CLINICAL SOCIAL WORK: DEFINITION, VALUES, KNOWLEDGE, AND PRACTICE

Josephine Arburua Jackson

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THE INSTITUTE FOR CLINICAL SOCIAL WORK

CLINICAL SOCIAL WORK: DEFINITION, VALUES, KNOWLEDGE, AND PRACTICE

A PROJECT DEMONSTRATING EXCELLENCE PRESENTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN CLINICAL SOCIAL WORK

BY
JOSEPHINE ARBURUA JACKSON, M.S.W.

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INSTITUTE FOR CLINICAL SOCIAL WORK

We hereby approve the Project Demonstrating Excellence

CLINICAL SOCIAL WORK:

DEFINITION, VALUES, KNOWLEDGE,AND PRACTICE

by

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ABSTRACT

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This research was completed as partial fulfillment of the requirements for the Doctor of Philosophy in Clinical Social Work from the Institute for Clinical Social Work.

In this thesis, the genesis of the professional title, clinical social work, is traced in California legislation and in the social work literature as the term is infrequently used outside the two national registries.

A national sample of clinical social workers was questioned and their responses were subjected to statistical analysis. The factor analysis links groups of items--clinicians' perceptions regarding definition of the title as well as values, knowledge-base, and practice--which appear to share underlying dimensions.

Clinical social workers define themselves by basic qualifications (M.S.W. plus social work values and knowledge) and by function. They provide counseling and psychotherapy for psychosocial problems and help create societal conditions favorable to human fulfillment.

The items relating to values express both strong commitment to the worth and dignity of the individual and belief that social work often represents society's responsibility to the individual.

Analysis of the data relating to knowledge-base indicates strong support for in-depth knowledge of practice theory articulated with appropriate interventions. Graduate education, social work practice wisdom, and continuing professional development (particularly regarding personality development and practice theory) are highly esteemed. While theoretical pluralism is acceptable, there is strong preference for psychoanalytic theory.

Data concerning practice demonstrate that clinical social workers provide mental health services for individuals, families, and groups; they teach and offer supervision and consultation. They focus on patient needs, intra- and interpersonal.

The conclusions suggest increasing cleavage between clinicians and academicians in social work. Differences involve language use, theoretical

framework, and perception of adequate academic preparation. Finally, the Institute for Clinical Social Work appears to be the most appropriate setting in which to explore the characteristics and integration of advanced social work practice with doctoral-level psychotherapy.

June 8, 1979
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I want to express my special thanks to Jeffrey M. Jackson for his consultation and important aid on the statistical aspects of this study. I appreciate, as well, the information and assistance given my by Lola Selby, Louise Jackson, Robert Dean, and Judith Capone.

To Dale

To every thing, Turn Turn Turn,

There is a season, Turn Turn Turn,

And a time for every purpose under heaven.

(Ecclesiastes - Pete Seeger)

INTRODUCTION

Definition by Audacity

Clinical social workers describe themselves primarily as the psychotherapists within the social work profession.

In November 1975 the author, one of three representatives of the National Association of Social Workers (NASW), met with the Medical Director of Blue Shield Insurance Company. The meeting was scheduled as part of the California Chapter's pursuit of vendorship[1] for Licensed Clinical Social Workers. The meeting, anticipated merely as an exchange of pleasantries, lasted 2½ hours. Once it had been clarified that M.S.W. did not stand for Medical Social Worker, we (the two practitioners in the group) audaciously defined, for the Director and his Contract Manager, clinical social work to be what we were doing. We were psychotherapists working, on an outpatient or inpatient basis, with individuals, groups, and families. Our services included dealing with others significantly involved in our patients' lives--school personnel, physicians and other health care professionals, law enforcement agencies, and so forth. The author, then Clinical Director of a large, private agency, indicated her professional staff engaged in similar clinical social work practice.

After this landmark meeting (Blue Shield did give provider recognition to Licensed Clinical Social Workers in 1977), the audacity of our forthright definition of clinical social work seemed extraordinary.

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[1]Vendorship: payment for psychotherapy provided by licensed clinical social workers by health care insurance and other contract plans.

Professional social work, much less clinical social work, had not achieved definition. In fact, the issue is a current one.[2]

Undaunted, we plunged ahead, seeking vendorship via legislation; the author became a member of NASW's Statewide Vendorship Commission. Together with the Society for Clinical Social Work and many other social workers, we lobbied effectively for passage of Assembly Bill (S.B.) 2374, the Torres "Freedom of Choice" bill, which mandated inclusion of licensed clinical social workers as mental health services vendors for private health insurance.

The passage of the legislation attested to the persistence and clarity with which we defined ourselves to legislators and physicians (whose letters of support we solicited). We proclaimed that clinical social workers were already sanctioned by California law as non-medical psychotherapists. We had special training and experience in working with our patients' real-life situations and we were professionals with high ethical standards. The public approval accorded clinical social workers often resulted in early, less fearful use of our services rather than those of psychiatrists.

We had found it necessary to set apart our group of social workers. After all, "social worker" can be title of the high school graduate who establishes eligibility for public hospital services or the Bachelor of Social work who licenses nursery schools. It had become apparent that the assumption of a distinguishing title which identified professional psychotherapists (within social work) was critically important.

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[2]NASW sponsored a forum in June 1979 in which participants contributed to a proposed definition of clinical social work practice.

The momentum for a distinguishing title was generated in California in 1968 when clinical social workers were licensed as psychotherapists. Social workers in other states are licensed as "certified social workers," "licensed graduate social worker," and a number of other titles. It was out of the California movement that national registries, which list over twelve thousand practitioners, incorporated the title, clinical social worker.

Who are clinical social workers? What do they do? What are their qualifications? What are the boundaries of their practice? Do they identify with essential social work values? How appropriate is the social work master's curriculum to clinical practice? Has this group evolved a new specialization with the profession?

Purpose of the Research

Research defining and describing social work practice and knowledge is extremely limited. Authors (more often academics than practitioners) describe what <u>should</u> be valued, known, and accomplished instead of researching the realities of practice. The title, clinical social work, delineating a special group of social workers, has emerged only within the last ten to twelve years; therefore, it is appropriate and timely to address how these publicly-sanctioned professionals describe themselves and what they are doing.

The purpose of the research described here is to collect information regarding the definition of the title, clinical social worker, as defined by the clinicians themselves, as well as their perceptions of identity and function, professional values, knowledge, and practice. Such research can be valuable and useful in a number of ways:

1. The results can be used to impact efforts to develop relevant professional education. Educators can better focus curricula and learning experiences to include that which clinicians describe as most appropriate. It is currently speculated that about two-thirds of social work students wish to become clinicians and about one-third of the schools of social work offer clinical sequences.
2. Those working with legislators can use research results to describe the role and function of social work clinicians; this information can be useful in the areas of licensing, vendorship, and other legislation.
3. Peer review mechanisms can reference research when judging questionable claims regarding appropriateness of service.
4. Vendorship negotiations with insurance companies and other third-party payers can be facilitated with better-documented descriptions of function and practice.
5. Those involved with declassification and personnel utilization issues can use such findings to support standards of education and experience for clinical social work positions.
6. Clinical social work, clearly defined and described, can be better represented in the public view.

For this research, social workers qualified for and listed in the 1976 National Registry for Health Care Providers in Clinical Social Work[3] were questioned. Their responses identify the important elements of their

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[3]National Registry of Health Care Providers in Clinical Social Work (3rd ed., Lexington, Ky.: Board of the National Registry of Health Care Providers in Clinical Social Work, 1978). (Hereinafter referred to as Registry of Health Care Providers.)

qualifications and serve to shape a definition of their title. Additionally, the results indicate the identification of these social workers with core professional values and knowledge, and give a description of practice activities as well. The collected data shape a profile of clinical social workers vis-a-vis demographic information, theoretical orientation, involvement in continuing education, concern for social action, and other parameters of professional practice.

Hypotheses

A number of hypotheses have provided a base for this research; they have shaped both the questionnaire and the data analysis:

1. Clinical social workers do not believe the B.S.W. is academic entry to the profession.
2. Clinical social workers identify with social work values.
3. Clinical social workers rely on the knowledge gained in their master-of-social work education.
4. Clinical social workers continue their education and training past the M.S.W. for ongoing professional development.
5. Clinical social workers rank highly psychodynamic theory and practice.
6. Clinical social workers prefer experiential to didactic learning.
7. Clinical social workers focus on the interaction of the biological, psychological, and social forces in the lives of their patients.
8. Clinical social workers offer mental health services to individuals, families, and groups.
9. Clinical social workers are involved with social action.

In the section on results and discussion (Chapter IV) these hypotheses will be examined with regard to the relevant questionnaire items and statistical analysis.

The California Experience: A Historical Perspective

Background to licensing

The title, clinical social work, was shaped in California. It developed out of crisis and its definition and development have been a part of considerable struggle within the profession. Clinical social work has followed a high-energy course; it has generated the Clinical Social Work Journal, the state Societies for Clinical Social Work, and the National Federation of the Societies; it has achieved warm acceptance or vociferous rejection by academe, NASW, and other professional organizations; it has affected the accomplishment of legislation and other political stature; it has sparked intense controversy regarding the education, practice, and goals appropriate to professional social workers.

It is useful to examine how this process began and to consider the context out of which clinical social work has evolved.

> Our California experience . . . culminated in the licensing of clinical social work practice in California, giving birth to clinical social work, our Society [for Clinical Social Work] and our Institute [for Clinical Social Work]. . . . Especially I wish to make clear that clinical social work, as it developed in California . . . does indeed represent the maturing of a profession.[4]

Legislation for licensing

Prior to the 1960s California social workers were involved with the legal regulation of practice. In 1928 a bill for registration was

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[4]Robert L. Dean, "A Self-Conscious History of Clinical Social Work in California" (unpublished manuscript, 1978), p. 3. (Typewritten.) (Hereinafter referred to as "History.")

introduced in the Legislature; in 1945 a law was passed authorizing voluntary registration of social workers and establishing the Board of Social Work Examiners to administer the law. The development of private practice during these years emphasized the need for standards and consumer protection. In 1953 San Diego enacted an ordinance to license the private practice of social work; in 1957 the Sacramento Chapter of NASW formalized a certification procedure for its members in private practice. Meanwhile, at the national level, NASW became interested in and alarmed about the validity of private practice within the social work rubric.[5]

Three Californians (Robert L. Dean, Gertrude Sackheim, and John Wax) participated in the proceedings of the Committee on Standards for Private Practice of the NASW Practice Committee. This group formulated the standards adopted in 1960 by the Board of Directors of NASW. These standards were later included in the California certification bill of 1967.[6]

During the 1960s many questions concerning the inherent value of clinical work within the social work profession were brought to fore. Social activism was the cause of the decade; professional training (as it had developed through the years) and public support of direct practice were in jeopardy. In the midst of the upheaval, "the notorious Attorney General's opinion of June 14, 1966, denying to California social workers the legal right to practice psychotherapy, provided a brutal shock to all clinicians"[7] and became the rallying point for the chain of events which was to impact social work throughout the country. The shock generated by

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[5]Ibid., pp. 19-20.

[6]Ibid., p. 5.

[7]Ibid., p. 27.

the Attorney General's opinion was enhanced by the realization that social workers had not been among the professional groups included under the psychotherapist-patient privileged communications regulations of the 1967 revision of the Evidence Code of the State of California.

These exclusions effectively aroused the wrath and determination of social work practitioners (who were not necessarily in agreement regarding solutions), and an ad hoc group met in October 1966 "to obtain a constructive legal solution to the Attorney General's opinion."[8] At this point, Verneice Thompson, Chair of the Private Practice Committee of NASW, Golden Gate Chapter, joined forces with Robert Dean, Chair of the Practice Commission of NASW, Golden Gate Chapter. The latter group sponsored a three-day workshop attended by clinicians in California and by Arnold Levin from Chicago.

At the end of this workshop, the group met in Thompson's private office and began the work which resulted in California being the first state to license clinical social work practice. Attending this meeting besides Thompson, Dean, and Levin, were Robert Aguado, Lester Fuchs, Margaret Rose, and an attorney from southern California.[9] With wide geographic and varied practice-setting representation, the group named itself the Statewide Ad Hoc Committee on Social Work Legislation. This Committee, having met in October 1966, was soon appointed by the President of the State Council of NASW as the Social Work Legislation Committee of the State Council of NASW. This group, entrusted with the task of drafting a licensing bill, came to grips with the problem of what to license:

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[8]Ibid., p. 34.

[9]Verneice Thompson, Personal communication, 1979.

> After considerable discussion we finally rejected the familiar title of psychiatric social worker because of its aura of dependence on medicine and on setting. The group accepted my recommendation of the title clinical social worker. This was a descriptive title already in use in the VA and in some medical settings. It broke the unfortunate tie with setting under which we had labored so long.[10]

Other members of the group involved in the adoption of the title have generously shared memories. Fischer, who chaired the committee that wrote the practice licensure statutes, notes that clinical social work was "conceptually . . . derived from the consideration of clinical psychology, clinical medicine, etc., in that it represented practice rather than theory."[11] He cites Webster's Collegiate Dictionary: "clinician, n. One versed in clinical medicine or surgery; also, an expert in social work clinics."[12] An information sheet prepared by the Social Work Legislation Committee describes some of the thinking of the times regarding the new title:

> The title clinical is being used to break the cast of social work settings, to describe social work practice to encompass all settings and methods. It means the use of direct observation of the client and the application of objective and disciplined methods to the description, evaluation and modification of human behavior. It includes community organization as a clinical process using these methods with clients and client groups toward these ends.[13]

It is apparent that the significant issue in the choice of the title, clinical social work, was the recognition of autonomous, responsible practice focused on the client rather than on setting and auspices.

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[10]Dean, "History," p. 34.

[11]Konrad Fischer, Personal letter, 1979.

[12]Webster's Collegiate Dictionary, 5th ed., 1947.

[13]NASW, Social Work Legislation Committee, "The Proposed Legislation to License the Title, 'Certified Clinical Social Worker'," 1966, p. 2. (Mimeographed.)

The Committee's efforts to define clinical social work for legislation was impacted by Grimm's The Common Ground of Social Work which focuses on the common purpose and special contribution of professional social work. Grimm insists that academic preparation, solely, is not a sufficient determinant of professional identity:

> Professional social work is a service in which a special knowledge of social work resources, social systems and social action, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate satisfying and productive lives--people whose circumstances and limitations in their capacities have prevented them from meeting basic human needs and availing themselves of opportunities to develop their natures which are their rights as individuals and their just entitlements as members of a democratic society.[14]

This was an important break with the time-honored standard that the M.S.W. was the criteria of professionalism in social work. In this significant statement, Grimm insists that social work professionalism must meet three standards: education and training (the M.S.W.), performance and expertise, and values.

The Committee, overcoming heated differences within the profession, developed what became S.B. 433 to license the title, Certified Clinical Social Worker. (Not until August 1970 did S.B. 480 extend privilege to communications between clients and Licensed Clinical Social Workers and Licensed Marriage, Family and Child Counselors.) S.B. 433 was introduced to the legislature on February 22, 1967, and signed into law by the Governor in August 1967. The title, clinical social worker, was thus certified and, almost immediately, came under fire. Executive reorganization of State threatened to abolish the Board of Social Work Examiners and its regulatory program of certification.

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[14]William Grimm, "The Common Ground of Social Work" (revised September, 1966), p. 3. (Mimeographed.)

Responding to this threat, the Committee agreed to revise and enlarge the language of the certification statute, and S.B. 1224 to license the practice of clinical social work was introduced to the Legislature on April 16, 1968. During the ensuing months the cleavage between NASW and the clinicians who supported the legislation became firmly entrenched. The former took the position that the profession was not ready for licensing practice and that any licensing should start at the entry level (M.S.W.) into the profession. NASW had strong objections to the licensing of advanced practitioners (the draft bill was written for five years of post-master's experience, but was modified in the legislative proceedings to require two years). However, S.B. 1224 was signed by the Governor, and the clinical social work title was official, legal, and defined. Thus, those social workers who had been principally known to the professional community and the public as psychiatric social workers or caseworkers acquired a new and largely unfamiliar title. Within the first year almost four thousand social workers were licensed. A little more than ten years later, there are now 5,541 persons licensed as clinical social workers in California.[15]

The Society for Clinical Social Work

The schism between NASW and the developers and supporters of S.B. 1224 made the notion of a separate professional organization an expectable and natural one. By September 1968, ninety-three social workers were ready to begin the groundwork for what, six months later, became the Society for Clinical Social Work. In six months' time, there were over two hundred members and now, ten years later, there are 1,500 members.

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[15]Dean, "History," pp. 54-58.

Robert L. Dean, an important participant in this historic process, became the first Executive Director.[16] Bernice Augenbraun and Verneice Thompson were elected President and President-Elect, respectively. The First Scientific Meeting of Clinical Social Work was held in 1971 in San Francisco under the direction of Thompson.

The "California experience" was quickly to become a nationwide thrust. Spearheaded by Dean, the National Federation of Societies for Clinical Social Work was formed in 1971. By the end of 1978, there were twenty-six state Societies for Clinical Social Work; eighteen of these were affiliated with the Federation. Societies were also forming in other states.[17]

A further development in California was the founding of the Institute for Clinical Social Work in 1974. The Institute was established by the Society for Clinical Social Work to meet the demand for advanced, individualized study toward a degree by experienced social workers who wished to maintain their practices. The program was expected to attract (and has attracted) clinicians with demonstrated capacity for autonomous work and considerable post-master's training. After two years of planning and discussion, the Institute convened a group of volunteer Fellows of the Society who paid $1,000.00 each and devoted tremendous energy to the development of structure and program. In 1977 the first doctoral candidates were admitted, and the Institute became qualified under California law to grant degrees. Programs in both the developmental year and the following two years were under the leadership of Dean Jean Sanville who

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[16]Ibid., p. 40.

