

ON REALITY AND ILLUSION

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The author reflects on his own experience in social work, and from his vantage point as an educator and consultant, he reflects on the state of the profession. Highlighted are some of the cross-currents that clinicians face, vis-a-vis the profession's social objectives.

With individuals and in groups, the clinical light shines most brightly on the distinctive inner life and intimate world. But if you continue further out, the illumination takes you to the macro-social, the collective social world. According to professional canon, the inner and outer are joined as indicated by the term, psycho-social. However, some critics assert that clinical supremacy produces one-sidedness, not the presumed union of person-environment. In a clash with basic professional doctrine, these doubters allege that a social mission is hazy at best, and at worst, something of an illusion. Is this a valid criticism?

Before I mull over my own experience, some general comments are in order. Manifestly, the profession's social vision tugs at those in the psychotherapeutic ranks, but to cross the divide is a real predicament. Some clinicians themselves say that a widespread psychotherapeutic orientation makes it difficult to attend to the larger social scene. In fact, three clinicians in this journal assert that personal temperament and a practice background in clinical social work is "not always the best background for advocacy or activism" (Kayser, Lyon, & Silver, 1991).

I think the strengths of clinician work are abundantly clear, and although space precludes my listing them all, it's worth citing two in particular: one is the clinician's intense concentration on authentic client needs, and another is an empirical grounding and evidence-based work that has become more vigorous over the years.

As for psychotherapy, the need speaks for itself. I will leave aside several issues: the

respective roles of the helping professions; the fact that the path to the therapist's office may be too well worn by the social immersion in self and the cultural blitz of psychobabble. Then, too, there is a restless, but unfulfilled, search for meaning in one's life through various types of trendy and personalized cures, some of which are provided by MSW's in clinical work gone astray. A few years ago, a former student told a class that she intended a career in sports medicine. Others are not far removed — cultish exploits like "finding your inner self," among others, take advantage of MSW degrees for bogus purposes, chasing after people hungering for psychotherapeutic answers that most won't find outside of history or community.

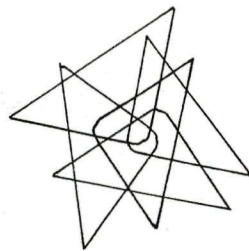
But truthfully, there is also a phalanx of people whose daily clinical work is full of organizational (agency) obstacles to the profession's social mission. The barriers make overgeneralization about clinical practice hazardous. And there are various contradictions and inner tensions in the profession itself, but let me defer these and concentrate on my own professional travels.

To take the long view of my career in social work and some of my perceptions of the field, I go back to my earliest years when I began as a clinician in private agencies, first in a child guidance clinic, then in a family service agency. I confess that working for those agencies was not deliberately thought out but rather the default position, so to speak. Nevertheless, I found an easy compatibility with some of my psychological interests and capabilities. I saw people come and go—children, individuals, families—and I didn't then,

nor do I now, doubt their needs for individualized help. To me, assisting people in trouble was always central, and I was well on my way to developing respected clinical skills.

Trying to retrieve portions of my own narrative and making sense of it is an arduous task, but well worth the effort. Retrospectively, it seems that I had let my social concerns nap while I was in the process of beginning to master therapeutic skills. Only after I had achieved that did my somewhat divided heart respond to the loud call from outside clinical practice.

Going back even further, I can recall the influence of the day when, for the very first time, at the age of 17, I saw public water fountains labeled "colored" and "white." I don't doubt for a moment that this experience and all that it represented burst forward in my life during a pivotal time. I can also now recall that not too much later after the water fountain episode, I was further influenced by Gunnar Myrdal's huge tome, *An American Dilemma* in which the Swedish Nobel laureate wrote searingly of race relations in the United States. Along with that, the heady liberalism of New York City had already swept me along.



But as I write, present and past seem almost to merge. This melding is triggered by today's agonizing memorial for 9/11. Together with a reading of the victims' names on the TV were the aching watchwords, "Never Forget." Then, in a painful flash, the phrase "Never Again" speeds across my mind, and I see a young man, still a clinician, struggling to understand passivity in the face of evil, pon-

dering, as well, lesser evils and what to do about aspects of the darker side of American life. It does not take a great reach to recall other troublesome events of collective oppressions: poor persons, child malnutrition, inadequate housing, and low-wage labor, to mention a few of the many that are composed in sorrow.

