Reflections on Overturning a Medical Model of Social Work Practice: Threads from the Past

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In the following narrative, the author reflects back on her groundbreaking article "Issues in Overturning a Medical Model of Social Work Practice," *originally published in* Social Work *back in 1983.*

Life rarely hands us the chance to come face-to-face with one of our selves from the past. In being given the opportunity to re-read and reconsider one of my earliest published articles, I have entered the precarious world of memory and history. It is a world both recognizable and mysterious. How did those ideas come to have such a powerful hold on me and become the groundwork for much of my future scholarship? How did a young woman who had been prepared as a social worker with all the rudiments of psychodynamic theory and a mostly-conventional MSW curriculum diverge from the path of professional orthodoxy and find infinitely new and challenging ways to think about a profession which had, early on, captured my heart and my head? My question to myself: who was that woman anyway?

One of the first things that must be said is that nothing about my upbringing lent itself to challenging conventional wisdom. Being a school child in the 1950's, raised as a Catholic and educated in Catholic schools, the script was strongly tied to acceptance of clearly-stated beliefs, presented by those in positions of authority. Because that orientation was generally supported not only by my family and school environment but by much of the broader society as well, the possibility of thinking differently was seen as a slightly dangerous and possibly immoral enterprise. Ironically, for those of us with a certain degree of persistent curiosity, the clarity of the rules served as a foil for raising questions. I developed a strong impulse to raise questions when the traditional answers were found wanting. For better or worse, this shaped my life as a student and as an academic.

My stint as a doctoral student occurred during the mid-1970s and benefited from the large social movements at that time. In the midst of significant societal unease, this period opened avenues that provided greater opportunity to raise fundamental questions and to seriously study and consider several seemingly divergent avenues of thought. A university setting was a particularly apt place for these mental meanderings because of its official stand on seeking knowledge in a disciplined and dispassionate way. I had the good fortune to be funded by a fellowship from the National Institutes of Alcohol Abuse and Alcoholism, and supported by a doctoral dissertation chair who gave me free rein to explore a way of thinking about the problem of alcoholism that joined together multiple areas of inquiry and research. Reading across disciplines and creating a multi-dimensional framework was exciting in itself, but, more importantly, it gave me the courage to experience and apply a strategy of intellectual probing that later served me well no matter what the topic.

As I stretched the boundaries of my questions, I also became interested in the history of science that introduced the grounds for a critique of a positivist scientific paradigm and a challenge to its orthodoxy. My introduction came by way of a book by Thomas Kuhn entitled *The Structure of Scientific Revolutions*. I can recall with a

vivid and sensory memory the range of emotions I felt as I poured over his thesis. Simply put, Kuhn was calling into question the scientific paradigm that, despite its formal goal of putting nature to the test through experimental methods, was, in fact a very human endeavor, affected by the all-too human elements of power and control. At the heart of this was a deceptively simple axiom: knowledge is power. When crucial knowledge is held and controlled by a few, with narrow channels for rigorously challenging basic claims, there develops what might be called a "knowledge aristocracy," a class of people who protect the dominant theory against all others. Change in scientific theory occurs only when the anomalies and weaknesses in that dominant theory become too pervasive to be maintained.

The idea that overarching theories and belief systems were not true in and of themselves but were shaped by human beings who derived benefit from them was a captivating idea to me. What could be more radical than to have the freedom to question the assumptions underlying pervasive structures of belief, whether these were scientific or religious or other? At heart they all had political cores that gave the "knowledge-tenders" their authority and their right to silence or punish, in one way or another, those who disagreed with them. The very act of questioning dominant beliefs by raising the possibility of another way of seeing held, for me, an allure that was almost palpable. My article on "Issues in Overturning a Medical Model of Social Work Practice" was an early attempt to see the underpinnings of the social work profession in a new way and to help reclaim some of the insights and commitments that, through its history, have given social work its radical and enviable perspective.

In writing this article, I wanted to share my conviction that social work is a receptacle, perhaps a Petri-dish, for revealing a form of knowledge not generally credited as legitimate. Underneath the embrace of ideas and theories from the social and behavioral sciences, social work had a powerful and poignant grasp of the challenges and possibilities in helping people right their lives. It has been based on a belief in the practice wisdom of the profession and its elaborate, age-tested, collective experience as a powerful form of knowledge. One way of revealing this hidden treasure was to contrast the medical model with what I called a "health model" of social work practice. The nature of the traditional model for medical practice, with its assumptions about the power of professional knowledge and often the diminishment of the client's own capacities and aspirations in the face of esoteric knowledge has permeated both medical practice but also professions like social work that are inextricably linked to it.