[17]Constance B. Margolin, "News of the Societies," Clinical Social Work Journal, VI (Winter, 1978), pp. 330-32.

awarded six Doctor of Clinical Social Work degrees at the first commencement in 1978.[18]

Dean concludes his valuable study, "A Self-Conscious History of Clinical Social Work in California," with a statement relevant to this research:

> As it approaches its tenth anniversary, the Society of Clinical Social Work can look back on some major professional accomplishments. However, there remain disturbing elements to consider. After ten years the professional identification problem of clinical social workers continues unresolved. Clinical social work theory has not evolved in any discernible fashion.[19]

Jannette Alexander, in her address as outgoing President of the Society for Clinical Social Work, describes her perception of this California experience. She notes that social workers had in the past accepted the idea that their identity was subservient to their employment (i.e., kidney dialysis worker, adoptions worker, hospital social worker) and that they would never fully achieve professional maturity. In the ten years between 1967 and 1977, however, clinical social work had become "'independent practice' determined by our own professional philosophy and expertise, and not by the function of the agency in which we practiced."[20]

The forward look addressed by Verneice Thompson in her Presidential Address at the Second Biennial Scientific Conference of the Society for Clinical Social Work illustrates the vision, energy, and confidence of

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[18]Jean Sanville, "The Play in Clinical Education: Learning Psychotherapy" (unpublished Ph.D. dissertation, International University, Los Angeles, 1978).

[19]Dean, "History," p. 61.

[20]Jannette Alexander, "Metamorphosis: The Consciousness Raising of Clinical Social Work" (Presidential address at the 8th Annual Scientific Conference of the Society for Clinical Social Work, Los Angeles, Oct. 28, 1977), p. 12.

the movement. In "The Need for New Myths" she notes that the role of social workers has long been governed by the "saviour of the world myth." New realities, she observes, focus on the person of the social worker: better integration of intellectual and emotional lives; growth of clinicians related to growth of clients; and, "the development of the full humanity of clinical social worker." Enhancing the quality of life for clients and clinicians means changing social systems and ourselves. She urges research and clinical training oriented "toward a study of clinical practice, social systems, and the psychological development of practitioners."[21] Such bold directions!

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[21]Verneice Thompson, "The Need for New Myths" (Presidential address at the 2nd Biennial Scientific Conference of the Society for Clinical Social Work, Los Angeles, Oct. 12, 1973), pp. 9-17.

REVIEW OF THE LITERATURE

The reader will recall that the purpose of this research is to explore the title, clinical social work, and its place within the context of social work. This review includes a brief presentation of the social work context out of which the title, clinical social work, emerged as well as summary material regarding values, knowledge, and practice. The review is based exclusively on social work literature in order to establish guidelines to determine how and if clinical social work fits within the social work rubric. The research questionnaire was developed from the same source as will be detailed later.

The Title

The social work context

It appears that the term "social work," key words in the title of this study, emerged in a fashion similar to the newer term, clinical social work. Other titles such as "applied philanthropy"[1] and "friendly visiting"[2] were turn-of-the-century terms. By 1908 the pioneer, Mary E. Richmond, settled on the title, "The Family and the Social Worker."[3]

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[1]Mary E. Richmond, "The Need of a Training School in Applied Philanthropy," Proceedings of the National Conference of Charities and Corrections, 1897 (New York, 1897), pp. 181-87.

[2]Mary E. Richmond, Friendly Visiting Among the Poor (New York: Macmillan, 1899).

[3]Mary E. Richmond, "The Family and the Social Worker," Proceedings of the National Conference of Charities and Corrections, 1908 (New York, 1908), pp. 76-80.

In 1917 the National Conference of Charities and Corrections was changed to the National Conference of Social Work. Perhaps this marked the official baptism of the name of the profession.

Early articles mark the beginnings of efforts to define the role, boundaries, professionalism, function, sanction, knowledge, theoretical base, fields, values, and methods of social work. Contributors asked important questions which continue to be addressed: "Is Social Work a Profession?";[4] "What is Social Casework?";[5] "What is Social Group Work?"[6] Together with the probing literature of the first decades was published a wealth of material regarding professional training, early theoretical frameworks, and the accumulating practice, knowledge, and experience (often referred to as practice wisdom). By the early 1930s social work readily fit within the definition of profession:

> A calling requiring specialized knowledge and often long and intensive preparation including instruction in skills and methods as well as in the scientific, historical, or scholarly principles underlying such skills and methods, maintaining by force of organization or concerted opinion high standards of achievement and conduct, committing its members to continued study and to a kind of work which has for its prime purpose the rendering of a public service.[7]

Within a few decades social work became a profession sanctioned by our society; a profession with a constellation of values, knowledge,

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[4]Abraham Flexner, "Is Social Work a Profession?" Proceedings of the National Conference of Charities and Corrections, 1915 (New York, 1915), pp. 576-80.

[5]Mary E. Richmond, What is Social Casework? (New York: Russell Sage Foundation, 1922).

[6]Wilber I. Newstetter, "What is Social Group Work?" Proceedings of the National Conference of Social Work, 1935 (Chicago, University of Chicago Press, 1935), pp. 291-99.

[7]Webster's Third New International Dictionary, 8th ed., 1971.

purpose, and methods taught within recognized educational institutions. This profession engendered a number of organizations (e.g., American Association of Social Workers, American Association of Medical Social Workers, American Association of Psychiatric Social Workers) concerned with maintaining high standards of education, conduct, and service.

Social work services were early defined as "direct" and "indirect": group work and casework fell under the former heading and community organization under the latter. Since clinical social work, in this research, is concerned with direct services, its antecedents are traced in the group work and casework literature.

Casework theory development

Mary Richmond was granted an honorary M.A. by Smith College which, in 1918, "established a training school for psychiatric social work in response to the increased demand for workers to handle the emotional problems of returning World War I veterans and their families. Thenceforth, casework was extended to persons above the poverty line."[8]

In the 1920s increased emphasis was placed on the inner world of individual experience in the culture and in the profession. Social workers rapidly became devoted to Freud, his writings, and his followers who became the teachers and trainers. These social workers, the diagnostic group, were first immersed in Freudian id psychology and, some years later, turned to ego psychology. Insights, treatment techniques, the importance of diagnosis, and exploration of the unconscious aspects of the treatment relationship (transference and counter-transference) focused on

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[8]Carel Germain, "Casework and Science: A Historical Encounter," in Theories of Social Casework, ed. by Robert W. Roberts and Robert H. Nee (Chicago: University of Chicago Press, 1970), p. 12.

service to the individual. Problems were defined in personality terms. "High value was accorded the client's motivation, verbal skills, and interest in introspection."[9]

The social workers who followed the psychoanalytic concepts of Otto Rank soon developed an oppositional approach, and founded the functional group. This group, centered at the University of Pennsylvania School of Social Work, wrote prolifically and are represented in the work of Virginia Robinson, A Changing Psychology in Social Casework[10] and Jessie Taft, A Functional Approach to Family Casework.[11] While the twenty-year functional/diagnostic controversy seems long ago, current social work literature still honors these approaches (e.g., Francis J. Turner, Social Work Treatment, 1974[12] and Robert W. Roberts and Robert H. Nee, Theories of Social Casework, 1970[13]). As with the diagnostic school, many now-familiar, core social work notions developed from the Pennsylvania school: concepts about the therapeutic process; important ideas about the use of time, fees, and treatment contracts; the meaning of beginnings and endings in the treatment relationship; and the awareness of the impact of giving and receiving help.

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[9]Ibid., p. 16.

[10]Virginia Robinson, A Changing Psychology in Social Casework (Chapel Hill: University of North Carolina Press, 1930).

[11]Jessie Taft, A Functional Approach to Family Casework (Philadelphia: University of Pennsylvania Press, 1944).

[12]Francis J. Turner, Social Work Treatment: Interlocking Theoretical Approaches (New York: Free Press, 1974). (Hereinafter referred to as Social Work Treatment.)

[13]Robert W. Roberts and Robert H. Nee, eds., Theories of Social Casework (Chicago: University of Chicago Press, 1970). (Hereinafter referred to as Social Casework.)

Two significant contributors who counterbalance the intrapsychic focus for caseworkers are Charlotte Towle and Gordon Hamilton. Towle writes, "We know also that unmodifiable adverse social circumstances are decisive and that the tender ministrations of an understanding relationship cannot compensate for basic environmental lacks, meager services, and restrictive agency policies."[14] Gordon Hamilton, publishing from 1923 into the sixties, developed ideas essential to the social work framework: the person-in situation or psychosocial configuration; emphasis on growth, development, and change; interaction and multiple causality in human events; and the engagement of the client as an active participant in change.[15]

Three somewhat later landmark publications bring together casework thought and practice at mid-century: Helen Harris Perlman, Casework: A Problem-Solving Process;[16] Florence Hollis, Casework: A Psychosocial Therapy;[17] and Ruth Smalley, Theory for Social Work Practice.[18]

Perlman, having made the shift from id to ego psychology, sees the problem-solving process in casework as "a forward moving course of transactions between active agents [caseworker and client]. . . . The problem-solving process aims to release and exercise the ego's functions of

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[14]Charlotte Towle, "Social Casework in Modern Society," Social Service Review, XX (June, 1946), p. 165.

[15]Gordon Hamilton, Theory and Practice of Social Casework (Rev. ed.; New York: Columbia University Press, 1951).

[16]Helen H. Perlman, Social Casework: A Problem-Solving Process (Chicago: University of Chicago Press, 1957).

[17]Florence Hollis, Casework: A Psychosocial Therapy (New York: Random House, 1964).

[18]Ruth E. Smalley, Theory for Social Work Practice (New York: Columbia University Press, 1967).

perception, feeling, cognition, comprehension, selection, judgment, choice, and action as they are required to deal with the problem under consideration."[19] Perlman's model further modified the analytic concern for bio-psychosocial organization of the total personality to diagnosis focused on the "problem-to-be-worked," the client's capacities and motivation, as well as the appropriate resources available to the client and/or those to be mobilized by the social worker.

Hollis sees the origins of the psychosocial or diagnostic approach in the psychoanalytically-oriented graduate programs at Smith and the New York School of Social Work. Additions to this theory were made from many sources including Piaget, Erikson, Lewin, and the social sciences. She writes:

> Casework has always been a psychosocial treatment method. It recognizes both internal psychological and external social causes of dysfunctioning, and endeavors to enable the individual to meet his needs more fully and to function more adequately in his social relationships. . . . Central to casework is the notion of "the-person-in-his-situation" as a threefold configuration consisting of the person, the situation, and the interaction between them. . . . Intrapsychic factors causing personal difficulties for adults are usually modified through work with the individual directed toward modification of the dysfunctioning aspect of the personality.[20]

It is interesting to note that in 1970 Hollis chronicles considerable change in psychosocial theory. "Today the psychosocial view is essentially a systems theory approach to casework . . . the person to be helped--or treated, if you prefer--must be seen in the context of his interactions or transactions with the external world; and the segment of the external

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[19]Helen H. Perlman, "The Problem-Solving Model in Social Casework," in Social Casework ed. by Roberts and Nee, p. 9.

[20]Hollis, Casework: A Psychosocial Therapy, p. 68.

world with which he is in close interaction must also be understood."[21] Diagnosis, the psychosocial study, and the treatment relationship remain central issues as the caseworker addresses environmental as well as interpersonal and intrapsychic problems.

Smalley updates still another viewpoint developed in the 1930s, the functional approach. She differentiates her approach from diagnostic theory which she states works from a psychology of illness; functional theory operates from growth, and the professional relationship is one which releases the client's own choices and development. Thus, rather than treatment, the functionalist engages the client in a helping process in which together they discover what the client could do with the help. The caseworker's responsibility is focused on his/her part in the process. The functional framework has drawn extensively from the behavioral sciences, Erikson, Pray, Selye, and many others.[22]

Group work theory development

By mid-century direct services in social work were carefully delineated into casework and group work. Hearn, in 1974, looks back at the dichotomous situation:

> Group work and casework were sharply differentiated in those days [1948] and a student was required, when entering school [graduate school of social work], to make a choice as to whether to specialize in work with individuals or work

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[21]Florence Hollis, "The Psychosocial Approach to the Practice of Casework," in Social Casework ed. by Roberts and Nee, pp. 35-6.

[22]Ruth E. Smalley, "The Functional Approach to Casework Practice," in Social Casework ed. by Roberts and Nee.

> with groups. The idea that one could be trained for or in subsequent practice that one could do both was strongly denied and discouraged.[23]

Since clinical social workers work with individuals, families, and groups, it is important to trace some development of group work theory in order to get a comprehensive view.

Therapeutic use of groups in social work has its heritage in social group work from the 1890s to the late 1930s. The social settlement movements, youth clubs, and adult education were the settings in which group work theory developed. Cooley introduced the idea that the group is a means of socialization as well as internalization of values and beliefs. The "group mind," a precursor of the notion of group contagion, interpersonal subgroupings (dyads and triads), role theory, concepts regarding group validation of the self, problem-solving groups, and the use of group to actualize personal growth and change were major ideas that came out of the work of Lindeman, Dewey, Allport, and many others. Concurrently, the knowledge about function, structure, interaction, and development of small groups burgeoned.[24]

Through the forties and fifties the uses of the group modality in social work shifted from adaptation and adjustment to change and rehabilitation. The further trend of group as a therapeutic modality was influenced by the early work of Grace Coyle[25] and W. I. Newstetter[26] as well as

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[23]Gordon Hearn, "General Systems Theory and Social Work," in Social Work Treatment ed. by Turner, p. 344.

[24]Robert W. Roberts and Helen Northen, eds., Theories of Social Work with Groups (New York: Columbia University Press, 1976).

[25]A classic paper which suggests human activity must be tested by its contribution to social change; see Grace L. Coyle, "Group Work and Social Change," Proceedings of the National Conference of Social Work, 1935 (Chicago: University of Chicago Press, 1935), pp. 393-405.

[26]This was the first theoretical approach to social work in group operation; see Newstetter, "What is Social Group Work?"

Wilson[27] who made notable advances in relating casework and group work. Gisela Knopka further elaborated the use of therapeutic groups in psychiatric clinics, hospitals, and in residential treatment settings.[28] Work with families is sometimes seen in the profession to have developed in the context of this expanding awareness of the therapeutic value of groups.

By 1972 Reid and Epstein had developed a typology of problems for which work in groups was effective: interpersonal conflict, dissatisfaction with social relationships, problems with formal organizations, difficulties in role performance, problems of social transition, common emotional distresses (e.g., loss, illness), and inadequate resources.[29]

The two direct services developed their theories and practice in almost total isolation from each other. Hearn, again looking back, describes his work on the faculty of the School of Social Welfare at the University of California, Berkeley in 1948:

> . . . student interest and actual practice was beginning to change the validity and practicality of this kind of specialization [group work and casework]. My colleagues and I found ourselves . . . "introducing" the group workers to the casework process, and we had an elective course in group aspects of professional practice, offered every term and taken by practically all the caseworkers . . . we were becoming more and more troubled by the separation of group work and casework. It did not seem to fit the realities of practice. It was foreign to the way clients lived their lives and it seemed like an unnatural way to provide social service.[30]

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[27]Gertrude Wilson, "Interplay of Insights of Case Work and Group Work," Proceedings of the National Conference of Social Work, 1937 (Chicago: University of Chicago Press, 1937), pp. 151-52.

[28]Gisela Knopka, Therapeutic Group Work with Children (Minneapolis: University of Minnesota Press, 1949) and Group Work in the Institution (New York: Whiteside, Morrow, 1954).

[29]William J. Reid and Laura Epstein, Task-Centered Casework (New York: Columbia University Press, 1972).

[30]Hearn, "General Systems Theory and Social Work," in Social Work Treatment ed. by Turner, p. 344.

Other schools, in the 1940s and early 1950s, began to search for common demoninators in casework and group work as they recognized the need for all social workers to know something about both methods. At the University of Southern California, for example, in the early 1940s all social work students had to take a course in group work (and in Community Organization), and by the mid-1950s all students had to take at least one course in the method other than the specialization. A curriculum emphasizing social work practice, involving both casework and group work, in both class and field placement was established in 1964.[31]

The direct-service methods were involved with fields, i.e., child welfare, family service, corrections, mental health, and so forth. Titles reflecting such things as client populations (e.g., gang worker, foster home worker), agency setting (e.g., welfare or school social worker), the needs or conditions toward which practice was directed (e.g., protective services worker), role (e.g., intake or crisis worker), and theoretical framework (e.g., functional or dynamic social worker) proliferated as did practice controversies which precipitated further divisions: generic versus specific fields of practice, social work versus psychotherapy, intrapsychic versus interpersonal focus, functional versus diagnostic theoretical frameworks, micro versus macro approach, and so on.

Fortunately, in contrast to the proliferation of titles and practice controversies, there were unifying counterforces in the 1950s. These forces included the establishment of a single, accepted professional degree, the Master of Social Work, and the development of a single professional organization, the National Association of Scoail Workers (formed by

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[31]Lola Selby, Personal communication, 1979.

previously separate groups, some of which are noted above), which enabled professional social workers to share a common identification.