After some four years or so as a clinical practitioner, I decided—not entirely without trepidations—to pursue a doctorate with a specialization in social welfare policy. It's noteworthy that among large numbers of social workers, there was then a deep commitment to psychoanalytic work, and typifying those beliefs, administrators in the agency for which I worked aimed to have me enter a program leading to "lay-analyst," which, they said, was the "professional" thing to do, never mind doctoral work. If that sounds more than a bit absurd, keep in mind the fixation with psychotherapy and how it has been carried to fantastic lengths. True, there has been much quibbling in the field about which version of psychoanalytic theory was the *right* one; however, the point of this tale is not about a theoretical approach, but about a profession's turn toward psychotherapy generically, one that reverberates to this day.

Whatever my own apostasy and its biases, during most of my career spent teaching social welfare policy, I have had intimate relationships with clinicians, close-up views of social work practice, and many, many dialogues with colleagues as we rambled through the clinical view and the policy view. These were sometimes complementary but at very different angle of vision. With individuals and in groups, the clinical view mined the deep, narrow wells of biography, while the policy perspective saw life through a wide-angle, latitudinal lens.

Then, too, each semester brought new opportunities to observe and interact with clinical students. Not uncommonly, semester's end often brought forth comments from stu-

dents about one or another aspect of social policy: "I never thought about that before" was fairly typical. Pleasing though it might have been, I always worried over how far that would carry because typically, when social concerns were evoked in students, preparation for a clinical role often eclipsed them. In fact, that was my own experience, too, but the path I eventually chose was poles apart from the typical decision.

The long-term culmination of a profession that consists mainly of clinical social workers has solidified, and perhaps terminally so. Short-term, I have, of course, seen countervailing trends, but these are temporary zigzags. Long before my time, sociology was influential, but by the 1920s, social work became detached from its sociological anchorage points, and fell head over heels in love with the psychological and psychiatric arts, an affair that might well be now and forever.

One of the most significant of the countervailing trends came during my early years of teaching—the ferment of the 1960s through the early 70s. Students had become intensely interested in social reconstruction, and some substantial numbers of them gravitated to the macro track. But that was not to last. Gradually, the so-called revolution gave way to social normalcy, and student interest in reform and reconstruction dropped off. I was saddened when, by the end of the 90s, specializations in social group were ended. Overall, graduate student enrollment in the macro-track dwindled.

In social work today, clinical work, including therapeutically oriented groups, has become the dominant interest, with upwards of 70 percent of students entering that specialization. Increasingly, too, social workers have moved into private practice, which over the years was encouraged by widespread state licensure.

But to generalize about prospective clinicians is difficult because of the large number

of schools of social work and, accordingly, the large population of recruits in different regions of the country. Even so, based on what I have seen in different schools of social work, the most striking characteristic among students has been a long-term decline in social awareness that has been particularly acute among the post-Vietnam age bracket. At the same time, they have an overriding sense of altruism and self-sacrifice, they reject money and wealth, and they have an almost instinctive feeling for the underdog. In those attributes, they are surely different from much of the population.

But the stamp of a radically individualistic culture was there, too: idealism and compassion, therefore, commingled with privatization and individualism. And too often, there was some distancing from electoral participation, and even more so, from government in general, especially among the young; and, of course, along with that went a certain lethargy before the most painful social issues. I have often asked myself how empathy and troubled faces could coexist with so much passivity in the face of, say, long lines at food banks and soup kitchens, engorged by the children of working men and women trying to make a go of it on substandard wages.

And despite some students' intentions not to be condemnatory or disapproving of welfare recipients, a semi-disguised moral judgment crept in. In that, they were not much different from lots of others among the public. As time passed, most would change in response to group norms and socialization, but it was also deeply troubling that a few would hide their moralism under a thin coating of professional jargon.

Remarkably enough, problems that were *au courant* seemed to rivet some beginning students; whether it was anorexia, or self-esteem, or false memory syndrome and child abuse, student attention would fly to whatever soared in popular thought. As time passed during classroom education, the some-

times layman-like and thin understandings of social dynamics would give way to individual dynamics that were reinforced by the structure of educational curricula in classrooms and in field internships, especially during second year. Yes, there were inter-school variations, but work with children appeared dominant among the young, while the shunted aside—growing numbers of older persons living independently and explosions in the size of prisons, which had become the nation's largest mental health "clinic"—were objects of relative student neglect, notwithstanding the acute needs.

And some of the results of neglect could be disastrous. On Thursday, July 13, 1995, the temperature in Chicago, where I live, hit 106 degrees and the heat index climbed to 126. It was a killer heat wave that continued until July 20, with the death toll running upwards of 700. The victims were primarily elderly: of the heat-related casualties, 73 percent were older than 65; and African-Americans had the highest proportional death rates. This was more than a social catastrophe; it was also a story of social isolation in life and in death (Klinenberg, 2002).

