evoked by their clients. Encouraging and facilitating insight into their own reactions to clients often leaves staff feeling less isolated and overwhelmed. Staff with no previous experience of receiving clinical supervision or clinically oriented consultation may expect a consultant to offer directives or invectives; however, accepting and containing attention to their internal experience of working with clients may be experienced as unexpected, and quite welcome.

Normalizing Countertransference Reactions

In reading and discussing Winicott's seminal article on "Hate in the Countertransference" (Winicott 1947), workers in a variety of positions have expressed surprise and relief. This article has helped them to accept, in themselves and others, their rage, resentment, envy, sexual attraction, and disgust toward clients. Helping staff to remain aware of the space between thought/feeling and action can allow for increased affect tolerance and an improved ability to reflect. This reduces their vulnerability to inadvertently act out their intense countertransference with clients. Reducing the shame of intense countertransference feelings opens up the possibility for increased mutual peer support.

It is reassuring to staff to recognize that most others would react to a client with similar thoughts and feelings (broad spectrum countertransference reactions). They also can recognize that the particulars of their own experience may lead to idiosyncratic and at times heightened subjective (narrow spectrum) countertransference reactions. Naming such concepts and suggesting the universality of having intense internal reactions to clients off-sets the latent shame when they are unduly affected by a client. Staff have commented that this process has helped them to make empathic connections to previously baffling and alienating clients.

Non-clinical staff need to have their subjective countertransference reactions normalized. These workers are in my experience typically dedicated and caring as they engage with clients in circumstances without clear roles or boundaries. A consultant can clarify that everyone has a particular history that is activated by working with clients and that staff may well find something particularly intense is evoked in them by a given client or worker-client dynamic. Staff may discover that they have something in common with a client. It's important to encourage staff awareness of the impact of identification with clients in readily developing a positive rapport, and the risks of over-identification with the attendant vulnerability to over-generalize from one's own experience. Many line staff have histories not altogether different from those of clients in programs in which they work, and their own experience – of living with HIV, history of drug or alcohol abuse, of domestic violence, history of loss, etc. – will likely become activated by client contact. Normalizing such experiences, encouraging self-care and offering referrals as needed for

outside support (e.g., to individual psychotherapy) are essential in supporting the workers.

Transference

Teaching the concept of countertransference before that of transference may feel more intuitive to staff than the reverse. Non-clinically trained staff are often more cognizant of the impact clients have on them than they are aware of the nuanced, unconscious and yet powerful ways in which clients experience their relationship to the worker. After a consultant first demonstrates a keen and empathic interest in the effect of clients upon staff and suggests the universality of countertransference reactions, non-clinical staff are primed to explore the impact of transference reactions, and to consider that the client views the worker in a particular light and in the context of the client's own unique history.

Certain non-clinical staff positions, particularly those that involve gate-keeping for services or doling out concrete benefits (e.g., money managers, rental subsidy coordinators, etc.), unsurprisingly have a high transference valence. Little is more evocative for clients than knowing a staff person has control over their access to money, food or other concrete benefits. While clients are likely to have intense feelings toward any person inhabiting a role so critical to meeting their basic needs, these gate-keeping jobs are typically filled by workers with little or no clinical training, who are often barraged by hostility, manipulation and accusations of incompetence by frustrated clients. As a supervisor or consultant, it's useful to discuss with staff the concept of transference, not only in the narrow sense – of ways in which the client may treat the staff person like an object (person) from their past – but in the sense of considering that the relationship, with all its characteristics, evokes and enacts a "*total situation*…transferred from the past" (Joseph 1985). Exploring the impact of transference can help staff to de-personalize intense client reactions to them and increase their capacity to empathize with clients who depend on staff for important basic resources.

Boundaries

The consultant or supervisor to non-clinical staff, particularly those involved in case management, ought to initiate discussions of the ways in which they consider and manage treatment boundaries. Much case management work involves crossing boundaries in ways that can be useful and therapeutic when applied judiciously. However, staff can quickly find themselves and their clients at risk of miscommunication, misunderstanding and boundary transgressions. Programs commonly require staff to make home visits to clients, to meet with clients on the street, and to transport clients in their personal vehicles. It is critical to discuss with staff the distinctions between boundary crossings and boundary violations (see Gabbard 1996), to sensitize staff to ways in which their work with clients outside an office setting requires them to operate on boundaries derived from within. At times staff may feel drawn to have extra-professional contact with clients (Williams and Swartz 1998) and may in fact see such involvement modeled by their colleagues or supervisors. The consultant can validate that such inclinations are expectable, and then explore with staff the (countertransferential) pull to make such contact with clients and to assist staff in making choices that clearly communicate to clients the exclusively professional nature of their working relationship. I have consulted on several cases in which staff had gone to coffee, lunch or the movies with a client, and I was left to explore with the staff person how the boundary transgression had led to an undesirable outcome in the client-worker relationship and how the staff might reflect upon their own conception of worker-client boundaries. Staff often have no formal training in establishing for themselves professional boundaries in working with clients in roles that offer little or no institutional boundaries.