The 1960s

The societal upheavals of the 1960s impacted social work tremendously. Traditional direct services and professionalism were decried; advocacy for the poor and underserved, societal change, and social action were the thrusts. In this context, NASW members voted to reduce the entry level to the profession from the Master of Social Work degree to the Bachelor of Social Work degree. Thus began a persisting trend of lessening of educational and experiential requirements for entry into professional practice. A further result has been the three-level licensing supported by NASW: (1) Bachelor of Social Work, (2) Master of Social Work, (3) Academy of Certified Social Work or two years post-master's practice. The deterioration of professional standards undoubtedly contributed to the new title, the need for which was already rooted in issues of practice.

Emergence of clinical social work

In the context of the evolving conceptualizations of direct services, the addition of the word, "clinical," to the title can be traced. It is useful to consider Webster's definition of "clinical":

> clinical: involving or depending on direct observation of living patients; of, relating to, or conducted in or as if in a clinic as applying objective or standardized methods (as interviews and personality or intelligence tests) to the description, evaluation, and modification of human behavior.[32]

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[32]Webster's Third New International Dictionary, 8th ed., 1971.

California law

In the section, "California Experience," the process which resulted in licensing clinical social work in 1968 was described. The legislation which began as S.B. 1224 became Chapter 17, Division 3, Business and Professions Code, Social Workers. Thus, the first official definition of clinical social work comes from the law. Article 4, Clinical Social Workers includes the following items:

> 9042. Each applicant shall furnish evidence satisfactory to board (of Behavioral Science Examiners) that he complies with all the following requirements:
> (a) Is at least 21 years of age.
> (b) Is of good moral character.
> (c) Has received a master's degree from an accredited school of social work.
> (d) Has had two years of full-time post-master's experience, acceptable to the board, in the use of psychosocial and psychotherapeutic methods and measures in a hospital, clinic, or agency in which the applicant, under professional supervision or with professional consultation or both, has employed such methods or measures. . .
> (e) Has not committed any of the offenses set forth in Section 9028 [e.g., moral turpitude, substance addiction that endangers the public, insanity, committing a fraudulent act as a social worker, and advocating overthrow of the government].
>
> . . .
>
> 9049. The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior is directed at helping people to achieve more adequate, satisfying and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families and groups, providing information and referral services, providing or arranging for the provision of social services, explaining and interpreting the psychosocial aspects in the situations of individuals, families or groups, helping communities to organize to provide or improve social and health services, and doing research related to social work.
>
> Psychotherapy, within the meaning of this chapter, is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which

> affect individuals, groups or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes.[33]

Careful reading of this definition reveals that clinical social work is indistinguishable from social work as often described and defined. And, indeed, the philosophy of many of those involved in the writing and passage of the 1968 law expresses just that. For example, Konrad Fischer who was centrally involved in the authorship of the practice licensure statutes, writes, "My intent was to write a law covering the existing practice of social work in order to protect the public and secure a social sanctioning of what was a reality in the marketplace." He further adds that this "was not a new category to be defined."[34] Gareth Hill writes, "The intent was to express coverage of all forms of social work practice, including administration, in which clinical principles are applied. If you read the law carefully, you will find that there is room for licensure of practically everyone in social work who is applying clinical principles in what is practiced."[35] Robert Dean, a central figure in all of this, writes, "It has long been my thesis that clinical work is not the specialization, but is the core of social work practice. . . . Group work, community organization, advocacy, administration, etc., in social work are the specializations and are legitimate or professional only when built on work practiced in the core clinical competency."[36] Finally, Beverly

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[33]Board of Behavioral Science Examiners, Laws Relating to Registered Social Workers, Licensed Clinical Social Workers, Marriage, Family and Child Counselors, and Educational Psychologists (Sacramento: State of California Department of Consumer Affairs, 1977), pp. 5-7.

[34]Fischer, Personal letter, 1979.

[35]Gareth Hill, Personal letter, 1979.

[36]Dean, Personal letter, 1979.

Filloy writes, "the term [clinical social work] was an effort to convey the common thread of psychological treatment concepts and framework pervading all levels, i.e., case, group, community--i.e., a way of looking at working with problems regardless if 'client' was one or many!"[37]

Thus, this new-born title was made legitimate . . . "to give legal status or authorization to" (Webster's New Collegiate Dictionary, 8th ed., 1977). Having both a name and legitimacy clearly did not mean that the definition offered identity or boundaries; in fact, the 1968 legislation produced a child indistinguishable from its parent profession. The resulting difficulties surrounding separation and individuation will be briefly traced.

The Board of Behavioral Science Examiners, vested with the responsibility of licensing, quickly began to interpret and delineate in order to administer the law. The Board's brochure of 1977 (9 years later) illustrates their work in this regard:

CLINICAL SOCIAL WORKER
Licensing Requirements

1. At least a master's degree from an accredited school of social work. (Section 9042 (c).)
2. Two years of supervised post graduate experience consisting of at least 3,200 hours. At least 800 hours which includes one hour per week of regularly scheduled consultation must be under a licensed clinical social worker. At least 800 additional hours must be under a licensed psychologist, a board certified psychiatrist, or a licensed clinical social worker. (Sections 9042 (d), 1873 and 1876.)[38]

The specificity introduced by the Board is readily apparent if the reader compares these regulations with the Section 9042 quoted above. The Board

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[37]Beverly Filloy, Personal letter, 1979.

[38]Board of Behavior Science Examiners, Clinical Social Worker Licensing Requirements (Sacramento: State of California Department of Consumer Affairs, 1977).

makes further delineation regarding acceptable experience (place of employment) and explicitly excludes experience which is solely "group work; community organization; research; administrative functions; eligibility determination; and information and referral.[39] Again, comparison with the actual wording of the law shows that what was voted into law in 1968 and what actually exists in 1979 are very different. The 1968 law and the material of the Board of Behavioral Examiners, which administers the law, offer quite different descriptions of clinical social work.

Books of the 1970s

Prior to 1974 it was almost impossible to find reference to clinical social work in the literature. Then, in 1974, several contributors to Turner's comprehensive work, Social Work Treatment, refer frequently to clinical practice but only three make use of the title (without definition). While the index does not include the term clinical social work, the editor uses the title a number of times without distinction from other references to practitioners. At most he dignifies the title as follows:

> Clinical social work practice in the 1970s remains an essential part of the profession's practice endeavors. . . . There is not to date, nor indeed will there be a single theory of clinical social work practice.[40]

In the same year Sackheim, one of those involved in the California experience, published The Practice of Clinical Casework. A number of titles (e.g., casework, social casework, casework therapy, and, much less often, clinical social work) are used without discrimination or definition. Work with groups is not a part of the practice described.[41]

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[39]Ibid.

[40]Turner, Social Work Treatment, p. 506.

[41]Gertrude Sackheim, The Practice of Clinical Casework (New York: Behavioral Publications, 1974).

In 1976 Roberts and Northen published an important work focused exclusively on direct practice with small groups. This volume, Theories of Social Work with Groups, includes contributions by sixteen authors only one of whom is not primarily identified as a professor. The title, clinical social worker, does not appear in the book.

In 1976 Meyer published a second edition of Social Work Practice. Both volumes (the first edition was published in 1970) are frequently-cited references. The terms "clinically oriented practitioners" and "clinically inclined practitioners" describe those social workers she believes to be inappropriately focused on psychotherapy. A sample reference to clinical social workers states, "This author is in disagreement with the aims of specialization sought by clinical social workers, but she is in total agreement with their aim of identifying a professional outcome in graduate education." Meyer criticizes the Council on Social Work Education for its failure to differentiate the practice of undergraduate-from graduate-level professionals.[42]

Clinical Social Work is the zenith in acceptance and use--a book title! Strean relates the strong emergence of the direct-service practitioner in the 1970s to the professional focus on social problems in the 1960s, reduced professional status (adaption of the B.S.W. entry level), and social change. An example of the strength of this emergence was the founding of the National Federation of Societies for Clinical Social Work (1971) "to establish standards for direct-service practitioners and a peer-review system to serve the needs of providers and consumers of direct services." Strean further indicates that the Clinical Social Work Journal

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[42]Carol H. Meyer, Social Work Practice (2nd ed.; New York: Free Press, 1976), p. 220.

was founded to address the professional direct-practice interests considered to be insufficiently honored in the established social work periodicals of the time.[43]

Strean defines clinical social work as specialization within the social work profession which:

> . . . has a psychosocial orientation to the problems of individuals, dyads, families, groups, and communities. . . . [It views] personal, interpersonal, and social functioning as propelled by both inner . . . and outer ones . . . regardless of the setting [in which the clinical social worker] works . . . and regardless of his unit of diagnostic and therapeutic attention, [he] needs to have certain basic clinical skills: skills in interviewing, making psychosocial assessments, planning interventions, implementing the intervention plan, and terminating treatment.[44]

It is noteworthy that no source listed in Strean's large and comprehensive bibliography uses "clinical social work" in its title.

There are thirty-four authors in the five volumes discussed. Of the thirty-four, twenty-nine are primarily identified as professors. These works represent comprehensive compilations of social work practice and knowledge and, therefore, are frequently referenced in the professional literature. The title, clinical social work, seldom appears. Meyer describes her antipathy to the group she identifies with psychotherapy; Turner and Sackheim do not define their use of the title. Strean goes against the tide and dignifies the title.

Periodicals

Sponsored by the National Association of Social Work, Abstracts for Social Workers began publishing in 1965; initially, 206 journals were

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[43]Herbert S. Strean, Clinical Social Work (New York: Free Press, 1978).

[44]Ibid., pp. 36-37.

reviewed and there have been further additions through the years. A line-by-line scan of the Abstracts for the appearance of the term, clinical social work, has been completed through 1978.

There is no mention of clinical social work in 1965, 1966, and 1967. In 1968 an article reviewed from the Journal of Education for Social Work anticipates that "the present three-track curriculum of case-work, group work, and community organization will disappear, and a two-track pattern--a clinical practice line for direct helping service and a community practice line . . . will evolve."[45] An abstract from Children by E. Glickman contains the term "clinical social work."[46] From 1969 through 1973, there is not mention of the title.

The first volume of Clinical Social Work Journal edited by Mary Gottesfeld, M.S.S., heralded another high point in acceptance and use of the title. The initial subscription form describes the publication as follows:

> Sponsored by the National Federation of Societies for Clinical Social Work, this is the only journal devoted exclusively to social work practice. Its aim is to publish high quality materials on clinical practice that is historical, theoretical, or practice-oriented. The Journal will be interdisciplinary in authorship, scope and content, and will aim to broaden and deepen the understanding and skill of the practitioner or teacher of clinical social work who is involved with individuals, couples, families, or groups. An eclectic orientation is expected to stimulate a re-evaluation of the reader's own positions and keep his thinking open and timely.[47]

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[45]Katherine A. Kendall, "To Fathom the Future," Journal of Social Work Education 3(1):21-8, 1967. Listing No. 231 in Abstracts for Social Workers, IV (Spring, 1968).

[46]E. Glickman, "Professional Social Work with Headstart Mothers," Children 15(2):59-64. Listing No. 919 in Abstracts for Social Workers IV (Winter, 1968).

[47]Clinical Social Work Journal, I (Spring, 1973), 64.

Two additional ideas from the current Guidelines for Consulting Editors offer further background: "We are primarily interested in clinical papers, those papers that stress clinical applications and include case illustrations"; and "Editorial Boards have a highly significant role in the intellectual base of a profession, since we decide what ideas are disseminated."[48]

In Fall 1973, Abstracts for Social Workers added the Clinical Social Work Journal to those reviewed. The following year, in Spring 1974, clinical social work appeared in both the Journal name (as it continued to do) and in an article abstracted from Social Case Work: "Today's professionals speak of clinical or direct-service social work activities as different from social policy and planning."[49] The title appears once in the Winter 1974 issue, as well.

Volume 11 of the Abstracts not only includes the term, clinical social worker, four times but also indexes "clinical" under Social Workers, Social Work Education, and Social Work. This Fall edition marks the inclusion of abstracts of doctoral dissertations; it is notable that those dissertations from the University of Southern California thereby increase the use of the title in the Abstracts. One such study appearing in 1976 involved a sample of "85 clinical social workers."[50] Kurzman, later in

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[48]Clinical Social Work Journal, "Guidelines for Consulting Editors," 1979. (Mimeographed.)

[49]S. Rotter, "Mary Richmond and Family Social Work Today," Social Case Work 54(5):284-89. Listing No. 156 in Abstracts for Social Work X (Spring, 1974).

[50]Marilyn A. Biggerstaff, "Social Work Practitioners' Conception of Sex and Social Roles" (unpublished D.S.W. dissertation, University of Southern California, 1976). Listing No. 670 in Abstracts for Social Workers XII (Fall, 1976).

1976, writes, "A private practice model may also serve to exacerbate the problem of many clinical social workers who perceive themselves as 'psychotherapists'--thereby losing sight of their dual commitment to social services and social action."[51] Clinical and clinical social work do not otherwise appear even in the Index for the year.

In 1977 the publication became Social Work Research and Abstracts in which clinical social work appears eleven times. In 1978 the term appears ten times.

A less detailed search through periodicals was completed for this same period, 1965 through 1978. Meinert equates direct service with clinical work[52] while Phillip addresses the split of social work leaders and educators with practitioners on the question of the validity of the "specialization" (i.e., clinical social work).[53] Meanwhile, there are occasional advertisements for clinical casework supervisors, clinical psychiatric social workers, and clinical social workers in "Personnel Vacancies" of Social Casework.

In the Clinical Social Work Journal, Perlman offers an identity and definition in an address to the Society for Clinical Social Work in California which was later published. She writes that "all clinical social workers are not all psychotherapists all of the time." The social work aspect of practice is that which is doing-influencing and modifying a

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[51]P. A. Kurzman, "Private Practice as a Social Work Function," Social Work 21(5):363-69. Listing No. 1151 in Abstracts for Social Workers XII (Winter, 1976).

[52]Roland G. Meinert, "What Do Social Workers Do? A Study," Social Work XI (March, 1976), 156-57.

[53]David G. Phillips, "The Swing Toward Clinical Practice," Social Work XX (January, 1975), 61-63.

person's outer reality. "To know and to value the core concerns and knowledge of social work, to value and to know the core concepts and principles that underlie effective help to people whose social and psychological functioning is impaired or hampered--these are the bases of our identity. . . . From this foundation, differentiation and specialization may occur." The clinical social worker, she indicates, combines psychotherapy with social work.[54] This dichotomizing, however impossible and unrealistic, is an important idea to be addressed later.

Among the periodicals of this period, two issues are of outstanding value to the background of this research. In 1977 a special issue of Clinical Social Work Journal presents the work of the Education Committee of the Federation of Societies for Clinical Social Work.[55] In juxtaposition, Social Work, the Journal of the National Association of Social Workers, appeared almost simultaneously in 1977 with a "Special Issue on Conceptual Frameworks."[56]

In the Clinical Social Work Journal symposium paper, by Pinkus, Haring, Lieberman, Mishne, and Pollock, "Education for the Practice of Clinical Social Work at the Master's Level: a Positon Paper," is accompanied by a number of articles which reflect only a small part of the heated discussion generated by the report. In essence, this presentation makes a statement vis-a-vis clinical social work "as a phrase whose time had come" since its use has spread so rapidly (outside the literature, of course). The symposium definition of clinical social work is important:

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[54]Helen H. Perlman, Confessions, Concerns, and Commitments of an Ex-Clinical Social Worker, Occasional Paper Number 5 (Chicago: University of Chicago School of Social Service Administration, 1974).

[55]Clinical Social Work Journal, V (Winter, 1977).

[56]Social Work, XXII (September, 1977).

1. A specialization within the field of social work
2. Drawing on social work values and ethics
3. Providing direct services to individuals, families, and groups
4. Encompassing a knowledge base which includes human development (biological, cognitive, psychological, and socio-cultural), both normal and pathological, and the social environment and social policy
5. Self-awareness enhanced by supervision, consultation, peer review, and continued education
6. Focus on individual biopsychosocial functioning within the family and the community and the larger society
7. Professional process which involves clients in active participation
8. Theoretical grounding in psychoanalytic theory in tandem with ego psychology and articulation into clinical practice
9. A health-care provider for those with problems in biopsychosocial functioning
10. Training which blends didactic learning with practice experience
11. Maintenance of the two-year Master of Social Work degree as entry level to the profession[57]

The special issue of Social Work, on the other hand, was an effort to publish a range of views on social work practice and "to identify and examine the major issues, dilemmas, and choices that face the profession." The Publications Committee of the NASW commissioned five social workers

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[57]Helen Pinkus, et al., "Education for the Practice of Clinical Social Work at the Master's level: A Position Paper," Clinical Social Work Journal, V. (Winter, 1977), 253-68. (Hereinafter referred to as "A Position Paper.")

with different perspectives to write papers addressing the mission and objectives of social work, what social workers do or should do to achieve these, the sanctions that social workers should have, and the necessary knowledge and skills. Finally, the authors were asked to look at the practical and educational implications of their views. The authors, Cooper, Dean, Minahan, Pincus, Morris, and Reid, presented to a meeting of the Publications Committee, the Editorial Boards of Social Work, and the Encyclopedia of Social Work in 1976. Briar's summary of the meeting emphasizes the diversity of opinion regarding definition of purpose in social work and the difficulty in articulating "what is common within the evident diversity." He further refers to "the long-standing, potentially divisive controversy over the relative emphasis to be placed on social change on the one hand, and individual change on the other." It appears that there was some agreement as to the "need for the provision of help to individuals, and none would do away with that function in the interest of social change." [!][58] The articles present conceptual frameworks for the understanding and analysis of "generalist" social work objectives in the hope that a model for specialization could then develop. Specialization, as addressed in this presentation, includes delivery of specific social services such as income maintenance plans, vocational training, mental health services, correction, psychiatric social work, rehabilitation, etc. Clinical social work is mentioned four times.

