

Conclusion

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We hope that as our readers conclude this book they will have a greater understanding of how every clinical encounter contains within it intersections of power and privilege, class and race, culture and religion, sexual preference, ability, history, and politics. These interwoven aspects of identity emerge in our relationships with our clients, and they need to be recognized, interrogated, understood, and made manifest when we work with those who are marginalized and oppressed. To do so requires a great deal of self-awareness on the part of the clinician, whose work it is to help clients become more aware as well. If knowledge is power, then self-knowledge, too, is power.

We also hope that the reader will make an ongoing effort to assess psychological problems within larger oppressive social structures. When working with those who have been discriminated against, we must be vigilant about the ways that social pathologies affect self and identity and even shape the brain. Immigrants may be made to feel as if they are aliens, gay or lesbian people may feel as if they must hide parts of themselves, people of color who have been disadvantaged may internalize their differential access to opportunity as reflective of self-worth. Those who have been institutionalized may feel dehumanized. Persons with disabilities may be treated as deficient. Prisoners or mothers who are pregnant and suffer from

addiction may internalize societal blame. Yet none may fully recognize the traumatic social and psychological sources of their distress. In short, stigmatized groups often internalize the stereotypes of the dominant group, and our work is to make this external and conscious.

Psychodynamically oriented practice is always about making knowable what is unconscious and unknown. It is about trying to understand with our clients how early relationships and social structures shape feelings, thoughts, and behaviors in ways that may not be adaptive but are reenacted unconsciously nonetheless. Psychodynamic theory and practice offer ways to create new kinds of relationships in which one may feel understood, valued, held, recognized, and known.

To work with those who have been oppressed, clinicians need to remain open and attuned to the nuances of poverty, addiction, and trauma. This is never easy. It means occupying emotional spaces that are uncomfortable, painful, unfair, and often traumatic. Empathic engagement also requires recognizing the systemic social structures that are truly pathological in which we all participate. As helpers, it is difficult to acknowledge our role in systems of domination and subordination. Yet we must recognize our power and privilege to not distance from or overly identify with our clients' victimized status.

In 1852 Karl Marx (1972) wrote, "The traditions of the dead generations weigh like a nightmare on the brains of the living" (p. 46). By this he meant that social histories, just like psychological histories, weigh on us all. These are inevitably reproduced in the consulting room, and we must feel their great weight in our everyday work.

In whatever system we work in, we are embedded in structures that tend to reproduce oppression. We have learned, for example, that the number of African Americans in the criminal justice system is simply staggering. One in every 31 U.S. adults in 2008 was in prison, on probation, or on parole—and of this population a highly disproportionate number were young black males, products of unequal educational systems, highly segregated communities, inadequate social services, and the expectations of failure from the dominant class. One in 15 black men above age 18 in 2008 was in prison, compared to 1 in 106 white men. More striking, minorities constitute 63 percent of youths held in juvenile detention, though they represent just 34 percent of the youth population. Prison affects every facet of life. It separates offenders from their families and partners, stigmatizes them, eliminates certain job opportunities, and has profoundly

isolating and damaging psychological effects (J. Berzoff-Cohen, personal communication, 2009). How do we deal with these social inequities, while still maintaining hope and finding value in the individuals with whom we work?

The authors of this book believe that holding a psychodynamically oriented perspective is essential. Psychodynamic theories have a long history. When considered critically and applied deliberately and empathically, they hold great merit for our work with vulnerable people today. In 1942, in the midst of a war and the wake of a depression, social worker Bertha Reynolds posed the following question in her book *Learning and Teaching in the Practice of Social Work*: “In a year of crisis, why should there be a book which is the distilled essence of experience of years that are past? . . . Should we not look forward rather than back?” (1965, p. v). The answer, both in Reynolds’s time and in our own, is that we must do both. A psychodynamic frame helps us as clinicians working on both a systemic and an individual level to keep our work grounded in the past with a sharp knowledge of the present and an eye to the future.

These theories allow us to understand the degree to which our clients may serve as repositories for society’s hate and fear. They guide us in helping our clients integrate thoughts, feelings, and experiences that have been split off and dissociated. Psychodynamic theories enable us to hold those split-off feelings and memories (as unbearable as they may be) until our clients are ready to integrate and metabolize them. These theories help us offer new kinds of relationships and attachments. They give us ways to help our clients see all sides of themselves and others. With a psychodynamic frame, we are more able to withstand our clients’ hate, often directed at us, without retaliation. We are able to understand our clients’ conflicts and needs to repeat what has not been mastered. We can better identify strengths in the individual, family, and community. Psychodynamic theories offer us ways to challenge environments that are neither average nor expectable. And they help us advocate for clients, changing environments that are pathological.

Inevitably, in relationally based clinical work, we enact and reenact traumatic situations and microaggressions with our clients. A part of our work is to make these enactments open to examination and to understanding, so that new and different outcomes are possible. Therefore, as clinicians we need to be flexible—willing to fully engage with our clients in ways that are sometimes difficult, while remaining consistent and attuned. Mistakes and

misattunements, however, are also inevitable and we should model ways of repairing them with our clients.

We cannot be neutral or objective, distant or blank screens. There may be times when we need to feed a client who is hungry, take a client who is blind shopping, or be open and real with someone who is chronically mentally ill. Very often we must name racism, state-sanctioned genocide, or homophobia. Always we need to be active in challenging policies that undermine attachments or perpetuate maintaining false selves. We are not only companions on a journey but active advocates, willing to break boundaries as long as we understand them first. Social justice and psychodynamic theorizing are not mutually exclusive. Both are essential to working with those who are most at risk.

Mary Richmond, an early social work pioneer, understood this in 1917. The author of the book *Social Diagnosis*, she wrote of the necessity of understanding a client “through her family history, family life, schooling and aspects of the environment.” She saw assessment as including “both the company one keeps plus the company that one’s ancestors kept” (p. 51). Richmond (1917) believed, “For the immigrant family, the deserted, the widowed, the neglected child, the blind person, the homeless person and the mentally ill person, casework involves understanding an individual’s relationships to others from as many sources as are possible” (p. 52).

Those many sources are social, psychological, and biological. If we can hold them in our minds simultaneously and help our clients do the same, the weight of the past may be easier to carry. We hope that our readers will stay engaged with those at risk in caring and consistent ways. We hope they will collaborate with their clients in making the unthinkable thinkable, the unbearable bearable. Recognizing ourselves in our clients and helping them find themselves in us is an essential part of our clinical work and of our shared humanity.

References

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