In the 1980's there was a movement, not just in social work but in related fields as well, that has been called holistic health. It expressed itself through a burgeoning number of health practices not initially accepted by the traditional medical model. Many of these approaches were derived from indigenous cultures that maintained strong ties to the healing practices of their people. In learning more about these methods, it became clear to me that our understanding of social work practice could be strengthened by assessing the impact of theories underlying our practice and by using a critical lens to rediscover some of our core insights about professional practice. Because of the broad acceptance of science, particularly medical science, as an overarching paradigm for practice, a close examination of its underlying tenets seemed a useful way to create a heightened level of consciousness about its limiting effect on the radical nature of social work practice. Challenging the basic assumptions of the medical model as it has been applied to social work practice became the engine driving this analysis.

What the analysis uncovered are some of the principles that have been with us all along. The power of healing points to a profound human capacity for self-righting and through this window, we can begin to see that the nature of change is not at all what we believed. Rather than requiring forces outside oneself, people are more likely to change their lives when they see the possibility for achieving something they see as personally important. The role of a professional person in encouraging the process of change is both more limited and

more essential than our theories would have us believe. What also seems evident is that principles that acknowledge and support personal and communal well-being are at the heart of good social work practice.

This article became a stimulus to pursue related topics. In subsequent articles, it was possible to explore other developments that have, in the past 20 years, created more generous boundaries for inquiry. The fields of medicine, physics, philosophy, ecology and gender studies all provided me with intellectual fodder for continuing to challenge and redirect my thinking about the nature of social work practice. While I hope that my writings have added to the field of social work, I also recognize that it is I who have been the most fortunate beneficiary of this process. Having, or perhaps taking the opportunity to unpeel the sometimes rough skins of accepted beliefs opened up intellectual vistas that, through all my selves that participated, has been a joyful adventure.

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Issues in Overturning a Medical Model of Social Work Practice

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A holistic orientation to social work practice is still emerging. Although the holistic view is compatible with the profession's most fundamental principles of practice, it challenges traditional assumptions about the nature of the relationship between social worker and client and about the nature of human change. This article examines some of the issues involved in the shift from a medical model to a health-oriented paradigm and suggests key principles for strengthening this shift.

THE EMERGENCE OF a health-oriented paradigm of human behavior is particularly felicitous for the social work profession. In its implicit emphasis on growth-enhancing possibilities for human beings, a health-oriented model strikes an affinity with the value base of the profession and stimulates reaffirmation of principles of practice that have always been present. Recent works by Germain and Gitterman, Pincus and Minahan, Meyer, and others have begun to translate the principles of a health model into practice.[1]

The promise of this new view still outstrips its application. In particular, awareness of conceptual traps, which can mute the full force of the new view, is necessary. In any process of change, the weight of old assumptions tends to color the radical possibilities in the new paradigms, leading to a diminished understanding and application of the new principles. While working toward conceptualizations of behavior that center on health, those in the profession must be equally attentive to sabotage from some of the familiar beliefs about the nature of change and particularly the profession's role in facilitating it.

In making a shift from a disease-oriented to a health-oriented model of practice, recognition must be given to some of the fundamental ways in which the disease model has shaped the view of how human beings grow and change. Becoming clearer about some of the important dynamics at work here will pave the way for a concept of change that is genuinely grounded in a health-oriented perspective of practice.

One of the striking things to consider with regard to the influence of the disease model is its emphasis on a static-mechanistic model of human behavior. In keeping with the Newtonian view of the universe, which dominated Western thinking until recent decades, human beings have been seen as organisms whose workings, albeit more complicated than in other forms of matter, could be understood through careful scientific observation. The human body was, and in many respects still is, viewed as a piece of machinery whose parts occasionally fail. Within this model of disease, the hardware of treatment is well known: a pharmacologic agent, a surgical procedure, or a therapeutic technique must be used for treatment to be effective.

A characteristic of this approach is its externality. The cause of disease is thought to be externally caused and somehow separate from the person it affects. People "get sick" and spend tremendous energy trying to identify the causes, which can range from invading agents such as viruses, bacteria, and toxins to schizophrenigenic family relationships. Built into this process of diagnosis and treatment is an analytic-linear-dualistic bias, which has at every turn reinforced a pathologic view of human troubles.