The special issues of these two journals present essentially mutually exclusive positions. In the Clinical Social Work Journal, clinical social work is a specialization seen to be the core of provision of

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[58]Scott Briar, "In Summary," Social Work, XXII (September, 1977), p. 415.

services no matter what the setting or function. In the second, Social Work, specializations (which seem synonymous with setting and function) are seen to develop from the core, which is described as "generalist." In the former, the clinical orientation is central, and in the latter social change is foremost.

The Registries

Two national registries of clinical social workers have come into print concurrently with the material reviewed above. "It was the Private Practice Council Third Party Vendor Task Force of the Division Cabinet of Practice and Knowledge which strongly urged the establishment of a Register of Clinical Social Workers."[59] In 1974 the issue of organization membership, once again, brought the differences between the Society for Clinical Social Work and NASW into sharp relief. The Board of Directors of NASW mandated that to be listed in the register a person must "be a member of the Academy of Certified Social Workers (ACSW) or be licensed or certified in a State at a level at least equivalent to ACSW standards."[60] Since ACSWs must be NASW members, this Board decision, in effect, eliminated "freedom of choice to qualified clinical social workers to join, or not to join, a professional organization."[61] As a result, the National Federation of Societies for Clinical Social Work developed a separate registry, The National Registry of Health Care Providers in Clinical Social Work. The title was chosen to reflect that clinical social workers are

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[59]NASW Register of Clinical Social Workers (2nd ed.; New York: 1978), p. vi.

[60]Ibid., p. viii.

[61]Estelle Gabriel, Personal letter, December 5, 1974, p. 1.

health care providers in the World Health Organization definition of health as a "healthy person in a healthy society."[62] This listing had the following objectives: to identify qualified practitioners for prospective consumers; to assist governmental agencies in assessing clinical social work manpower, planning programs, and for research; and to enable insurance companies to determine those qualified to provide independent, autonomous services for reimbursement. The Registry listed approximately 1500 clinical social workers in its first edition in 1976[63]

The third edition, in 1978, cites these criteria for eligibility that must be documented:

1. Master's or doctor's degree in social work with a core of clinical course work or demonstrated equivalent, from a school accredited by the Council on Social Work Education.

2. Graduate field work placement of at least two semesters or its equivalent, providing direct clinical services to individuals, families or groups.

3. A minimum of two years or equivalent (3,000 hours) of clinical social work experience under supervision of a graduate clinical social worker.

4. Current licensure or registration for those residing in states where social worker registration, certification or licensure is mandated.

5. Agreement to submit to review by professional peers.[64]

The basic decisions by the Board of Directors regarding these criteria are based on concern for social work's commitment to the bio-psychosocial

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[62]National Registry of Health Care Providers in Clinical Social Work (3rd ed.; Lexington, Ky.: Board of the National Registry of Health Care Providers in Clinical Social Work, 1978), p. 3. (Hereinafter referred to as National Registry.)

[63]National Registry of Health Care Providers in Clinical Social Work, "Questions and Answers," (Bethesda, Md.: 1975).

[64]NASW Register of Clinical Social Workers, p. vii.

approach to individuals and families, on possession by practitioners of clinical theoretical knowledge, on the need for lengthening rather than shortening educational programs, and on the belief that supervised post-master's experience is essential to autonomous practice. The 1977 edition concludes its philosophic basis for a definition with the following statement: "However, it was agreed that clinical social work is not determined solely by the setting in which the clinician practices, but rather by the knowledge, values and competencies possessed and the services rendered."[65] This statement is reminiscent of the position taken by Grimm described in Chapter I, "California Experience," above.

The NASW Register of Clinical Social Workers was also published in 1976. The Board of Directors of NASW adopted these goals:

1. Provide listings of qualified clinical social workers to the general public, voluntary and governmental agencies, insurance and business companies, and information sources.

2. Encourage the acceptance of the NASW Register standards as criteria for key clinical social service positions in organizations and for private individual or group practice.

3. Assist third-party payment vendors to improve service standards, delivery and costs through professional recognition and contract inclusion of clinical social workers.

4. Enable improved inter-professional referrals and consultation.[66]

The editors reflect on the growing acceptance and currency of the title, clinical social work, in society and in the profession. They believe publishing a clinical register is responsive to "that segment of the social work profession which engages in direct clinical practice, including

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[65]National Registry, p. 3.

[66]NASW Register of Clinical Social Workers, p. x.

private practice."[67] Additionally, the Board of Directors makes a significant contribution to the definition and description of clinical social work with the following statements:

Definition

A Clinical Social Worker is, by education and experience, professionally qualified at the autonomous practice level to provide direct, diagnostic, preventive and treatment services to individuals, families and groups where functioning is threatened or affected by social and psychological stress or health impairment.

Setting

Clinical social work is practiced within a private office or under the auspices of public, voluntary or proprietary agencies and institutions addressing familial, economic, health, recreational, religious, penal, judicial, and educational concerns.

Model of Clinical Social Work Practice

Within the practice setting, the problem is identified, and a plan of intervention is designed and implemented with the client. The plan is supported by securing historical facts and clues to the latent forces within the individual that shape personality. Individual strengths in conjunction with community resources are activated and utilized to implement the clinical plan.

Education and Experience Criteria

A Master's or Doctoral degree in social work from a graduate school of social work accredited or recognized by the Council on Social Work Education; two years or 3,000 hours of post-master's clinical social work practice under the supervision or with consultation from a master's degree level social worker, or, if social work supervision could be shown to have been unavailable, supervision by another mental health professional (up to June 30th, 1977) with the added condition of giving evidence of continued participation and identification with the social work profession; at least two years or 3,000 hours of direct clinical practice within the last ten years; be a member of the Academy of Certified Social Workers (ACSW) or be licensed or certified in a State at a level at least equivalent to ACSW standards.[68]

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[67]Ibid., p. vi.

[68]Ibid., p. viii.

The later editions of each of these registers are considerably more clear and precise in the statements regarding definition and description of clinical social work than are those in 1975 and 1976. The statements are in no way mutually exclusive. The comprehensive quality of the 1978 NASW description is notable and, as the reader will later note, closely approximates the results of this research data which was gathered prior to the publication.

The last four publications (Clinical Social Work Journal, Winter, 1977; Social Work, September, 1977; National Registry of Health Care Providers in Clinical Social Work; and NASW Register of Clinical Workers) described represent two national professional organizations often seen in widely divergent positions. The special issues address the differences represented by NASW and the Societies for Clinical Social Work quite well. The qualifications for listing in the registries sponsored by NASW and by the Federation are quite similar (especially in those states where licensing is at least equivalent to the ACSW). A major difference is the Federation's insistance on a core of clinical course work in the graduate curriculum, while NASW demands simply an M.S.W. and the clinical post-master's practice. The Publications Committee of NASW which commissioned the conference reported in Social Work in 1977 also sponsored The Register. The results of these two commissioned publications are diametrically opposed in their views of appropriate professional social work practice!

In summary, it is apparent that the emergence of the title, clinical social work, within the social work literature has only just begun to be considered. On the other hand, the title is widely used and recognized in the public and professional vernacular. The definitions and descriptions of clinical social work which began with the 1968 California law

have been furthered by the Board of Behavioral Science Examiners, the work of Pinkus at al, and the Boards of the two nationwide registries. It will be useful to compare these efforts with the clinicians' responses analysed in this study.

Social Work Values

Values are enduring beliefs, preferences, and standards that guide modes of conduct while giving direction to life and making behavior meaningful. Values are ultimate, abstract concepts which have strong cognitive, affective components. Instrumental values are ideas concerning the means to achieve ultimate values and, undoubtedly, evoke the most intense differences among social workers. Ethics, on the other hand, are sought-after principles to guide decision-making; they are guidelines for solving moral problems.

Meyer writes that "social work practice rests upon a set of values that guide its working principles and define the ways in which knowledge is used. These values have been described as traditional humanistic, Judeo-Christian values that include acceptance of people as individuals in their own right, respect for their differences and their integrity, and promotion of the social good."[69] Pinkus et al. consider the clinical social work values to be these: "the worth and dignity of the individual; society's responsibility to meet the needs of its members; the interdependence of man and society; the right of the individual to pursue his own destiny as long as it does not interfere with the rights of others; and the right to privacy."[70]

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[69]Meyer, Social Work Practices, p. 166.

[70]Pinkus et al., "A Position Paper," 261.

Strean indicates that social workers have become increasingly aware that interventions and practice decisions derive from a value system. He cites the following as identified with social work:

> Belief in the dignity and worth of the human being regardless of his or her social, psychological, intellectual, or political orientation, sex, race, or age.
>
> Belief in the human being's ability to grow and change toward social and personal ideals related to a liberal-humanistic concept of human betterment.
>
> Client self-determination--i.e., the right of each person to live his or her life in a unique way, provided that it does not infringe upon the rights of others.
>
> Acceptance of each client and client-system as unique.
>
> Helping others to develop or recover the capacity for self-help.
>
> Client participation--the human potential is always taken as a given by the social worker, and therefore he accepts the client as an interacting partner in a professional relationship that will psychosocially enhance him.[71]

It is interesting that Strean's list, in Clinical Social Work, does address issues of clinical orientation and does not include the mutual responsibility between the individual and society. The latter, repeated often in the literature, emphasizes society's responsibility to provide opportunity for each individual to realize full potential.

Social work is often described as society's conscience. "It is an institutionalized expression of society's interest in meeting common human needs."[72] In tracing the development of the profession, it is clear that social work has a long history of putting society's prevailing values into practice. Early in the century there was faith in environmental manipulation and the scientific method. "Scientific philanthropy" emphasized

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[71]Strean, Clinical Social Work, pp. 29-33.

[72]Meyer, Social Work Practice, p. 119.

linear causality--uncovering the cause of the problem would suggest the cure. The stage was set for acceptance of the medical model with focus on diagnosis, treatment, and cure. Such responsiveness to society's prevailing values, then, triggered the shift in the 1960s to emphasis on societal change.

Involvement with social change has occurred as a continuum of action and might best be expressed as commitment to alleviation of social problems by means of prevention and remedial social intervention. Turner writes, "There are few experienced practitioners who have not committed much of their professional and personal time and resources to this broad area of concern (community organization and development, social action, and social change)."[73]

It is clear that shared professional values do not preclude heated controversies. Is the basic responsibility for providing services a government responsibility? Or, does the government step in only when the family and the other local resources cannot deliver adequate services? Do social workers, as professionals, have the right to organize to improve their own financial and working conditions? And, do they have the right to strike and stop the delivery of services to clients? Are devotion to licensing and vendorship steps toward elitism and a denial of social workers' roots in the alleviation of poverty and social injustice? Or, do licensing and vendorship protect the consumer and expand available, responsible services? Does clinical work directed toward family and individual growth and adjustment help to maintain acceptance of social injustice? Does social work participation in corrections and the penal system maintain racism, sexism, and injustice?

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[73]Turner, Social Work Treatment, pp. 99-100.

Social work is a profession which seriously considers its values and ethics. The clinician's identification with such beliefs is important to inclusion within the profession.

Social Work Knowledge-Base

"Social work practice is based upon knowledge as well as upon values and skills. . . . However, this is a more complicated issue than it seems, because of several related phenomena. One fact is that in the current period the profession of social work has not agreed upon the kinds of knowledge it requires in order to do its job."[74] This author adds that the expert practitioner knows the bio-psychosocial characteristics of the target population, relevant legislation, research, and organizational constructs. Knowledge in a profession ultimately must result in doing, in activity, in rendering services and fulfilling purposes.

Comparison of a number of graduate-school catalogs indicates the following curriculum for the Master of Social Work degree (California State University at Fresno, University of California at Berkeley, University of Southern California, National Catholic School of Social Service of the Catholic University of America):

1. Social welfare policy and services
2. Human behavior, personality development, and the social, political, economic, biological, and psychological environment
3. Social work theories and practice
4. Research
5. Field instruction

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[74]Meyer, Social Work Practice, p. 119.

These general areas, of course, have been and will continue to be influenced by the theoretical orientation of a particular school (the Chicano program of the San Jose State University or behavior modification of the University of Michigan, for example), the particular faculty, the social and cultural times, and much more.

Strean describes the six "main behavioral science orientations that have made and are making substantial contributions to social work scholarship and social work practice." These include psychoanalytic theory and ego psychology, role theory, systems theory, communication theory ("Because almost all of social work involves communication, communication theory is one of its most used and useful theories."), learning theory, and organization theory.[75]

This consideration of the knowledge-base of clinical social work focuses, primarily, on the second and third curriculum areas. Pinkus et al. expand the second area as follows:

> The information that is used includes knowledge of normal developmental, cognitive and psychological processes of personality functioning in various contexts throughout cultural variations, environmental pressures, and supports. The effects of crises, frustration, deprivation, and developmental problems upon people and normative ways of coping. . . . Group and family dynamics, as well as an understanding of environmental pathology, are studied.[76]

Ultimately, among clinicians and educators, differences around practice theory elicit more passion and spleen, more attention, and more pages than the other areas of knowledge. Practice theory is an intellectual structuring of ideas which enables the clinician to understand and organize data, to plan and design interventions, and to extrapolate and

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[75]Strean, Clinical Social Work, pp. 26-28.

[76]Pinkus et al., "A Position Paper," 259.

predict outcomes and results. Selby points out that such theory encompasses a number of aspects: a view of man and society; ideas about the appropriate purposes of social work; a concept of diagnosis; description of relevant treatment procedures and processes; a special organization of knowledge; and conceptualizations about change--how it comes about, what causes it, what impedes it, and what are the effects of it.[77]

The literature reflects three recurrent thrusts: that of proponents who hold a single theoretical framework as inalterably correct and suitable, that of proponents who hold a theoretical framework which offers a unifying structure for the profession, and, finally, pluralism.

The symposium paper on Education for the Practice of Clinical Social Work at the Master's Level, often cited in this review, offers an excellent example of the first option.

> The theoretical bete noir, of course, has been psychoanalytic theory and ego psychology, often attacked by those least familiar with its applications in practice. As Rueben and Gertrude Blanck, (1974) have stated, "We think that there can be only one science of human behavior--either psychoanalytic theory (and therefore techniques derived from it) is correct or another theory is correct." It is believed that for a clinical social worker psychoanalytic theory in tandem with ego psychology is correct in that it offers the most cohesive and comprehensive view of personality development and of subsequent therapeutic interventions. . . . Thus, it is postulated that all clinical social workers must learn psychoanalytic theory and modern ego psychology both as a base for practice and to be able to utilize the many contributions of dynamic casework.[78]

Efforts to develop a unifying theoretical framework began at the outset of the profession. Mary Jarrett wrote "The Psychiatric Thread

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[77]Lola Selby, "Theoretical Bases for Practice of Social Work" (unpublished material for Social Work 742, University of Southern California, Fall, 1977). (Mimeographed.)

[78]Pinkus et al., "A Position Paper," 63.

Running Through All Social Case Work."[79] By the 1930s and 1940s there were two major frameworks: the functional school and the diagnostic school (later the psychosocial approach) which were described earlier in this chapter.

A present-day model of a unifying structure is the ecological systems model, sometimes referred to as the eco/systems perspective. This view moves from the focus on linear causality to attention to the interconnectedness of variables in the case situation. Meyer states that the person-in-environment core of social work practice remains central but the perspective encompasses the "mutality of individuals and their specific environments interacting with each other."[80]

> We are now talking about relationships of variables and the consequences of their transactions; we are not talking about how things become the way they are and what caused them. When we contemplate the person in his milieu, we are dealing with mutuality of one to the other, of adaptations going both ways, of assessing imbalance and righting it, of devising an appropriate "fit" between the person and his environment, of interventions in the environment as well as with individual coping mechanisms.[81]

Siporin sees the ecological systems model as a framework for giving "order, structure, and meaning to diverse theories and techniques."[82]

During the last ten years advocates of pluralism have written for and edited a number of volumes, some of which have been cited in this review. Important examples of such collections are Roberts and Nee,

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[79]Mary Jarrett, "The Psychiatric Thread Running Through All Social Work," Proceedings of the National Conference of Charities and Corrections, 1919 (New York, 1919).

[80]Meyer, Social Work Practice, p. 129.

[81]Ibid., pp. 130-31.

[82]Max Siporin, "Practice Theory for Clinical Social Work," Clinical Social Work Journal, VII (Spring, 1979), 83.