In this short paragraph, I grope for words to convey the magnitude of the disaster. I know that the social workers avoided "no-go" areas where marginalized elderly lived: stigmatized African-American neighborhoods and housing projects. I also know that the risks to the personal safety of the social workers were high and that they received little agency support. There was probably no bright line to help illuminate what those social workers might have done; but maybe it's better not to rummage around too much because searching myself, I find small comfort when I think of those poor souls who lived and died alone.

For a certainty though, I also know that there is neglect in situations in the high schools around the country where harassment, abuse, and violence are directed against gay, lesbian,

bi-sexual, and transgender youth. Far too often, even school social workers overlook these problems (Hatred in the Hallways, 2001). Yes, they might well turn from feeble drug-prevention programs to focus attention here and to help establish support groups for the victimized youth. Make no mistake, the problem is not limited to socially conservative areas, but especially in these kinds of places, opposition might well be expected from school administrators, teachers, and parents. However, it would be worth the struggle to try to include all of them to alter the culture of harassment and violence.

So far, I may be guilty of being excessively harsh. If so, it's a many faceted by-product, not just of portraying an average practitioner, if you will, but also because I've intermixed facts with interpretations and judgments, one of the hazards of writing this type of account compared, say, to a research article. But to be fair, I must say that the picture of clinical work is not all black or white.



No doubt about it, some clinical students enter school with a reasonably well-developed understanding of social trends and dynamics and a strong commitment to social change that endures throughout school and beyond. And despite practical limitations, clinicians are sometimes able to carry forward on individual and group advocacy. Moreover, a goodly number of clinicians spend large amounts of time in their work with a sprawling network of agencies, with and on behalf of clients. Various kinds of crisis intervention also have to come in for mention because it's in these efforts that clinical social workers deal with a collective trauma, say, for example, a school shooting or a natural disaster. Then, too, there are those who enter public service,

mostly in child welfare, where they do vital service on behalf of neglected and abused children and beleaguered parents. No doubt there are more examples; these are simply the ones that come most readily to mind.

But it is also important not to use exceptions as if they represented the typical actions of clinicians. I have also excluded efforts in NASW such as its pro-child and family-friendly policy, its advocacy of decent health care, Social Security, and many more. Exemplary as these are, they coexist with the push to privatization. However, my essential concern is not about what a professional association advocates; it is about the thousands of clinicians across the land and what they do in their everyday jobs. When talking about day-in day-out labors, keep in mind that the acid test of work in a practice profession is the action or behavior that it leads to. In fact, this is the very definition of a practice profession while, in comparison, professional associations are far more peripheral.

If the fruits of clinical work deserve a searchlight, I would not leave out the educational enterprise. Especially symbolic here are the heroic but—I must say it—misdirected efforts of clinical faculty to try to uphold a social vision even though it is profoundly at odds with much clinical practice. Emblematic are the classroom stories told of those true icons, Jane Addams and the Abbot sisters, among others, who were associated with a social reform vision. Proudly, the faculty tell the tale of social change as if it were to be emulated and upheld. Unspoken is the contradiction with most of contemporary practice, the very practice to which faculty are committed. After all, Addams and the others were ultimately swamped by the “psychiatric deluge” (Field, 1980), and, sadly, their reform practice is now virtually dead. So...is this “Jane Addams mantra” and its tenacious invocations a sort of window dressing or protective coloration for faculty? That’s speculative, and perhaps it is not so. But consider

the alternative that cognitive dissonance does some strange things; maybe there is a meta-rule governing the holding of contradictory beliefs, a “no-notice” mindset akin to the injunction not to notice the elephant in the room.

I should also mention the Council on Social Work Education (CSWE) and its support of psychotherapeutic work. In echoes of the Addams refrain, the 1991 version of the CSWE educational policy statement did not mention the importance of serving the poor and deprived, dependent children, the mentally ill, or the frail aged (Specht & Courtney, 1994). Although the educational policy statement was subsequently corrected in response to complaints, the deep divide within the profession could hardly have been more revealed.



Taxing as the split is, one can think of some possible remedies and reforms in clinical practice. As a lead in, it may be useful to contrast the medical model and the public health approach. Although it’s somewhat popular to criticize the medical model, that’s actually what has been adopted: wait for clients to experience a hurt (illness or dysfunction) before they come for help, a passive aiting mode of both the psychotherapist and the physician.

Public health practice, on other hand, actively intervenes in environmental and population issues, attempting to prevent illness. In fact, some of the great advances that have contributed to longevity are a result of public health achievements, much more so than medicine, and include, for instance, the eradication of typhus and typhoid and many infectious diseases, and environmental sanitation. And there are also the public health nurses

and Head Start workers who visit families to keep an eye out for parent/baby bonding and postpartum depression, intervening as needed. Why have clinicians turned their backs on such home visitations?