The nature of treatment within the current illness model has been largely influenced by medical conceptions of disease. As Mechanic says,

> These conceptions are derived from a model that attempts to identify clusters of symptoms causally related in some fashion and to establish the etiology, course and treatment of the particular entity. . . . The approach, however, proceeds on the assumption that disease states are entities that are definable; and a great deal of effort is devoted to more reliably identifying new disease states and searching out their various characteristics and appropriate treatments.[2]

In order to highlight the consequences of this view, it is useful to see how the role of practitioner has been skewed. Underneath the disease model of human behavior is an assumption about change that leads directly to the nature of the relationship between practitioner and client. Because so much hangs on a clear conceptualization of this role (if a move to a health-model of practice is to be achieved), it is essential to understand how deeply enmeshed professionals are in a view of professional relationships that is not health-oriented.

THE "GIVING OVER" PROCESS

One of the effects of a mechanistic view of behavior has been a reliance on professional expertise. This exper-

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tise comes from acquired, specialized knowledge, which sets practitioners apart from their clients. The literature of the professions emphasizes the power that accrues to professionals because of their specialized knowledge and the corresponding vulnerability of clients because they lack this knowledge.[4] It is worth examining in detail some of the dynamics surrounding the role of the expert and how the expert has come to be viewed as the agent of change. The central dynamic in this accession to professional knowledge is called the "giving over" process.

In order to fully understand the effect of the accession to professional knowledge, it is useful to look to history for antecedents. Foucault provides a persuasive exemplar of the way sexuality became part of the giving over process.[4] He documents in great detail the evolution by which seventeenth-century penitents consigned judgment of their sexual behavior to confessors. The reasons for what ultimately must be interpreted as a transfer of power are central to Foucault's analysis but only peripheral to ours. What is important is the act of giving over to another not merely information about oneself but also the power to create the meaning of this information. The following clarifies this concept:

> The truth did not reside solely in the subject who, by confessing, would reveal it wholly formed. It was constituted in two stages: present but incomplete, blind to itself, in the one who spoke, it could only reach completion in the one who assimilated and recorded it.[5]

As science in general (and behavioral science in particular) continued its development during the nineteenth century, new brands of priests emerged. Central to all these developments was the giving over process, whereby the patient, client, or lay person bowed before the expert knowledge of the professional. In his historical study of the development of the medical profession, Mohr shows how the processes of childbirth and birth control were transferred from women and midwives to the exclusive preserve of the emerging medical profession.[6] The genesis of psychoanalysis created yet a new breed of priests, whose "penitents" confessed all their thoughts and waited for meaning to be assigned.

It is important to understand the nature of this giving over process. It is not the expertise of the professional that needs to be challenged, although at times this may be appropriate. The process of human judgment has been radically overturned, and, as a consequence, knowledge that is naturally accessible to people because it is personal knowledge is no longer admitted or accepted by them. The result is that their knowledge about themselves becomes partially or wholly hidden. In addition, whatever information they give to the professional is without meaning until the professional confers meaning on it. What is seen, therefore, at the base of the giving over process, is a willingness to give someone else power to define one's personal reality.

The prevalence of this phenomenon does not mitigate its serious effects. It is simple to see, for example, that this dynamic accurately describes the relationship of professional and client in a pathology model of behavior. The essential condition of "getting well" is a giving over of oneself to a professional caregiver. Ever since Parson's classic depiction of the characteristics of "good" patients, it has been generally recognized that an essential attribute of such patients is their willingness to cooperate with treatment plans.[7] It is not, however, the patients who design the plans but the professionals, on whose expert knowledge the patients rely.

The acceptance of a diagnosis is the clearest reflection of an individual's consignment of judgment to a professional. Brody suggests that, in medicine, "the diagnosis is the primary mechanism for conferring meaning upon an illness event."[8] In a manner not unlike the confessional, the patient or client brings the raw material and the professional, through the diagnostic process, makes something of it. The attachment of a diagnostic label or other descriptor serves the client by providing a socially meaningful explanation for a particular condition, especially when that condition is thought to show a hidden defect.

It should be remembered that the medical model is deeply rooted in notions of individual fault and deficiency. Although people have ostensibly moved away from archaic convictions with regard to mental and physical illness as signs of divine retribution, there are still remnants of guilt when one's body or mind falls from perfection. The process of the acceptance of diagnosis partially mitigates this guilt because in this process the superior judgment of the professional is acknowledged and the psychological cost of giving over to whatever treatment another determines to be best is absorbed.