Theories of Social Casework (1970), Roberts and Northen, Theories of Social Work with Groups (1976), and Turner, Social Work Treatment (1974). Turner includes presentations of fourteen "thought systems in social work practice" and concludes that "there is not to date, nor indeed will there be a single theory of clinical social work practice. There are, and will continue to be a range of understandings and tested findings about effective and planned change."[83]

Further aspects of the knowledge-base for clinical social work that appear in the literature and influenced the inclusion of elements in the research questionnaire include the following:

1. Self-knowledge through supervision, consultation, personal therapy, and experiential training
2. Continuing education
3. Use of research
4. Enhancing sensitivity to the impact of culture, racism, sexism, poverty, and deprivation
5. Acquisition of practice wisdom in social work--the combining of concrete services with treatment processes, facilitating the use of resources and the development of resources
6. Recognition of appropriate limits to and responsibility for practice
7. Acquisition of knowledge about formal and informal helping networks

In summary, Simon notes that knowledge is useful "for background, for depth and breadth of vision about man and man in interaction with his

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[83]Turner, Social Work Treatment, p. 506.

environment" as well as "for a way of doing in the solution of problems in the domain of social work practice."[84]

Social Work Practice

Practice refers to the ways in which clinical social workers help people, individually and in groups, to function better or to recover from dysfunction. "Method refers to the actions that we take, the means we use to accomplish goals . . . methods to modify behavior or personality patterns of individuals, the structure and functioning of milieus, and their transactional relationships or exchange balance."[85]

A cursory review of the social work literature concerned with practice can be divided into the following areas: diagnosis; contract for and goals of service; relationship; and technique and skills. It is important to note once again that this material is from social work literature. The literature of psychiatry or psychology, for example, might well address practice very differently.

The central goal of social work practice is change: changed role performance; changed self-concept, changed expectations of self and others; change of individuals, groups, systems, and/or societal institutions. These changes involve providing opportunities for new relationship experiences, stimulating client(s) to take increased responsibility for self, facilitating competence in functioning, releasing energy and feelings, enhancing coping with societal institutions, and working for social change. Most authors believe that intrapersonal and interpersonal processes are

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[84]Bernece K. Simon, "Diversity and Unity in the Social Work Profession," Social Work, XXII (September, 1977) 399.

[85]Siporin, "Practice Theory for Clinical Social Work," 81.

appropriate to professional concern. From the almost exclusive concern with unconscious conflicts and early genetic material in social work literature, there has been a shift in focus on intrapersonal conflict to focus on conflict in interpersonal transactions, from person viewed against the background of the past to person viewed as part of an interacting role network in which he is both acted upon and acting, both being and becoming.

Social work practice has long been involved with diagnosis. Since Richmond's Social Diagnosis (1917), a central concern has been the practitioner's knowledge of human behavior and social realities as a context within which to assess and understand the client and his world. Early emphasis on diagnosis was closely related to social work's adoption of the medical model for practice. Diagnosis, which implied an understanding of cause, provided the framework for sorting significant data and planning treatment interventions. Until very recently social workers have most often dealt with their practice in a framework tied to linear causality. Initially, the clinician engages the client in the helping process and, then, frames assessments in terms of problems which can engage both, each with different responsibilities. "Diagnosis and assessment is an ongoing process necessary for knowledge and understanding of individual-family situation in order to predict and guide treatment interventions.[86]

There is considerable agreement regarding the necessity of treatment contracts which specify problems to be addressed as well as goals, methods, and expected duration of service. Recent authors emphasize that these explicit agreements must be relevant to presenting problems, feasible to attain, and specific.

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[86]Bernece K. Simon, "Social Casework Theory: An Overview," in Social Casework ed. by Roberts and Nee, p. 375.

Social workers have long espoused the professional relationship as the core of their practice. This relationship between practitioner and client is seen to include emotional and intellectual involvement, mutual respect and trust, collaborative working for change, and the professional's constructive use of self and self-awareness. While this treatment relationship has been viewed in the literature almost exclusively from the psychoanalytic framework in the past, recent authors emphasize transference/counter transference to a lesser degree. It is recognized that the therapeutic encounter deals with both objective reality and components tied to the past; present practice encourages moving focus from past conflictual, genetic material to the present realities, both personal and situational. For example, Siporin writes

> Social situations are now more clearly comprehended as immediate stimulus, reinforcement, and meaning systems, and they therefore are essential elements of behavior and interactional systems. Personality development and functioning are intimately dependent upon processes of situational interaction, expectations, feedback, and change.[87]

Thus, the professional relationship model has shifted from almost exclusive one-to-one to that of clinician with individual, dyad, family, group, "network" or other system.

The foregoing elements of practice evoke considerably less disagreement than the aspect of appropriate techniques. In the best of clinical practice, of course, the choice of interventions is based on the clinician's self-awareness and a clearly articulated, well-defined theoretical framework. Given the pluralism of frameworks, it is both expectable and appropriate that selection of interventions is tremendously varied. For this research, then, practice techniques from a large number of authors

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[87]Siporin, "Practice Theory for Clinical Social Work," 82.

with a variety of theoretical orientations were assembled. This assemblage provides the basis for elements in the research questionnaire:

1. Behaving as a change agent implies a quite active clinician
2. Maintaining movement and tempo is keyed to client(s') readiness
3. Encouraging the client(s') expression of feelings and thoughts
4. Providing group experiences for actualizing both interactional change and enhancing individual potential
5. Offering acceptance and response
6. Making reflective, clarifying statements
7. Focusing on problems as well as reality expectations and goals
8. Listening with empathy, perceptiveness, and concentration
9. Fostering self-worth by pointing to past and current accomplishments
10. Encouraging development of problem-solving and other personal skills
11. Facilitating group process
12. Accepting one's own biases and limitations
13. Avoiding free association and interpretation of dreams
14. Avoiding recovery of repressed material
15. Facilitating the client(s') assumption of responsibility for self, for choices, and for personal growth
16. Correcting disparities between the client(s') perception and reality
17. Focusing on achieving insight
18. Opening up communication among clients
19. Interrupting dysfunctional patterns of thought, affect, and behavior

20. Facilitating movement from self-understanding to action and improved functioning
21. Facilitating linkages with social environment
22. Collaborating with others on client(s') behalf as part of being client(s') advocate
23. Using persuasion
24. Making appropriate referrals
25. Taking part in organizing and planning delivery of services
26. Offering consultation, supervision, and other professional training
27. Using case management abilities (assessment of client(s'), development of treatment plan, and enabling its use)
28. Making, and following through on, professional recommendations (e.g., guardianship, child abuse, and voluntary or involuntary hospitalization)

Pinkus et al. make a cogent statement regarding the therapeutic skills and techniques appropriate to clinical social work.

> The skills of the clinical social worker evolve from systematic understanding of the individual client and what is best for the client; one or a variety of methods, including individual psychotherapy, group psychotherapy, family therapy, interventions on behalf of the client on social systems and the environment, and the provision of concrete services, may be used. The determination of method is based on the need of the client; where the worker is not skilled in a particular approach that diagnostically appears necessary, referral is made to the appropriate source.
> . . .
> The basic skill is the ability to conduct an interview in the one-to-one context; this may be supplemented by skill in family interviewing and group leadership. These abilities are supported by skill in listening, seeing, and understanding manifest and latent communications which may contribute information to a dynamic diagnostic assessment which include a clinical diagnosis. From this, a treatment plan is formulated. Communication skills are essential to the process

and include verbal and nonverbal methods. Other techniques such as support, confrontation, interpretation, insight, and advocacy are used differentially based upon the dynamic understanding of the client's needs at any one time.[88]

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[88]Pinkus et al., "A Position Paper," 258-59.

METHODOLOGY

The purpose and design of this research is descriptive. Such research systematically describes the facts and characteristics of a given population or situation. The data accumulated offers description rather than explanations, meanings, or causality.[1]

The Subjects

Two hundred professionals were selected (by use of a Table of Random Numbers) from the approximately 1500 listed in the National Registry of Health Care Providers in Clinical Social Work (1976). The author determined that study of a nationwide group of practitioners would offer results less skewed by the concentrated experiences in California that were described previously. The National Registry of Health Care Providers in Clinical Social Work requires validation of qualifying criteria. This population, then, would most likely have the training and experience appropriate to the study. Additionally, the author suggests that those choosing to be listed in the Registry sponsored by the National Federation of Societies for Clinical Social Work are those most identified with and knowledgeable about the issues germane to the research.

In June 1978 each subject selected was sent a packet which included a letter and the questionnaire (see Appendix B) together with a stamped, addressed envelope for return. The envelope and letter were printed on

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[1]Stephen Issac and William B. Michael, Handbook in Research and Evaluation (San Diego, Ca.: Edits Publishers, 1971).

Institute for Clinical Social Work stationery to emphasize the legitimacy of the venture. In addition, the letter described the study, urged participation, and set a date for return.

Twenty questionnaires were returned as undeliverable; ten were too incomplete to be tabulated. Of the 180 delivered, 85 (or 47 percent) were used for statistical analysis.

Questionnaire

The questionnaire was developed from quotations taken from social work literature; this material was sorted into the four areas with which the study is concerned: Definition, Values, Knowledge, and Practice. In most cases the quotations were abbreviated and focused in order to address a single concept in each item or question.

The questionnaire was field-tested by twelve practicing clinical social workers in California and Nevada who represented a variety of practice settings and theoretical orientations. Some members of this group did not know the author. Appropriate deletions, additions, and modifications were made to the original document to reflect the thought-provoking, useful comments of field testers.

The four sections of the final questionnaire were assembled in a random pattern to avoid, as much as possible, fatigue effect associated with any one section.

Statistical Analysis

Eighty-five returns were processed. Means and standard deviations were calculated for each of the 166 variables. Correlation coefficients were computed for all pairs of these variables.

Four principal axis-components factor analyses with verimax rotation were performed on each of the four sets of data (Definition, Values, Knowledge, and Practice). Initial communality estimates were the maximum off-diagonal elements for each row of the correlation matrix.

The personal information data were analysed. The hypotheses listed in the Introduction were each descriptively tested. The means of the items addressing each hypothesis were computed and averaged. Since there was no control group in this research, no comparison of means is possible; while this reduces the significance of these means, the responses to the items do provide some view of the respondents' perceptions.

In addition, the subjects' comments have been included in the following chapter, Results and Discussion.

RESULTS AND DISCUSSION

OR

"FACTS AND FANCY"

Demographic Data

A random (and therefore representative) sample of those practitioners listed in the National Registry of Health Care Providers in Clinical Social Work was made. The following description of the eighty-five subjects can be assumed to be a good estimate description of the population of all clinical social workers. The information on participants is summarized in Figures 1 through 7.

The respondents reside in twenty-two states. The balance of representation of Eastern and Western states is close; twenty-seven subjects in the former and thirty-three in the latter (Figure 1). Average age is 46.6 years with a range from 29 to 70 years of age (Figure 2). There are twice as many female respondents as males. Of the twenty-seven men responding, twenty-two are between 33 and 43 years of age. Possible explanations of this tendency of the men to be in the younger portion of the population may be that men are more recently entering the field (a "trend" reported periodically throughout the author's twenty-nine years in the profession) or that men do not remain clinicians within social work.

It has been about seventeen years since the average participant in this study was awarded the M.S.W. There is high correlation of this fact with average age ($r=+.68$, $p<.0001$), showing that older clinicians have had their M.S.W.s longer. These subjects, then, are practitioners with long

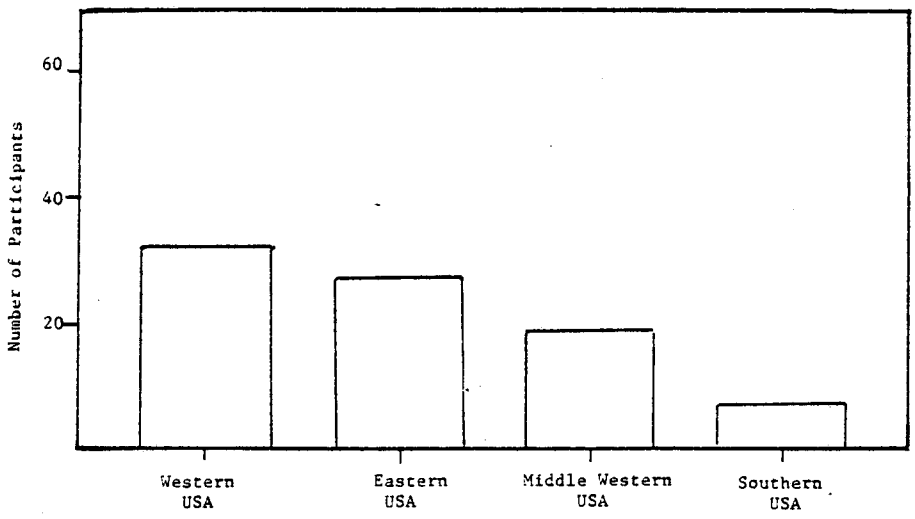

Fig. 1. Region of Residence. Number of respondents living in the four geographic regions of the U.S.A.

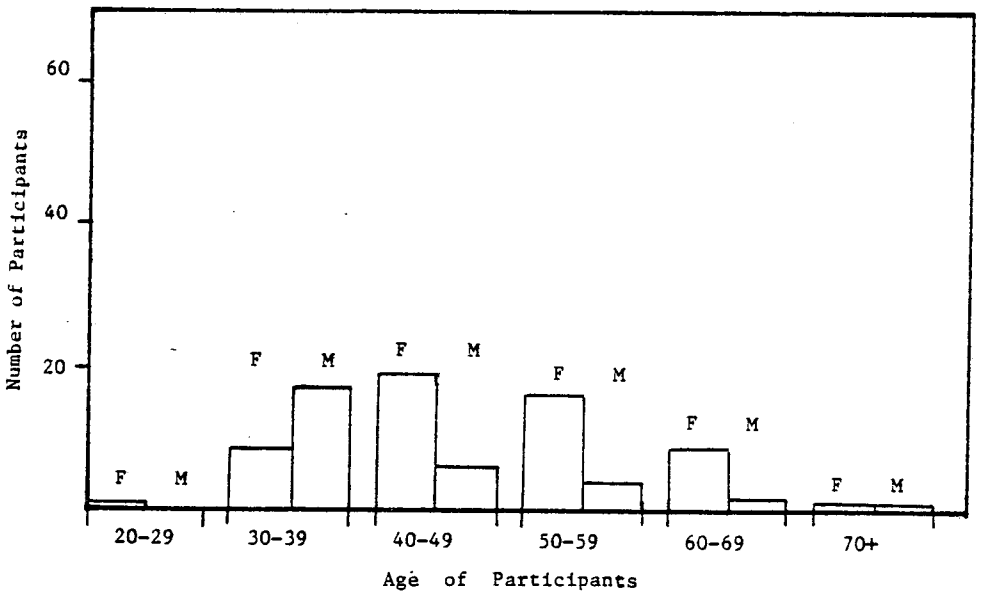

Fig. 2. Age and sex distribution of respondents.

experience in the field rather than a group that has sought professional training later in life. Almost half (41) of the practitioners were graduated from schools of social work during the sixties when the profession was undergoing a number of shifts in emphasis--from work with individuals to social action, and the lowering of the academic entry level from M.S.W. to the Bachelor of Social Work.

In this group over half the clinicians are state-licensed and many hold memberships in numerous professional organizations (Figure 3). On the average, respondents hold one license and belong to slightly more than three professional organizations. It is worth noting organization membership data of the study respondents with respect to the differences between NASW and the Society for Clinical Social Work noted in Chapter II. Memberships in both organizations are held by 66 percent of the population, while 24 percent belong only to NASW and 10 percent only to the Society. Apparently conflicts in organization policy do not affect membership choices. For example, NASW supports the B.S.W. as academic entry to the profession; the Society, on the other hand, supports the M.S.W. as the entry degree. The latter position is strongly supported by this group of respondents although a large proportion belong to both organizations.

Most respondents whose clinical practice is within an agency (Figure 4) also engage in other professional activities (e.g., administration, teaching, consultation, supervision, or research). Of those in private clinical practice only, one-fifth provide other than direct clinical services (e.g., teaching, consultation, or research). Subjects were asked to give approximate percentages of current clinical practice with adults, children, families, couples, and groups (Figure 5). Adult therapy is the treatment of choice (59 percent) and work with children, couples,

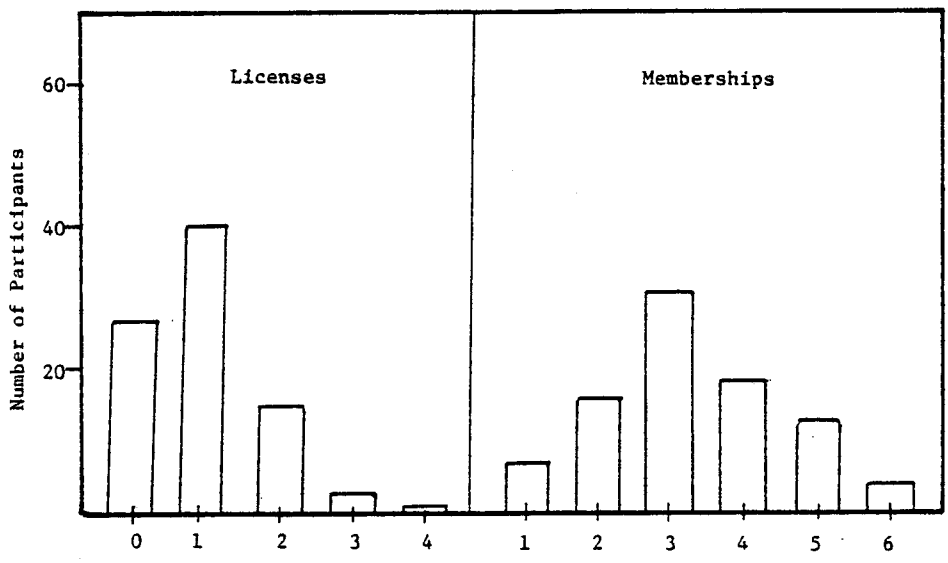

Fig. 3. Licenses and Memberships. Number of state licenses and number of memberships in professional organizations held by respondents.