There are some clear lessons. Rather than emulating the passive waiting mode of the physician, the pivot point of clinical practice might well be the more proactive model that is tied to public health. Again, like public health, practice could be tilted toward social risk, i.e., a demographic or social approach. This leads intervention to populations and sub-populations that have high rates of the problem at hand. Then, if the actual risk variables are uncovered, they might conceivably lend themselves to work that is something of a more traditional nature. But clearly, the starting point for intervention would not be the waiting mode that so dominates clinical practice.

I claim no credit for knowledge about suicide among the elderly, but it is a good case in point of what I have been saying: first, the rate is a high rate, and second, the loss of a spouse is a major *risk factor*. Knowing this, we do not have to wait for serious depression to occur. Instead, reaching out and group support become the mode. To take another example, if there are sub-populations vulnerable to "failure to bond," and we can identify the risk factors, then intervention should be geared accordingly, rather than waiting for the negative consequences to show up much later. Perhaps the day will come when there will be resources sufficient to a universal "well baby" approach for all parents and for early screening and intervention, but for now, we need to focus effort on those most at risk. Inevitably, such an approach leads to a greater prominence of prevention efforts, even though the scarcity of resources makes for hard choices.

I am long overdue to take up ideas that have been central to social work. Probably the most honored concepts in social work, the person-environment framework and the closely related systems perspective, are of

such vital importance that they define the professional boundaries that set social work apart from other helping professions.

To understand systems, the first key lies in the boundaries that define them. If you are interested in clinical practice, what boundaries do you put into the client's world? Into your own clinical world? To concentrate on the clinical world, the meaning of this question is easy to understand intuitively. The answer is a bit more complicated and involves both knowledge boundaries and behavior boundaries.

In conventional thinking, the knowledge boundaries of clinical social workers are much broader than those of psychologists. The knowledge required of the social work clinician is supposedly extensive and constitutes a tall order indeed. What, for example, are the effects on clients of social role definitions, class and stratification, ethnic culture, family orientations, social values, and so on? Clearly, it's part of professional doctrine that human behavior is seen as influenced by various social and cultural factors. But in the real world of clinical practice, the lights shine most strongly on intra-psychic knowledge, personal identity, and inter-subjectivity. These are the truly magnetic features that cast a long shadow on social knowledge. In short, we should be clear about the discrepancy between reality and the rote repetition of professional slogans. To extend this, it's something of a paradox that knowledge of populations, social risk, and risk variables prove to be relatively underdeveloped among clinicians even though this knowledge has a better fit with a social sort of practice.

Even if knowledge boundaries were less limited, I see an unfortunate tendency in clinical work to stop with knowledge, as if it were like a shell. But if taken to their logical conclusions, the environmental-social perspectives hinge on what to do, that is, behavior. Given the boundaries of clinical work and its supremacy, it seems to me inescapable that

the social perspective of the profession is somewhat illusory. There are probably many reasons for resistance to changing this. I can only conjecture that one of them is that illusions offer the comforts of self-deception, something that should be well understood by clinicians. But whatever the truth is here, if clinical knowledge were reversed, i.e., first risk, then secondly those "deep wells," there would be two significant effects. I foresee that the clinical focus on pathology would inevitably move towards health promotion, and clinical service would make the first move, rather than waiting for potential clients to say, "help me."

Another way of thinking about professional change is to envision a more radical sort of practice, one that would bring into therapeutic focus the less visible, taken-for-granted aspects of social and cultural life, thereby generating fresh alternatives for social action (Abels & Abels, 1997; Chambon, Irving, & Epstein, 1999). Such a solution would be limited to those sorts of situations in which social, political, or cultural factors are truly significant to the case at hand, and though the conventional belief might hold that such situations are rare, they are probably far more frequent than is commonly imagined.

If the idea is fraught with varied social and political obstacles to enlarging the boundaries, it has much to commend it. We know very well that external stressors, say long-term job loss, can test coping capacities, but save for an individual focus, say the depressing self-talk of the unemployed or a behavioral rehearsal for an interview combined with group feedback, the terrible magnitude of the problem remains background. As for the background, clinicians may sometimes protest somewhat dismissively, "That's not what we're trained to do."

This may be a conceit, but it also turns out to be literally true. Most clinicians have a good understanding of the "close in" and are prepared to deal with it, yet if their educa-

tional experience exhorts them to "fight the good fight," this is mostly pietistic encouragement. The truth is that clinicians are given relatively few tools with which to impact the larger social scene; by personal inclination, it is not on the agendas of most prospective clinicians, nor is it encouraged in the vast proportion of organizations within which they will work.