THE ROLE OF BELIEF

In looking more closely at the nature of the relationship between the professional and the client as it plays itself out within the traditional model of diagnosis and treatment, it is clear that this area of relationship moves into the more subtle aspects of the professional role, namely, the nature of the beliefs of the patient/client about getting well. An observation of Frank's helps set the stage:

> Treatment always involves a personal relationship between healer and sufferer. Certain types of therapy rely primarily on the healer's ability to mobilize healing forces in the sufferer by psychological means.[9]

As this statement is examined, three elements become clear: the presence of a relationship, the healer's ability, and healing forces in the "sufferer." The use of the word "healing" is a point that will be explored in greater depth. What must be grappled with here are the dynamics in the relationship itself that may contribute to a positive change in the patient or client. To begin examining this aspect more directly, one can draw on an observation made by Kiev:

> There exists the possibility that certain general features of therapeutic relationship in various cultures—for example, the hope, expectation, and faith of the patient in the designated healer, coupled with the healer's use of meaningful symbols and group forces—might contribute more to therapeutic results than is ordinarily recognized in contemporary theories of psychodynamic psychiatry.[10]

His sharp focus on the elements of hope and belief pinpoints an element

of getting well that is as illusive as it is challenging. What is the role of these "soft" emotions in the otherwise technical armamentarium of disease eradication?

A useful approach to this question comes from the literature on placebos, those "biomedically inert substance[s] given in such a manner to produce relief."[11] The patient receiving a placebo is under the impression that it is an active drug; whatever positive effect it may have upon the patient is known as "the placebo effect." In the patient's positive response to a placebo, there is "no evidence of correlation with personality variables, age, sex, intelligence, IQ tests or presence of neurosis or psychosis."[12] This suggests a certain universality that makes the placebo effect a worthy area of investigation.

From the perspective of intervention, by taking a researchers' view of placebos, a veritable goldmine has been overlooked. In the course of scientific experiments, every precaution is taken to control for undesired and unintended effects. For example, medical researchers want to ensure that any effect of a drug is caused by its pharmacologic properties and not by the special attentions of those conducting the research. Elaborate research methodology has been constructed in order to pinpoint causal relationships.

What the research is trying to control is exactly what practitioners ought to be studying. Imagine how valuable it would be to know why placebos are effective. By looking more closely at the placebo effect, the possibility of the existence of a much wider and richer range of stimuli for change than usual would be acknowledged.

Those who have examined the efficacy of placebos largely attribute it to the patient's belief in the physician's power to effect a cure. Frank suggests that the efficacy of the placebo must lie in its "symbolic power, . . . [gaining] its potency through being a tangible symbol of the physician's role as healer.[13] Brody, in his analysis of the placebo effect, also notes that patients' "expectations are commonly cited as an important factor in producing the placebo effect."[14]

Although placebos are thought of as being confined to the medical field, this effect is also present in clinical work (and in any process of change.)

> ***The medical model is deeply rooted in notions of individual fault and defiency.***

Applebaum calls suggestion a placebo "which silently functions in all manner of therapeutic transactions where the need to believe and to benefit is strong."[15] In seeking therapy, a person expresses an "intention to bring about change [and] thereby produces in himself an expectation and impetus toward change."[16] Brody also suggests that

> one might view psychotherapy . . . as a highly organized way of bringing the placebo effect to bear on a special class of patients who otherwise would be very resistant to it.[17]

It is not surprising that the role of the professional "healer" receives such prominence in effecting change, for the current model is devised to produce just such a result. Culture always shapes the way reality is constructed.[18] It is a commonplace that "the roles assigned to both the practitioner and the recipient of medical care represent, in large measure, socially prescribed behavior."[19] What must be asked is whether the change in a person's condition, which is evident in a placebo effect, is best accounted for through the real or imagined powers of the professional caregiver. Is the caregiver, therefore, the most salient feature in the dynamics of getting well?

It is not possible, of course, to solve that problem solely through intellectual analysis. However, it is possible to imagine a different way of looking at the dynamics, a way that establishes the assumptions of a different paradigm about health. If the effect of placebos can be seen as an anomaly in the Kuhnian[20] sense, it must be admitted that any attempts to place this odd piece of the puzzle back into the dominant illness model will fail.[21] One could argue, further, that current attempts to explain the placebo effect by focusing on the professional caregiver is essentially a tautology: To attribute the effect to the patient's belief in the power of the professional is simply to demonstrate a belief in the current medical model, which is based on the concept that professional treatment is the vehicle for change and that without it a good effect cannot be achieved.