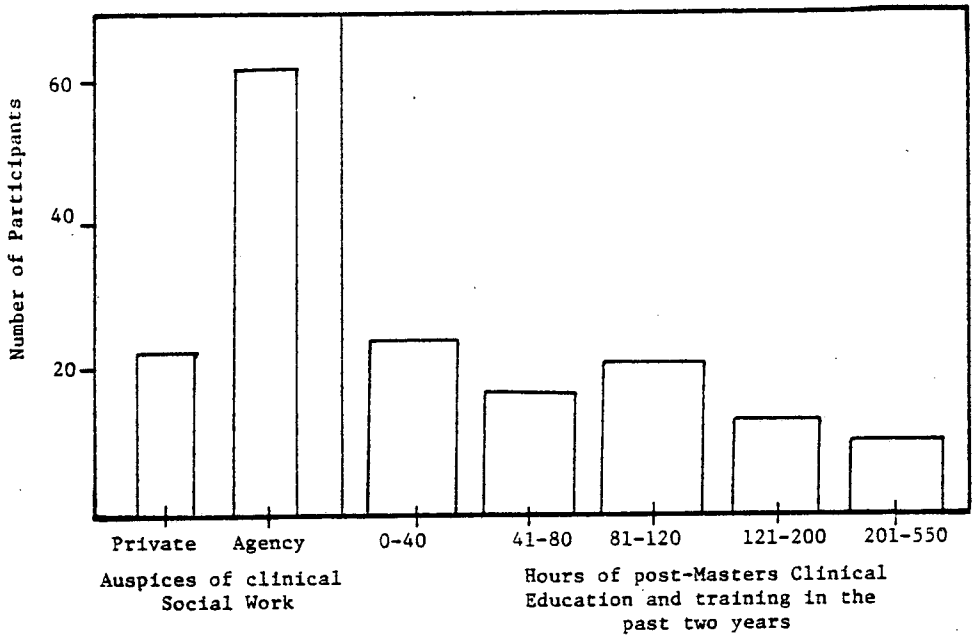

Fig. 4. Practice auspices and recent education of respondents.

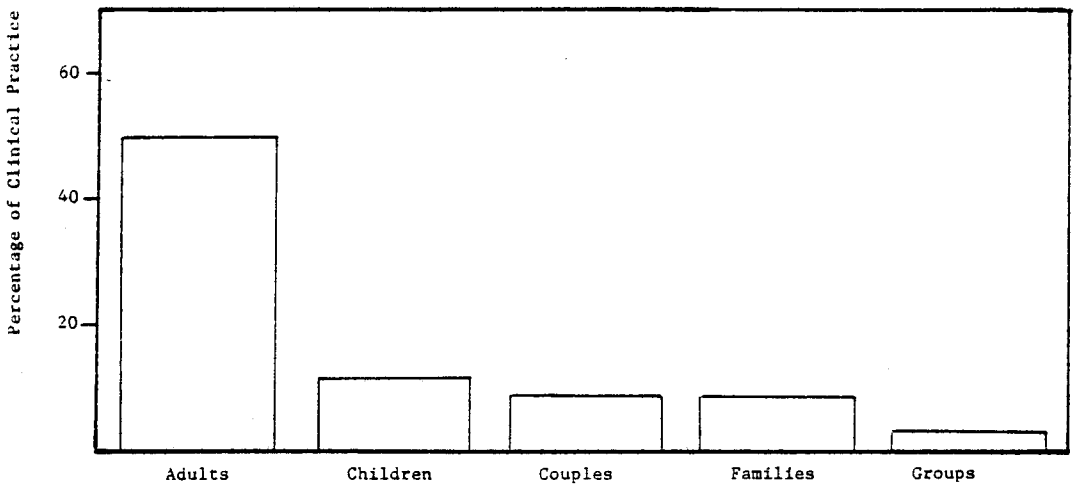

Fig. 5. Modalities of Clinical Practice. Distribution of respondents' clinical practice by modality of treatment.

and families each range between 10 percent and 12 percent. Groups are least favored (8.2 percent).

Participants estimated the number of hours of post-master's clinical education and training in the past two years (Figure 4). The responses ranged from 0 to 550 hours; the average was 64 hours. Only 36 percent of this advanced education comprised training by social workers, and less than 23 percent took place in a university setting. Older subjects showed a tendency for fewer total hours of training ($r=.22$, $p<.04$). Apparently clinical social workers are turning to mental health professionals outside social work and academia for their growth and development. In addition, it appears that clinical social workers engage in continuing education whether or not it is a mandate of licensure.

Participants were asked to "rank in importance to your practice the following psychological frameworks (with a value of 1 being most important and 5 being least important): psychoanalytic, behavioral, existential/growth, systems, and other (specify)" (Figure 6). Over 74 percent of the subjects ranked psychoanalytic as a first or second choice. This high ranking may be strongly influenced by the respondents' graduate education in the late 1950s and early 1960s. At that time, courses in personality development and practice theory were heavily influenced by psychoanalytic theory and ego psychology. Psychiatrists and psychoanalysts were still teaching these subjects in schools of social work and espousing the medical model which conceptualizes diagnosis and treatment as quite distinct phases and activities. The reader will recall this distinction in the section on practice in Chapter II. The most frequently-occurring combined ranking is psychoanalytic and existential/growth. More than 40 percent of

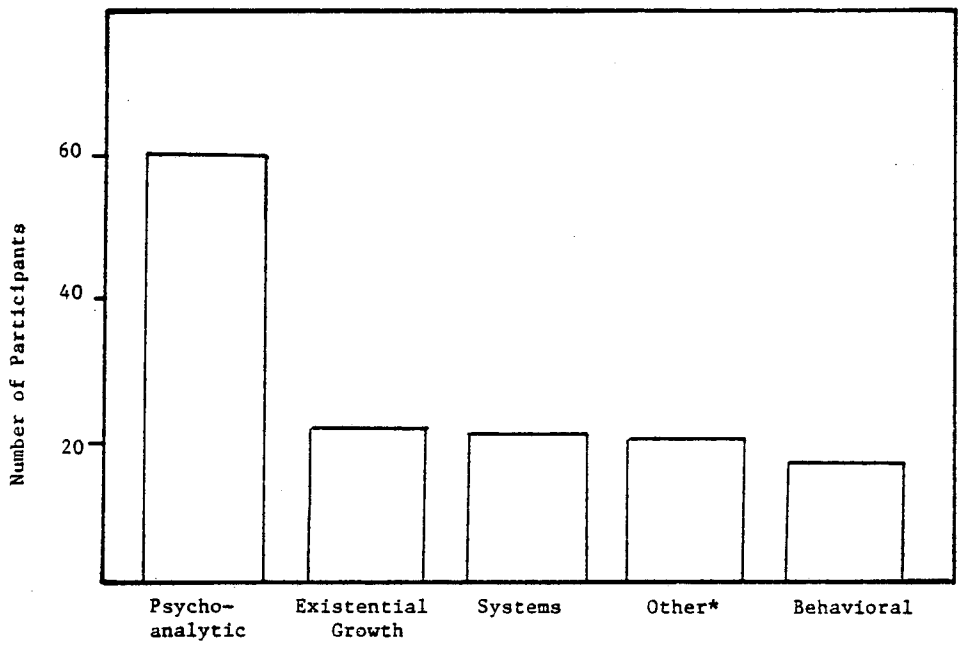

Fig. 6. Ranking of Theoretical Preference. Respondents' first preference for practice theory. (Other includes ego psychology, eclectic, gestalt, holistic, functional, Rogerian, family therapy, and cognitive.)

the population practice with a theoretical stance which includes both of these frameworks as highly rated.

Individuals with a psychoanalytic framework tend to be more exclusively involved in adult practice ($r=-.26$, $p<.02$) and less involved in work with couples ($r=+.30$, $p<.005$). Clinical social workers with a behavioral orientation tend to be older than those with other frameworks ($r=-.24$, $p<.032$), received their M.S.W.s a greater number of years ago ($r=-.24$, $p<.032$), and belong to fewer professional organizations ($r=.22$, $p<.046$). Existential/growth clinicians tend to have more licenses ($r=-.22$, $p<.046$) and are more involved with child practice ($r=-.24$, $p<.037$). Systems practitioners generally work more with families ($r=-.31$, $p<.005$) than do those with non-systems orientation, and do less adult and couple practice ($r=.40$, $p<.001$ and $r=-.22$, $p<.051$, respectively). These systems respondents also tend to work more in agencies ($r=.26$, $p<.02$) and they have more additional areas of practice (administration, etc.). Finally, those who do not fall in any of the above categories ("other") have generally spent fewer hours in education and training in the past two years ($r=.24$, $p<.036$).

Subjects were asked about their participation in supervision and consultation (Figure 7). Those who receive supervision are younger than those who do not ($r-+.29$, $p<.007$); those who offer supervision are younger ($r=+.36$, $p<.001$). Youth and involvement in supervision suggest agency practice; there was, however, no significant correlation to indicate younger workers are more likely to be practicing in agencies. Those who receive consultation had fewer hours of education and training in the past two years ($r=-.23$, $p<.034$). Consultation, on the other hand, often provides professional growth and development. Finally, the supervisors and

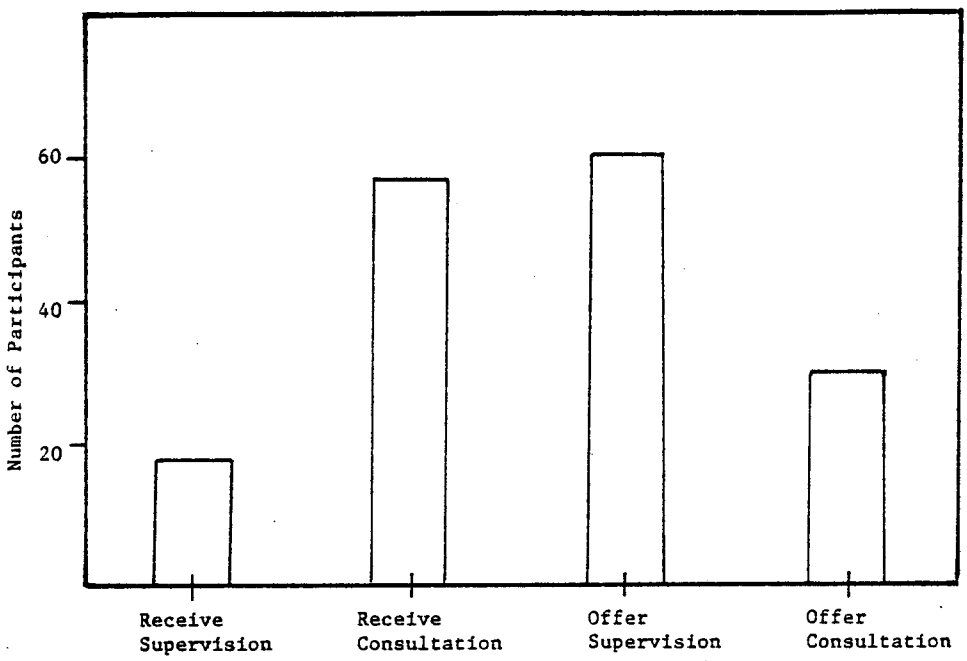

Fig. 7. Supervision and Consultation. Distribution of respondents receiving and offering supervision and consultation.

consultants in the group belong to more professional organizations ($r=-.27$, $p<.014$ and $r=-.28$, $p<.011$, respectively).

Our "typical" respondent lives in the Western United States, is 46.6 years of age and female. She was awarded her M.S.W. seventeen years ago, holds one state license, and belongs to three professional organizations including both NASW and the Society for Clinical Social Work. She is employed by an agency where, in addition to her clinical practice which is chiefly with adults, she may be an administrator or supervisor. She had 64 hours of post-master's professional training in the past two years; about one-third of that was received from other social workers but only one-fourth was under university auspices. She values psychoanalytic theory.

Factor Analysis

Separate factor analyses were performed on the four major portions of the questionnaire: Definition, Values, Knowledge, and Practice. The sample size of eighty-five respondents was relatively small for these analyses. Any conclusions drawn from them, therefore, may be suspect, especially when the analyses deal with many items/questions as in the Knowledge and Practice sections (forty-two items and fifty-four items, respectively). However, objections may be tempered by not relying on exact weightings or loadings. Factor analysis links groups of items which appear to share underlying dimensions.

Definition

Four factors

The factor analysis for the eighteen Definition items produced four important groups of items or dimensions. The first factor (represented by Definition items 1, 8, and 3) involves basic qualifications: a

clinical social worker holds the M.S.W. degree, social work values and ethics, and has a background of social work knowledge and theory. The second factor (represented by Definition items 15, 16, and 12) addresses the basic function of the clinician: a clinical social worker provides counseling and psychotherapy for psychosocial problems to help clients enhance or restore functioning. The third dimension (represented by Definition items 18, 14, and 6) expresses the unique social work focus on the interface of the individual and society: a clinical social worker helps people obtain tangible services and helps create societal conditions favorable to human fulfillment. The fourth factor (represented by Definition items 4 and 7) looks to the professional self: a clinical social worker has clinical expertise and knowledge and continues professional education and development. The factor loadings for this analysis are presented in Appendix A, Table 1.

The conclusions of this analysis are that clinical social workers define themselves in terms of four criteria: they meet basic educational qualifications which include holding both the M.S.W. and the profession's values and ethics, they provide mental health services focused on improving social functioning, they are committed to social work's basic mission to the enhancement of the individual and of society and the interaction between the two, they possess professional knowledge and are involved in continuing education and development.

Comparison with the literature

How does this experimentally-derived definition of clinical social work fit with those in the literature? It is considerably narrower than that of the California licensing law. It is similar to the position

statement of the Education Committee of the Federation of Societies for Clinical Social Work (Clinical Social Work Journal, 1977). In addition, the definition related closely to those of the Registries (1978); both emphasize the M.S.W. as well as knowledge, values, and competencies. For the requirement that post-master's work be supervised by a clinical social worker, they appear to acknowledge the need for continuing socialization to the profession. With the addition of Definition item 11, which was affirmed by a mean of 6.43, our definition includes the capability of autonomous, self-directed practice. This definition, as supported by research and the literature, eliminates the dichotomy of working with groups or individuals; clinical social workers choose appropriate modalities of treatment to deal with their clients in their real-life situations.

The view that clinical social work is also a specialization within the social work profession (Definition item 9) was validated with a high mean response of 5.84.

Values

Four factors

The factor analysis of the responses to the twenty-two items of the Value section of the questionnaire reveals four underlying dimensions. These factors are those values perceived by practitioners as most appropriate to clinical social work. The first (represented by Value items 21, 20, 16, 3, 22, and 2) addresses social work's representation of society's responsibility to the individual as well as the commitment to participating in the solution of social problems. The second factor (represented by Value items 4, 5, and 1) expresses the primary belief in the worth and dignity of the individual. The third dimension (represented by Value items 11, 19, and 7) includes conservative stances with regard to

professionalism and social work; these are concern for giving service more than receiving personal gain, emphasis on clinical practice more than social action, and identification with residualism (the belief that the basic responsibility for service delivery is private rather than public). The fourth factor (represented by Value items 10 and 9) focuses on liberal stances: the clinicians' rights to organize and to seek licensing and vendorship. Factor loadings for this analysis are presented in Appendix A, Table 2.

It can be concluded, then, that clinical social workers accept that they often represent society's responsibility to the individual and they believe in involving themselves in the betterment of society. They are committed to the value and dignity of the individual. In close juxtaposition, there are identifications with both conservative and liberal professional stances. Obviously, diversity regarding instrumental values is honored.

Comparison with the literature

How do these experimentally-derived values fit with those in the literature? The value statements concerned with the dignity and worth of the individual and the commitment to alleviation of social problems echo through the writings of the century. Recent examples, Meyer and Pinkus, et al., are cited in a previous chapter. The view that social work is the institution established to represent society's conscience appears to be reflected in a particularly balanced manner in factors three and four. Perhaps, these are two polarities of the conscience!

The values cited from Strean in Chapter II of this thesis relate primarily to clinical practice issues. While labeled "values" by the

author, they appear to be ehtical principles--those principles which guide decision-making. Value items 4, 5, 8, 14, and 16 address many of the concepts described by this author. Averaging the mean responses of these items (again, on a seven-point scale) produces a significantly high mean, 6.4, which validates these ethical principles.

Clinical social workers, then, believe in the profession's basic values as well as the ethical standards which guide practice decisions.

Knowledge-Base

Six factors

The factor analysis for the forty-two items of the Knowledge section produced six underlying dimensions. These factors indicate the areas of knowledge that clinical social workers perceive as central to their practice. The first (represented by Knowledge items 27 and 30 through 42) expresses concern for a theoretical base to practice and acknowledges the appropriateness of a variety of theories. The second (represented by Knowledge items 23, 22, 7, and 8) shows regard for the importance of continuing acquisition of practice wisdom as well as the value of the professional relationship for guided, experiential learning and help-giving. The third dimension (represented by Knowledge items 3, 2, 11, 21, and 15) is close to the graduate curriculum for the M.S.W. as described in Chapter II. The fourth factor (represented by Knowledge items 11, 12, and 20) focuses on the importance of a background of information about personality development and practice theory. The fifth factor (represented by Knowledge items 28, 5, 1, and 29) is concerned with knowledge of dynamic Freudian theory (including ego psychology) which is sometimes described as psychosocial theory. The sixth factor (represented by Knowledge items 14,

13, 15, and 26) involves understanding and appreciation of elements of practice wisdom unique to social work; such areas include awareness of personal responses to the stress of poverty and the impact of helping processes (seeking, using, and providing). Factor loadings for this analysis are presented in Appendix A, Table 3.