Finally, I want to think about some core aspects of the clinical model. It can hardly escape notice that I am apprehensive over what has been called the "expressive individualism" (Bellah, et. al., 1986) of clinical practice, including family therapy and therapeutic groups, all of which replicate that particular variant of American individualism. Also, clinicians, with some sense of superiority, may assert that social work is really the only helping profession that is truly holistic in its orientation to the client's world. The person-environment construct or systems theory, cornerstones of social work, are said to be distinctively ours. But to think that social workers alone have an all-inclusive or holistic viewpoint is more wrong than right. As I have tried to show, this belief is too often disconnected from *social intervention*, a point that I cannot emphasize too strongly. Remember, the acid test for a practice profession is what it *does*.

It is not so unusual that fiction will be transformed into believable fact via the practice of repetitive assertions, a familiar process. To recapitulate it briefly, a network within which clinicians are embedded constitutes a sub-culture that is mutually reinforcing for participants, it fortifies belief systems, and it confirms assertions based on selected examples. From the inside, participants build on these seeds of truth about environmental intervention, and under continuous repetition and reinforcement, these assertions assume a quality of rightness. Eventually the claims become completely usual and unquestionably correct to those who are a part of the culture. The person-environment formulation and its

variants follow this process.

But look in from the vantage point of an outsider and a very different perspective emerges. Here, assertions like psycho-social intervention may have a political character in the form of claims or constructions that advance interests in order to protect or to advance the professional domain (and/or oneself). But generally, we must start with a position of neutrality. In other words, claims may be true or false. What's important from this perspective is that the profession and those within it constitute just one of many professional interest groups whose claims are subject to various kinds of truth tests. Faith accepts claims as unshakable truths, but rationality requires good evidence. That's the reason for strong skepticism about the social part of psycho-social.

If this kind of analysis seems too heretical, too political, or even too cynical in relation to the largest, most dominant segment of the profession, why then, throw it away and be done with my account of the profession's claims. But do pay attention to the confirmed fact that therapists, regardless of orientation or even discipline, come to resemble each other over time. And consider some of the implications of this convergence.

The last possibility, suggested by the similarity of helpers, is a fundamental and far-reaching realignment of the professions so as to bring other psychotherapists, say clinical psychologists and clinical social workers, under one roof. Compared to some earlier suggestions for reform, this would be quite radical, and it is probably a long shot at the present time, particularly since it lacks a constituency. Aside from disparities in terminal degrees, there are all sorts of political problems, turf issues, and differences in history and traditions. Because of all that, it is frankly utopian at this time, even though it makes sense.

To the extent that the professional association advocates progressive social policy, this is all to the good. But in the final analysis,

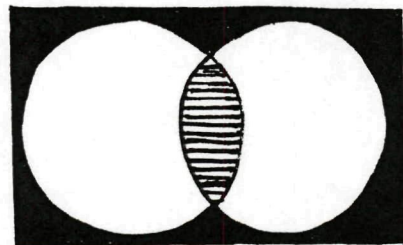
so far as everyday practice is concerned, it is an open question in my mind whether we can heal the wound between our prevalent individual emphasis and what we nominally call social work. Absent that healing, these two come perilously close to being an oxymoron.

I understand too well that this will challenge some cherished beliefs. Therefore, if you find it unpersuasive, keep in mind that the contours of clinical work were developed many decades ago and may no longer fit so neatly with advancing knowledge and the dramatic changes that have taken place in the lives of children, of families, and of society itself. Now it's noting the inadvertent exploitation of the esteemed value of equality which admits of no distinctions in the distribution of risk. To take but one example of many possibilities, saying that all families are subject to mental stress (maybe to de-stigmatize it), is literally correct, but it masks the unequal distribution of risk in society. We also know so much more now about the multiple variables involved in inequality, and they all point to significant shifts in conventional psychotherapy.

Where we go from here may be a matter of guesswork. Safeguarding personal career choice is an imperative in a free society, but this does not provide profession immunity. Reconfiguring clinical work is not impossible, but it is long past time to forget such easy platitudes as, "we can't be all things to all people," or "don't throw out the baby with the bath water." These are self-protective enemies of change and are useful only for making rhetorical points. Perhaps clinical practice will continue to be in command of social work, but then again, perhaps not. Who knows? What I do know is that transformation is rarely, if ever, easy, and if it is to occur, one thing is certain – some treasured beliefs will have to give way, especially the one that labors to dress up contemporary psychotherapy as if it were social intervention.

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