SELF-HEALING

A different concept with regard to the placebo effect is that individuals are the source of their own healing. This assumption is central to a health model of behavior. It suggests that the capacity to "get well" is inherent in individuals and exists whether or not there is an external agent such as a professional. It implies an internal process, occurring by virtue of the individual's own physical and emotional resources. In essence, this view is based on the belief that human beings have the innate capacity to be the source of their own change and that the process of self-healing is one expression of that capacity.

Because of cultural conditioning, self-healing is generally activated only in conjunction with standard medical or therapeutic practice. The process seems to require the presence of complicated outside forces: a professional healer, a ritual, a specific physical setting. But instead of looking at outside forces and imagining them to be the key variables, one should assume that the capacity for change is inherent in people and can be self-motivated.

Focusing on healing as an innate capability forces a radically revised view of the professional expert as the central figure in the process of change. This shift places question marks on all the assumptions that undergird the disease model. It throws into a speculative arena the notions of illness being caused by identifiable entities, of pharmacological substances and therapeutic techniques holding curative powers, and of helping professionals holding the expert knowledge that activates the cure.

In order to put some flesh on this skeletal conception of health and the nature of healing, the author would like to derive some principles of the health paradigm from Norman Cousins's well-known description of his experience in moving from illness to health.[22] In many ways, his story exemplifies the principles that constitute a new model of health.

Cousins fell seriously ill after a stress-filled trip abroad and was diagnosed as having a serious collagen disease, which affects connective tissues in the body and results in severe physical weakness and impairment. The chances for full recovery were thought to be one in five hundred. The medication for pain and inflammation was not expected to cure the condition but only make the symptoms tolerable.

If one looks quickly at the general process Cousins went through to act upon his illness and eventually reverse its course, several principles emerge. First, he decided that "if I was to be that one case in five hundred, I had better be something more than a passive observer."[23] Then he began to consider various reasons for the cause of his illness, something his physician was not able to ascertain. Based on his prior extensive reading of medical and scientific journals, he began to put together some guesses: the presence of physical and emotional stress during the trip, the likely impairment of his system because of the stress, and the greater susceptibility in this weakened state for environmental stresses. He then began to consider ways to reverse this state of susceptibility. His plan contained two interlocking strategies: First, he decided to remove himself from the hospital and from prescription drugs, both of which he viewed as negative contributors to his well being; second, he decided to replace this standard treatment with vitamin therapy and laughter. He had deduced from his reading that ascorbic acid (vitamin C) could be helpful in combating collagen breakdown. The introduction of humor via old movies was his approach to replacing negative emotions with positive ones. It is important to add the final variable: the close cooperation provided by his physician, who supported his decision and oversaw the medical aspects of his self-selected treatment.

As these various steps are looked at, the key elements in Cousins's complete recovery from his illness can easily be abstracted:

1. He took an active role in determining the course of his treatment.
2. He relied on past knowledge and his own intuitive-rational processes to understand what was happening to him.
3. He decided on a course of action based on his guesses.
4. He sought and received cooperation from his physician.
5. His physician acted as a consultant, not as the "prime mover."
6. He chose a healing process that allowed mind and body to interact and be mutually reinforcing.

In each step of the process, what Cousins chose to do is diametrically opposed to the current conceptions of how change occurs. His approach challenges current perceptions of figure and ground, for what people perceive to be the central feature (the professional paraphenalia) is, in fact, the background. The professional person's role, in the new paradigm, is as a supporter of the naturally occurring processes already within the client's repertoire. As Watson suggests:

> Healers heal . . . by getting their patient[s] to sit up and take notice. They prod them into the natural business of healing themselves.[24]

This role is crucial in the process of reframing that often needs to occur before a person sees or can respond to the choices available. Its import comes from professionals' capacity to elicit and strengthen clients' inherent ability to heal or change themselves. In turning briefly to Cousins's experience, his acceptance of his own knowledge can be seen as a pivotal dynamic. True, it was not naive knowledge based on isolated mental stirrings; he used information gained from professional sources. However, the attribute that characterized his search was his belief that he could put this information together in a way that would be helpful to him and that he could confer his own meaning on it.