It is noteworthy that factor three of the Definition section and factor six of the Knowledge analysis appear to be closely related as regards the concern for the involvement of social work with the interrelatedness of the individual and society. As a check on the validity of this assumption, correlations were computed between the Definition items 18, 14, and 6 and Knowledge items 14, 13, and 15. All the correlations were significant, with r's ranging from +.21 to +.52. Therefore, it is likely that each of these factors is tapping the same dimension.

Comparison with the literature

How does this experimentally-derived knowledge base fit with that described in the professional literature? The appropriateness of the areas of study incorporated in typical graduate social work education is validated by the respondents. Three further areas of knowledge are emphasized:

1. The need for practice theory. While psychoanalytic theory is ranked highest, pluralism is espoused. Clinical social workers are not advocates of "doing what works" but, rather, are concerned that there be theoretical underpinnings to practice. This concept is further validated by a number of comments appended to the questionnaire: "In my opinion there is no right or wrong frame of reference but some frame is required and interventions should be rooted in theoretical frame;" "Although my

preference is for ego psychology, the other theories are legitimate and useful;" "I believe any of the theories mentioned are appropriate for a clinical social worker to draw from but it is an individual matter as to which ones should be developed and used in depth in his/her own practice."

It is interesting that some comments indicate preference for the two positions regarding theory besides pluralism (unifying theory and a single, chosen theory) that were described in the review of the literature concerning the Knowledge dimension. For example, a respondent commented that, "As a profession social work needs to draw on a unified theory base--there is much work needed here." Another remarks, "I think clinical social work should be based on the psychodynamic conceptual model with eclectic borrowing of all of the best of the other frameworks."

2. The value of the practice wisdom developed through the years within the profession. The knowledge gained in social work's long experience at the interface of the person with society is an important heritage. This, of course, is the content of much of the literature. Knowledge item 10 addresses this particular reading directly; the mean response was fairly high: 5.82. A remark from the field-tested questionnaire: "Re: literature--I probably read less social work literature than psychiatric, psychosomatic, family, and medical. 'Social work theory' bored me."

3. Preference for guided, experiential learning which can include supervision, consultation and personal therapy. This concept appears to be very similar to Hypothesis 5. Statistical analysis of the specific items will be presented in the discussion of the hypothesis.

Practice

Seven factors

The factor analysis of the forty-six items of the Practice Section produced seven underlying dimensions. The first factor (represented by Practice items 24, 41, 38, 28, 20, and 37) views practice with groups and families within an interactional or systems framework. The second (represented by Practice items 18, 33, 16, 14, 15, and 34) underscores the social work emphasis on diagnosis as a core treatment process and indicates a trend toward analytic techniques. The third (represented by Practice items 48, 46, and 45) describes elements of indirect clinical practice such as consultation, supervision, and teaching. Here, again, is a factor which overlaps one in another section, Knowledge factor two. Dimensions which overlap between the sections tend to validate the data and reflect that the clinician's knowledge and practice are also interrelated. The fourth dimension (represented by Practice items 31, 30, 12-negative, and 10) focuses exclusively on interventions focused on intrapsychic material and, thereby, appropriate to psychoanalytic practice. The fifth factor (represented by Practice items 44, 7, 23, and 8) focuses, in contrast, on interpsychic material concerning the client and her/his world. The sixth (represented by Practice items 6, 42, 21, 40, 39, and 2) indicates a strong trend for psychoanalytic practice and includes the clinician's self-awareness. The seventh (represented by Practice items 47, 43, 25, 22, and 5) concerns active advocacy both on behalf of the client and for improvement of community resources. It is noteworthy (and consistent with the personal information data) that Knowledge factor five and Practice factors two, four and six reflect the strong preference for psychoanalytic theory and practice. This strong preference may, as suggested above, be

related to the respondents' graduate education. Factor loadings for this analysis are presented in Appendix A, Table 4.

Clinical social workers consider there to be these underlying elements to their practice. They work with individuals, families, and groups as well as offer supervision, consultation and teaching. They perceive diagnosis as an essential treatment process and they prefer psychoanalytic practice. In addition, they focus on client needs, both personal and interpersonal, and they are willing to take action in the community on the client's behalf.

Comparison with the literature

How does this experimentally-derived view of clinical social work practice fit that of the literature? The consistently-expressed goal of social work practice is change, growth, and improved social functioning. The focus on change of self-concept, role-performance, and expectations of others are represented particularly in factors one, four, five, and six. This analysis, then, fits well with the literature regarding focus and goals. Diagnosis, long a central concern in the professional practice literature, is an important element in factor two. The analysis emphasizes that consultation, supervision, and offering of professional training are appropriate elements of clinical social work. Direct practice is no longer dichotomized into casework and group work but, rather, articulates with the real-life situation of clients; this reflects the statements of the Education Committee of the Federation and other material the reader will recall from Chapter II of this thesis. The strong preference for psychoanalytic techniques is also consistent with the Education Committee report and much of the pre-1970 social work literature. There is further

validation of the unique focus of the social worker on the patient's inner and outer life, and interaction of the intra- and interpsychic experience, and the patient in her/his real-life situation. Finally, this analysis underscores the acceptance of social advocacy and improvement of community resources as part of clinical social work practice.

Hypotheses

Nine hypotheses have been basic to this research; each was descriptively tested. The means of the items that address each hypothesis were computed and averaged. Since there was no control group in the study, there is no comparison of means possible. While this reduces the meaningfulness of these means, the responses to the questions do provide some view of the respondents' perceptions.

Hypothesis 1

Clinical social workers do not believe the B.S.W. is academic entry to the profession. The question that addresses this hypothesis is Definition item 2. The mean of 1.22 on a seven-point scale indicates strong opinion that the Bachelor of Social Work degree is not adequate preparation for entry to clinical social work.

Definition item 1 holds the Master of Social Work as appropriate. The mean of 6.9 indicates almost total support.

Hypothesis 2

Clinical social workers identify with social work values. The eight questions which relate to this hypothesis are Definition item 8 and Value items 12, 3, 8, 14, 15, and 16. The mean response is high, 6.37, indicating the hypothesis is supported.

Hypothesis 3

Clinical social workers rely on the knowledge acquired in their postgraduate education. Seventeen questions involve this issue: Knowledge items 2, 3, 4, 5, 7, 8, 9, 10, 13, 15, 16, 17, 22, 23, and 26. The mean response was quite high, 5.17, and the hypothesis is sustained.

Hypothesis 4

Clinical social workers continue their education and training past the M.S.W. for ongoing professional development. Twelve questions are concerned with this idea: Value item 13; Definition item 4; Knowledge items 7, 8, 9, 10, 23, and 25; and Practice items 40, 45, 46, and 48. The mean response is high: 6.13. The personal information data also supports this idea; the average number of post-master's training hours in the previous two years was 64 (Figure 4).

Hypothesis 5

Clinical social workers prefer experiential to didactic learning. The nine questions addressing experiential training are Definition item 3; Knowledge items 7, 8, and 25; Value item 13; and Practice items 46 and 48. These yield a mean of 5.39. Didactic learning items are Definition item 5; Knowledge items 1, 10, 2, 3, and 27 through 42. The mean of these items is 5.40. The hypothesis is not supported.

Hypothesis 6

Clinical social workers rank psychoanalytic theory and practice highly. Thirteen questions address this statement: Definition item 7; Knowledge items 27 and 28; and Practice items 2, 6, 10, 11, 21, 27, 30, 31, 33, and 42. The mean response, 5.73, supports this hypothesis, as does

personal information data which showed that 59 of the respondents ranked this framework as most important.

Hypothesis 7

Clinical social workers focus on the interaction of the biological, psychological, and social forces in the lives of their patients. Nineteen questions refer to this statement: Definition items 12, 13, 14, 15, 16, and 17; Knowledge items 1, 11, 13, 15, 17, 21, 16, and 29; and Practice items 5, 20, 26, 44, and 47. The mean response to these items is 6.16, indicating strong support.

Hypothesis 8

Clinical social workers offer mental health services to individuals, families, and groups. Eleven items pertain to this statement: Knowledge items 38, 39 and 4; and Practice items 1, 6, 8, 20, 24, 28, 41, and 44. The mean response, 5.56, provides evidence for agreement with the hypothesis.

Hypothesis 9

Clinical social workers are concerned with social action. The seven related questions are Definition item 18; Value items 20, 21, and 22; Knowledge items 4 and 26; and Practice item 22. The mean response was well above the midpoint of the scale at 5.40 indicating agreement with the hypothesis.

Further Comments

A number of respondents indicate their concern for the differences between practice in agencies and private practice:

> "If you are in private practice or agency practice, I believe your answers would differ."

"Fee setting--practitioners' initial conflicts re: direct fee for service vs. earlier experience of salary for work--subtle shift from identification with institution/agency to identification with one's self and one's profession--the unaccustomed growth of professional autonomy or 'the buck stops here!'"

"Difference the clinical social worker sees as agency employee vs. private practitioner."

"You do not ask if I consider myself primarily as a clinical social worker or psychotherapist or psychoanalyst and this perception is influenced by private or agency practice."

"Clinical practice is done through private practice and agency practice. . . . If one were practicing in an agency many of the responses would be different than for those practicing privately. Private practice and agency practice are two different therapy environments and endeavors for both the therapist and the patient."

"You didn't mention money. I do my work and see my patients to make a living. I do my work within an economic structure and this does on occasion change some of my clinical choices."

"Not much on private practice."

It is apparent that these subjects believe that there is a difference between the clinical practice in an agency and that in a private office. They imply that these differences affect values or ethical choices as well as clinical behavior. Perhaps further research will illuminate these variables, if any, and will chronicle the changes in professionals who make the transition from agency to private practice.

CONCLUSIONS

Clinical Social Workers Are Social Workers

Clinical social workers define themselves primarily as the psychotherapists within the social work profession. The basic service is psychotherapy focused on the interaction of the biological, psychological and social aspects of their patients' lives. Clinical social workers retain their socialization to the profession despite their frequent involvement with post-master's continuing education and training outside the profession. They are committed to participation in the solution of social problems. These practitioners perceive their values, knowledge-base, and practice as well within the social work rubric. In fact, the research data validates most closely the statements regarding definition, setting, practice, education and experience criteria in the NASW Register of Clinical Social Workers, Second Edition, 1978. The reader will recall these as quoted in Chapter II of this thesis.

Clinical social workers make an unambiguous declaration of their social work identity. Over 12,000 have qualified themselves for listing in the national registries (about 1,500 in the National Registry of Health Care Providers in Clinical Social Work, 1978, and about 10,000 in the NASW Register of Clinical Social Work, 1978). How is it possible to reconcile such large numbers and such forthright adoption of the distinguishing title with the dearth of reference to clinical social work in the professional literature?

Academicians Versus Clinicians

Basically, this appears to focus on authorship--or, the issue of "Who publishes?" The figures cited in Chapter II regarding authorship of the major volumes of the decade indicate a high preponderance of professors (usually D.S.W.s and Ph.Ds) among the authors. Professors are those most likely to profit from publishing (gaining promotion and acclaim in the academic system) while clinicians lose when they do not schedule appointments to make time for research, writing, and education for doctoral degrees. It seems reasonable to conclude, then, that this research points to a cleavage between academicians and practitioners such that language differences are developing. While professors hew to terms such as psychiatric social worker, clinically-inclined practitioner, and direct service practitioner, our group has unequivocably settled on a title. Comments on the questionnaire from the respondents substantiate this idea. Those items which included terms from current social work literature (change agent, case manager, taking care of people who must be cared for, using persuasion, etc.) elicited remarks from the respondents such as "confusing" and "unclear." These comments may also indicate that practitioners are not keeping current with the professional social work literature; this notion is informally supported by the writer's experience.

In addition, the "accreditation standards of the Council on Social Work Education have tended to see the M.S.W. as a basic course of study covering the parameters of social work philosophy and practice skills--rather than intensive preparation for one aspect of practice. There has been a move toward a basic, generic curriculum rather than orientation to a specialization within social work. . . . This has undoubtedly influenced the vocabulary." Selby further suggests that the professorial responsibility

to integrate "new knowledge from the behavioral and social sciences . . . with social work professional theory" has heavily influenced the academicians' choice of language.[1]

A further cleavage which appears between academicians and practitioners is that of theoretical framework. This study validates the continuing preference for psychoanalytic theory and interventions among clinical social workers. Meanwhile, professors are writing prolifically about role theory, task-centered theory, small-group theory, client-centered theory, and so on. Substantiating the notion that resistance builds persistance is the adamant adherence to polarities, and there appear two, somewhat mutually-exclusive, trends regarding theoretical orientation.

Dichotomy in language and theory also focuses on the differences regarding educational levels within the profession. Schools of social work and the Council on Social Work Education have in recent years concerned themselves primarily with the Bachelor of Social Work degree and, under certain circumstances, reducing the length of the M.S.W. curriculum. Meanwhile professionalism and autonomous practice indicate the need for increased education and training. There are few doctoral programs in clinical social work. Academic senates are chary of approving practice doctorates of any kind (doctorates, the myth states, are awarded to the intelligentsia or thinkers rather than to the doers of any group). Tension regarding appropriate degrees affects publishing, professional education, legislation, practice, public sanction, and association with other health professionals.

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[1]Selby, Personal communication, 1979

It is apparent that clinical social workers must recognize themselves as their own intelligentsia, seek advanced degrees, and publish their work and research. Integration of theory and practice by advanced clinicians studying at the doctoral level can best respond to the need for theory construction in social work. We are fortunate that both faculty and students have, to some extent, begun to answer this need, especially in the Clinical Social Work Journal.

Integration of Clinical with Social Work

This research has been completed in partial fulfillment of the requirements for the degree of Doctor of Philosophy from the Institute of Clinical Social Work. The author participated in the development year, 1976-77, as well as in the years since then. The concern of the Institute is for excellence, and this has shaped student selection, evaluation processes, curriculum development, and many related areas. From the original "working papers" developed out of the 1976-77 year to the presentations to colloquia and convocations, this excellence has been almost exclusively devoted to the therapeutic aspect of clinical social work. There has been very little addressed to the social work aspect of professional activity. For example, in 1977-78 a curriculum grid was developed to include the areas in the course of study. There were thirty-eight items on the grid. Thirty-four specific elements were concerned with psychotherapy; only four items were focused on social work.

While the Institute has chosen a close identification with social work as expressed in both its name and the degree it awards, there has been only meager focus on the social work aspect of professional activity. This research indicates that practitioners, clearly identifying themselves

with the social work profession, validate the Institute choice of name and degree. It is important, then, that the Institute become involved not only in developing doctoral-level sophistication of psychotherapeutic practice but also doctoral-level sophistication of social work practice. In the Institute the underlying assumption seems to be that students are social workers so that the unalterable fact is that whatever they do is social work. Further exploration of this assumption as well as other aspects of advanced social work practice are clearly appropriate to the goals to which the Institute is committed.

The theory-building aspects of the integration of clinical with social work include such questions as these: are there specific, unique elements to this practice; does this clinician have a special philosophic framework; are there unique social work additions to the clinician's practice theory and interventions; does advanced, doctoral-level psychotherapy include equally sophisticated social work? Answers to these questions would enhance the recognition of the operational procedures by which clinical social workers have become a distinguishable group within the social work profession.

Exploration of these questions and others within the Institute program might involve an ongoing convocation study group reading and winnowing current social work literature and pursuing, through case material, clarification of the uniqueness and boundaries of clinical social work. In addition, material presented at colloquia and other groups might be viewed in regard to some of the questions noted above. Such activity would appear to be an implementation of the development of <u>both</u> clinician and client suggested by Verneice Thompson, the incoming Dean of the Institute. The reader will recall her directions as quoted in Chapter I of this thesis.

The distinguishing title, clinical social work, has enabled the psychotherapists within the social work profession to make important gains in licensing, vendorship, professional stature, and public acknowledgement. It has, as well, provided an identity which cuts across old limitations of modalities and fields of practice to emphasize central values, function, qualifications, knowledge, and psychotherapeutic practice. These very gains and enhanced identity have helped generate a number of practice doctorate programs, the largest of which is the Institute for Clinical Social Work. Study and theory building regarding the unique characteristics and integration of clinical with social work are, therefore, particularly appropriate to the work of the Institute.