Staff who make home visits can quickly become socialized into expecting to make these

visits alone, often as a consequence of staffing shortages or scheduling dilemmas. They may then find themselves confronted with situations with which a highly trained and clinically experienced clinician would struggle. I have consulted with a case manager who made a previously scheduled home visit to a client in a single-room-occupancy hotel where the client answered the door nude with pornographic videos playing, only to invite the staff person into the room; and a case manager who made a home visit to a married couple embroiled in a shouting match, the husband pushing the wife, and a hunting knife within the man's reach; and a housing subsidy coordinator directed to "go deal with" an apparently paranoid, homeless man loitering outside the agency. Staff are commonly put into highly charged and volatile clinical situations in which they have no clinical theory to turn to as a compass and no prior work experience to draw on as a map. They are left to reach for whatever they have available to them from within themselves or within arm's reach.

Within the realm of managing boundaries, staff not trained in clinical work struggle to navigate the quicksand of self-disclosure. Some staff may freely speak of themselves with little apparent inhibition or awareness of possible unwanted impact on the client. Clinical staff can rely on their past work experience, their knowledge of clinical theory, and clinical supervision to inform their choices regarding self-disclosure. However, non-clinical staff, typically without such resources, may follow the decorum of what may be appropriate and helpful in a social milieu, and thus quickly sink into problematic exchanges. I have noticed the inclination to share ways in which staff may identify with clients, in terms of ethnicity, HIV status, and history of addiction to or recovery from drugs or alcohol. While such self-disclosures can potentially offer clients a sense of being understood, there is the ever-present risk of over-identification and both clients and staff collapsing important differences. Also, increasing self-disclosure can incrementally erode (or impede the initial establishment of) a professional relationship directed at assisting a client in which the client feels held at a safe remove, by professional rapport, and free to accept what assistance is available without excessive guilt brought on by having to hold and care for delicate aspects of the provider's own experience. I have found it useful to explore among non-clinical staff the motivations for such disclosures and to discuss the agency culture for sharing such experiences with clients, as well as to probe the impact of transference and counter-transference issues on self-disclosure. Further, encouraging peer consultation among staff can enlarge the holding environment for intense countertransference states and invite informal peer supervision, typically resulting in more caution and containment among staff dealing with clients.

Giving and receiving gifts, both to and from clients, is in my experience not uncommon among line staff in certain programs. Discussion with staff who are drawn to give their own possessions or unauthorized agency resources to clients has repeatedly revealed an underlying experience of hopelessness and powerlessness in these workers. As the focus on most line staff jobs is on *doing* for and on behalf of the client, line staff are particularly prone to measuring the success of their work by behavior, by what gets done. Concrete plans can indeed assist clients in making significant psychosocial changes and can make important resources available to a client, but this investment in doing leaves the staff person vulnerable to serious disappointment and demoralization when action does not take place. Such staff are heavily invested in taking action, to a certain degree, as a manic defense against the feelings of overwhelming hopelessness and helplessness stirred up in them by the most difficult of clients in difficult circumstances. Emphasizing to such staff that their feelings are a revealing and potentially useful guide is an important starting point for often demoralized and under-supported line staff. This can carve out space for increased expression of feelings of helplessness and the development of more realistic expectations in the worker.

Conclusion/Manic Defense

A primary function of providing clinical supervision and consultation to non-clinical staff is to offer holding or containment of the supervisee. It is important to communicate explicitly and by example the value that case management, and even those job duties that are primarily administrative, can offer to clients: that listening to, feeling with and thinking with the client can offer important benefits. As staff may malign these dynamic functions as not adequately helpful in the concrete sphere in which they are drawn to facilitate and measure change in clients, the consultant or supervisor can hold this way of viewing the work and (re-)introduce such ideas to staff on an as-needed basis. The investment in omnipotent control by line staff may leave them feeling personally responsible for client outcomes, like a parent alternately blamed and credited for their child's behaviors. Recognizing that staff have done all they can for a client, and that the client may not be ready to take in what help is available, can often lead to an expression of deep sadness and demoralization at the fact that the client may well continue to flounder. The depressive states induced by such latent feelings of helplessness and hopelessness are often chronically avoided by manic doing -- always *doing.* And this is transferred to the next client and the next situation. Instead of allowing for the sadness and grief that underlie the manic defense, the staff person may become increasingly frustrated, feeling more and more ineffective and even resenting and hating the clients. Acknowledging with staff the tendency toward omnipotent control and encouraging them to make room for underlying grief can help relieve some measure of the exhausting burden of feeling responsible for clients' choices. This can assist staff both in creating more realistic worker and client goals and in moderating worker vulnerability to burnout.

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