It is worth spending a moment with this notion. The radical element in Cousins's action was that he allowed himself to know what he knew. He did not dismiss this self-knowledge, as most people are taught to do from their earliest years. He believed implicitly that he knew himself and his condition better than anyone. Perhaps it was the prospect of death that gave him this conviction. He acted in a holistic way on this conviction, by allowing himself to discover what his body and mind needed in order to regain health.

This must be at the heart of what is called healing. The root meaning of the word "heal" is "to make whole or sound." The insight that Cousins's experience gives us is that individuals heal themselves and have the power to make themselves whole. This is the radical stream that flows under the new paradigm.

HOLISTIC PRINCIPLES FOR SOCIAL WORK

What, then, are the crucial principles in moving social work more surely toward a holistic view of practice? Most important, a reenergized conception of the principle of self-determination must be a linchpin in the new model. In its least complicated version, the new model must assume that people do know what is best for them. This requires a deep respect for people's innate wisdom about themselves and their lives. There is a tendency to overturn too quickly this radical value by appealing to arguments of socialization or social conditions. It is true that neither socialization nor social conditions are irrelevant. Clearly, these factors shape us individually and collectively and often disguise new possibilities or prevent them from emerging. However, our willingness as social workers to denude the power inherent in the principle of self-determination has the effect of leaving us the determiners of what is best for clients.

A close corollary to this principle is the right of individuals to establish meaning for their life events. The giving over process, both as it is reinforced by the social worker and sought by the client, establishes outside authority as the interpreter of events. By acceding to others' definitions of one's life events, the most fundamental piece of personal power is lost. Empowering a client is dependent upon the social worker's willingness to relinquish his or her power to create the client's context of meaning.

The next principle cuts into the profession's heavy tendency toward overemphasis of technique: Whatever techniques are employed in the helping process must always be used in service to the central goal of creating an environment where clients have at their disposal the resources necessary for accomplishing what they want. The cues come from the client. The

talent of social workers is expressed in the versatility with which they are able to provide multiple levels of resources. The resources are linked with their understanding of the multiple environments that affect people: the physical and social environments that are both internal and external to individuals.[25] In order to effectively present these possibilities to the client, the social worker must go far beyond one or two favored techniques or therapies.

As a quick test of a favored technique, one must ask whether that technique in any way undermines the principles discussed above. For example, is it a technique that puts control of the situation in the hands of the social worker instead of the client? Does it present a way of interpreting reality that the client has to "buy"? Does the technique assume that human problems are caused or affected by one major dynamic, for example, communication patterns or family relations? One can argue that to the extent any therapeutic technique or approach subverts basic social work principles, it is primarily serving a function other than client growth and development. The fact that some clients may experience positive growth through enforced technique says more about the flexibility and growth-potential of human beings than it does about the efficacy of the technique involved.

Last, there must be a commitment to process. Knowing that oppressive forces serve to hide people from themselves, it is understandable why people are wrapped in disguises. The unveiling does not occur quickly or easily. As social workers engage in a process of change with their clients, they share with their clients, through the medium of the relationship, their belief in the clients' strength and power. The profession's true expertise comes from understanding the delicacy of this change process and the knowledge of the conditions that best support human growth. Focusing this considerable talent and wisdom on the process of empowering is a crucial factor in helping people gain full possession of what they have always possessed.

CONCLUSION

There is much to be clarified as a new paradigm of health continues to emerge. Understanding the nature of healing in all its complexity will take years of study and research. So, too, the accompanying reconceptualizations of the role of the professional will require careful thought. It is impossible to ignore the tremendous weight of the current model of illness on the profession's view of sickness and health. As in all world views, willing collusion among individuals keeps this view in place. The passivity, the lack of control, and the indignity of the "giving over" process may not be liked, but at the same time, workers find relief in the way this process shields them from responsibility for the shape of their lives. For workers to imagine that they (much less their clients) should take the risk of this new kind of power radically reverses their ingrained views of the way things are.

And yet, one of the captivating forces of the social work heritage is the profession's persistent willingness to look to the edge of the way things are. The ethical commitment of workers to self-determination suggests, better than they know, their search for conceptions of human behavior and human change that can lead to greater health and wholeness for people. The new paradigm of health is not alien to social work principles and values. On the contrary, it is a natural reflection of those values. By focusing on health as a significant expression of behavior, social workers' view of change and of their roles in facilitating change can be reconstructed and strengthened. And the honorable effort of developing and refining a holistic view of practice that gives expression to some of the keenest insights about the needs and capacities of human beings for growth and change can be continued.

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