APPENDIX A

TABLE 1

DEFINITION

Factor 1

Variable	Factor Loadings
D1	.872
D8	.696
D5	.670

Factor 2

Variable	Factor Loadings
D15	.895
D16	.852
D12	.724

Factor 3

Variable	Factor Loadings
D18	.777
D14	.725
D 6	.492

Factor 4

Variable	Factor Loadings
D4	.642
D7	.544

TABLE 2

VALUES

Factor 1

Variable	Factor Loadings
V21	.721
V20	.612
V16	.575
V 3	.563
V22	.553

Factor 2

Variable	Factor Loadings
V4	.681
V5	.651
V1	.542

Factor 3

Variable	Factor Loadings
V11	.565
V19	.494
V 7	.479

Factor 4

Variable	Factor Loadings
V10	.615
V 9	.525

TABLE 3

KNOWLEDGE

Factor 1

Variable	Factor Loadings
K37	.875
K40	.873
K34	.870
K41	.812
K38	.811
K35	.793
K27	.787
K42	.785
K31	.769
K33	.746
K32	.733
K30	.700
K39	.695
K36	.528

Factor 2

Variable	Factor Loadings
K23	.797
K22	.760
K 7	.579
K 8	.523

Factor 3

Variable	Factor Loadings
K 3	.761
K 2	.727
K11	.510
K21	.497
K15	.493

Factor 4

Variable	Factor Loadings
K11	.784
K12	.703
K20	.427

Factor 5

Variable	Factor Loadings
K28	.699
K 5	.619
K 1	.472
K29	.405

Factor 6

Variable	Factor Loadings
K14	.717
K13	.692
K15	.468
K26	.410

TABLE 4

PRACTICE

Factor 1

Variable	Factor Loadings
P24	.710
P41	.667
P38	.629
P28	.533
P20	.509
P37	.506

Factor 2

Variable	Factor Loadings
P18	.716
P33	.689
P16	.688
P14	.676
P15	.628
P34	.603

Factor 3

Variable	Factor Loadings
P48	.908
P46	.885
P45	.847

Factor 4

Variable	Factor Loadings
P31	.826
P30	.782
P12	.622
P10	.570

Factor 5

Variable	Factor Loadings
P44	.654
P 7	.627
P23	.525
P 8	.502

Factor 6

Variable	Factor Loadings
P 6	.620
P42	.577
P21	.454
P40	.453
P39	.448
P 2	.439

Factor 7

Variable	Factor Loadings
P47	.760
P43	.749
P25	.687
P22	.681
P 5	.610

APPENDIX B

nstitute For Clinical Social Work

THE FORUM BUILDING □ ROOM 1010 □ SACRAMENTO, CALIFORNIA 95814 □ (916) 441-1155

Dear Colleague:

As a clinical social worker you are aware of the diversity of definitions of this specialization in our profession. I am engaged in research to develop both a definition and a description of knowledge, values, and practice. Because of your identity with clinical social work, I am hoping that you will participate in this study. The research is partial fulfillment of the requirements for the Doctorate of Clinical Social Work.

Hopefully, the study will provide a profile of the values, knowledge, and practice considered to be most appropriate to clinical social work. Such a profile could be of immense value to curricula development, lobbying for legislation, and negotiating insurance vendorship. This information could also be very useful in providing a realistic image of our profession to the public.

You have been randomly selected from the National Registry of Health Care Providers in Clinical Social Work (1976). Your participation will certainly affect the results of the project. Your information will be kept anonymous and you, in no way, will be individually identified with this research.

The accompanying questionaire will take about 45 minutes. Please consider the statements in the questionaire from the clinician's point of view although you may be also engaged in another field of social work.

Your opinion is important; there are no "right" or "wrong" answers. Please return the completed questionaire in the stamped, addressed envelope by June 30, 1978.

Many thanks,

Josephine A. Jackson, M.S.W.

JAJ:sm/do

PERSONAL INFORMATION

1. Age_____ 2. Male_____ 3. Year Awarded MSW_____
   Female_____ 4. Present State of Residence_____

5. Membership(s) (Check 1 or more)
   Society for Clinical Social Work_____
   National Association of Social Workers_____
   Academy of Certified Social Workers_____
   Other (Specify)_____
   _____

6. License(s)_____State_____
   _____State_____
   _____State_____

7. Give approximate percentage of current clinical practice:

   Adult_____Child_____Couple_____Group_____Family_____

8. Is the majority of your clinical practice in an agency_____
   or in private practice_____.

9. Are you currently engaged in professional practice other than
   clinical?_____Specify_____

Post-Masters Clinical Education and Training:

10. Estimate number of hours of education/training received in past 2 years_____.

11. What percent of this education/training was in a university setting?
    _____.

12. What percent of this education/training was received from social worker(s)?_____.

13. Do you receive regular clinical supervision at present?_____
    If yes, is your supervisor a clinical social worker?_____

14. Do you receive regular consultation at present?_____
    If yes, is your consultant a clinical social worker?_____

15. Do you offer supervision at present?_____
    If yes, whom do you supervise: clinical social workers?_____
    Others?(Specify)_____

16. Do you offer consultation at present?_____
    If yes, whom do you consult: clinical social workers?_____
    Others?(Specify)_____

17. Do you have another advanced degree?____Specify Degree_____Field_____

18. Rank in importance to your practice the following psychological frameworks (1 is most important; 5 is least important):

    Psychoanalytic_____

    Behavioral_____

    Existential/Growth_____

    Systems_____

    Other (Specify)_____

DEFINITION OF CLINICAL SOCIAL WORKER

These statements can be parts of a description of a clinical social worker. By circling the numbers, weigh the appropriateness, in your opinion, of each of the statements listed below.

A CLINICAL SOCIAL WORKER. . .	Not Appropriate						Very Appropriate
1. Holds Master of Social Work degree	1	2	3	4	5	6	7
2. Holds Bachelor of Social Work as most advanced degree	1	2	3	4	5	6	7
3. Has completed at least 2 years of post masters supervised clinical work	1	2	3	4	5	6	7
4. Continues own education and training throughout professional career	1	2	3	4	5	6	7
5. Has a background of social work knowledge and theory	1	2	3	4	5	6	7
6. Has special knowledge of interaction of human capabilities and social resources	1	2	3	4	5	6	7
7. Has knowledge of the part that unconscious processes play in determining behavior	1	2	3	4	5	6	7
8. Holds social work values and ethics	1	2	3	4	5	6	7
9. Has developed a specialization within the social work profession	1	2	3	4	5	6	7
10. Possesses a reservoir of skills and techniques and the professional judgment to use these selectively	1	2	3	4	5	6	7
11. When certified (ACSW or state licensed), is capable of autonomous, self-directed practice	1	2	3	4	5	6	7
12. Practices counseling and applied psychotherapy of a non-medical nature	1	2	3	4	5	6	7
13. Provides direct, diagnostic, preventive and clinical services	1	2	3	4	5	6	7
14. Helps people obtain tangible services	1	2	3	4	5	6	7
15. Helps individual(s) enhance or restore capacity for social functioning	1	2	3	4	5	6	7
16. Helps troubled people with psychosocial problems	1	2	3	4	5	6	7
17. Provides clinical services to those whose functioning is threatened by psychological stress or health problems	1	2	3	4	5	6	7
18. Helps create societal conditions favorable to human fulfillment	1	2	3	4	5	6	7

VALUES

Values are defined are beliefs and standards about what is preferred and desirable. By circling the number, weigh the appropriateness, in your opinion, of each of the statements listed below.

A CLINICAL SOCIAL WORKER. . .	Not Appropriate						Very Appropriate
1. Is committed to the worth and dignity of each human being	1	2	3	4	5	6	7
2. Believes society is responsible to provide opportunity for each individual to realize her/his potential	1	2	3	4	5	6	7
3. Believes in mutual responsibility between individuals and society	1	2	3	4	5	6	7
4. Is committed to the right of self-determination for each person	1	2	3	4	5	6	7
5. Values the individual's own view of the situation (including definition, goals and participation in outcomes)	1	2	3	4	5	6	7
6. Believes the basic structure for delivery of services is a government responsiblity	1	2	3	4	5	6	7
7. Believes the basic structure for delivery of services is the responsibility of the family, community, church	1	2	3	4	5	6	7
8. Is committed to each individual's right to services	1	2	3	4	5	6	7
9. Forgoes the committment to humanitarian values when he/she seeks public status such as licensing and vendorship	1	2	3	4	5	6	7
10. May withhold services to clients in order to realize one's own rights (as in a labor strike)	1	2	3	4	5	6	7
11. Is more concerned with providing service than personal gain or benefit	1	2	3	4	5	6	7
12. Is willing to relinquish some autonomy to adopt the professional code of ethics	1	2	3	4	5	6	7
13. Values personal psychotherapy	1	2	3	4	5	6	7
14. Is committed to enhancement of client(s) social functioning	1	2	3	4	5	6	7
15. Believes each client has a full right to all the information needed for decision-making	1	2	3	4	5	6	7
16. Believes tangible services must be delivered in a way to enhance self-determination	1	2	3	4	5	6	7
17. Is willing to be an agent of social control when working with involuntary clients	1	2	3	4	5	6	7
18. Believes in the right to privacy	1	2	3	4	5	6	7
19. Is more concerned with clinical practice than social reform	1	2	3	4	5	6	7
20. Is committed to non-violent solutions to social problems	1	2	3	4	5	6	7
21. Believes the professional has a responsibility to be involved with public issues which impact private troubles	1	2	3	4	5	6	7
22. Recognizes the need to change our basic social institutions	1	2	3	4	5	6	7

KNOWLEDGE

By circling the numbers, weigh the appropriateness, in your opinion, of each of the statements listed below.

A CLINICAL SOCIAL WORKER DRAWS ON. . .	Not Appropriate						Very Appropriate
1. Understanding of the dynamics of human behavior	1	2	3	4	5	6	7
2. Historical view of social welfare policy issues	1	2	3	4	5	6	7
3. Historical view of the development of professional social work	1	2	3	4	5	6	7
4. Knowledge of the legal responsiblities of professional practice	1	2	3	4	5	6	7
5. Knowledge of professional ethics	1	2	3	4	5	6	7
6. Integration of theory and experience in practice	1	2	3	4	5	6	7
7. Self-knowledge acquired through supervision	1	2	3	4	5	6	7
8. Knowledge acquired through consultation	1	2	3	4	5	6	7
9. Working knowledge of research methods	1	2	3	4	5	6	7
10. Regular reading of social work literature to gain knowledge and skill	1	2	3	4	5	6	7
11. Understanding of biological, psychological, and social aspects of personality development	1	2	3	4	5	6	7
12. Understanding of the processes by which interference with normal growth can result in dysfunction/pathology	1	2	3	4	5	6	7
13. Understanding of personal responses to the stress of poverty	1	2	3	4	5	6	7
14. Understanding of the impact of helping processes: seeking, using, and providing	1	2	3	4	5	6	7
15. Appreciation of the impact of cultural factors (including sexism and racism) which impact human behavior	1	2	3	4	5	6	7
16. Recognition of clinical limitations (referral for medical evaluation, hospitalization, etc.)	1	2	3	4	5	6	7
17. Understanding of factors involved in combining concrete services (i.e., foster home placement) and counseling skills	1	2	3	4	5	6	7
18. An in-depth knowledge of at least one practice theory	1	2	3	4	5	6	7
19. Theory which provides an intellectual structure for understanding facts encountered in practice	1	2	3	4	5	6	7
20. Theory for planning interventions and predicting their results	1	2	3	4	5	6	7
21. Knowledge of and skill in use of community resources	1	2	3	4	5	6	7
22. Recognition that the core social work process is the responsible, conscious, disciplined use of self in a professional relationship	1	2	3	4	5	6	7
23. Continued acquisition of "practice wisdom": the professional experience of self and others accumulated through the years	1	2	3	4	5	6	7
24. Recognition of the realistic limits to one's own skills and abilities	1	2	3	4	5	6	7
25. Self-awareness acquired in personal psychotherapy	1	2	3	4	5	6	7
26. Knowledge of and skill in participation in legislative processes	1	2	3	4	5	6	7

By circling the numbers, weigh the appropriateness, in your opinion, of each of the theories listed below.

A CLINICAL SOCIAL WORKER DRAWS ON. . .	Not Appropriate						Very Appropriate
27. Task-centered theory	1	2	3	4	5	6	7
28. Freudian theory (including ego psychology)	1	2	3	4	5	6	7
29. Psychosocial theory	1	2	3	4	5	6	7
30. Jungian theory	1	2	3	4	5	6	7
31. Problem-solving theory	1	2	3	4	5	6	7
32. Behavioral or learning theory	1	2	3	4	5	6	7
33. Functional casework theory	1	2	3	4	5	6	7
34. Socialization theory	1	2	3	4	5	6	7
35. Client-centered theory	1	2	3	4	5	6	7
36. Crisis-intervention theory	1	2	3	4	5	6	7
37. Cognitive theory	1	2	3	4	5	6	7
38. Systems theory	1	2	3	4	5	6	7
39. Small group theory	1	2	3	4	5	6	7
40. Role theory	1	2	3	4	5	6	7
41. Communication theory	1	2	3	4	5	6	7
42. Existential or growth theory	1	2	3	4	5	6	7

PRACTICE

These statements include skills and abilities clinical social workers may choose to use. By circling the numbers, weigh the appropriateness, in your opinion, of each of the statements listed below.

A CLINICAL SOCIAL WORKER. . .	Not Appropriate						Very Appropriate
1. Has practice competence in all three methods: casework, group work, and family therapy	1	2	3	4	5	6	7
2. Focuses on developmental material which determines behavior	1	2	3	4	5	6	7
3. Focuses on client(s) responsibility for his/her own behavior	1	2	3	4	5	6	7
4. Facilitates growth toward autonomy and self-awareness	1	2	3	4	5	6	7
5. Takes part in organizing and planning delivery of services	1	2	3	4	5	6	7
6. Practices psychodynamically-oriented casework and group therapy	1	2	3	4	5	6	7
7. Helps client(s) develop and use his/her own problem-solving and coping resources	1	2	3	4	5	6	7
8. Provides opportunity for enhancement of interpersonal relationships	1	2	3	4	5	6	7
9. Takes care of people who must be cared for	1	2	3	4	5	6	7
10. Helps client(s) achieve insight into unconscious conflicts that interfere with functioning	1	2	3	4	5	6	7
11. Realizes that focus on early genetic material usually emphasizes the client(s) feelings of helplessness	1	2	3	4	5	6	7
12. Focuses exclusively on here-and-now in client(s) life	1	2	3	4	5	6	7
13. Offers feedback including clarification of the clients' feelings	1	2	3	4	5	6	7
14. Views diagnosis as the process by which clinician understands the client and analyses factors relevant to the situation	1	2	3	4	5	6	7
15. Expresses the diagnostic statement in such a way as to engage the client(s) in the change process	1	2	3	4	5	6	7
16. Shares with the client(s) the assessment-diagnosis	1	2	3	4	5	6	7
17. Sees diagnosis and assessment as ongoing therapeutic processes	1	2	3	4	5	6	7
18. Assesses ego functioning as a guide to interventions	1	2	3	4	5	6	7
19. Uses persuasion	1	2	3	4	5	6	7
20. Becomes directly involved with client(s) significant others (relatives, mates, etc.)	1	2	3	4	5	6	7
21. Recognizes that client(s) insight into own feelings, actions, and formative experiences will result in better functioning	1	2	3	4	5	6	7
22. Is an active change agent	1	2	3	4	5	6	7
23. Establishes an atmosphere in which the client(s) can express feelings, viewpoints, and her/his own tempo	1	2	3	4	5	6	7
24. Works with groups to facilitate awareness of interactions	1	2	3	4	5	6	7
25. Collaborates with other professionals on behalf of the client(s)	1	2	3	4	5	6	7
26. Makes appropriate referrals	1	2	3	4	5	6	7

A CLINICAL SOCIAL WORKER. . .	Not Appropriate						Very Appropriate
27. Views understanding of the individual as basic to work with the family unit	1	2	3	4	5	6	7
28. Views family members as involved in a relationship system rather than as individuals	1	2	3	4	5	6	7
29. Offers active, concentrated, perceptive empathy	1	2	3	4	5	6	7
30. Interprets dreams	1	2	3	4	5	6	7
31. Encourages free association	1	2	3	4	5	6	7
32. Helps client make the transition from self-understanding to action and improved functioning	1	2	3	4	5	6	7
33. Is aware of the time involved in learning and integrating new patterns of behavior--"working through"	1	2	3	4	5	6	7
34. Corrects disparities between client(s) perception and reality	1	2	3	4	5	6	7
35. Helps client(s) understand own contribution to the problem	1	2	3	4	5	6	7
36. In crisis, stimulates hope for relief and confidence in the clinician's ability to help	1	2	3	4	5	6	7
37. In the family, opens up channels of communication about the feelings attached to content	1	2	3	4	5	6	7
38. Interrupts dysfunctional patterns of thought, affect, and behavior	1	2	3	4	5	6	7
39. Fosters a sense of worth by pointing to past accomplishments and successes	1	2	3	4	5	6	7
40. Accepts own biases and limitations which will be implicity or explicitly conveyed	1	2	3	4	5	6	7
41. Sees group participation as a means of enhancing individual potential	1	2	3	4	5	6	7
42. Knows the therapeutic relationship has both objective reality and components tied to the past	1	2	3	4	5	6	7
43. Becomes client(s) advocate	1	2	3	4	5	6	7
44. Has case management abilities (assesses client, develops treatment plan, and enables client to make constructive use of plan)	1	2	3	4	5	6	7
45. Offers professional training and teaching	1	2	3	4	5	6	7
46. Offers supervision of professionals and para-professionals	1	2	3	4	5	6	7
47. Implements client strengths in making use of community resources	1	2	3	4	5	6	7
48. Offers consultation	1	2	3	4	5	6	7
49. Works to modify problem behaviors by strengthening positive behavior	1	2	3	4	5	6	7
Establishes a therapeutic alliance which includes:							
50. Emotional and intellectual involvement	1	2	3	4	5	6	7
51. Mutual trust and respect	1	2	3	4	5	6	7
52. Acceptance of different responsibilities by participants	1	2	3	4	5	6	7
53. Uses termination as an effective consolidation of therapeutic gains	1	2	3	4	5	6	7
54. At termination, leaves opening for the client(s) return at the time of felt need	1	2	3	4	5	6	7

WHAT ASPECTS OF CLINICAL SOCIAL WORK HAVE NOT BEEN COVERED?

PLEASE COMMENT ON QUESTIONAIRE, RESEARCH PROJECT, OR ANY OTHER ASPECT OF THE ISSUES INVOLVED.

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