CURRENT SOCIAL WORK PERSPECTIVES ON CLINICAL PRACTICE

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ABSTRACT: Several forms of progress in the development of clinical practice theory and method are identified. There is a renewed positive valuation of psychodynamic approaches, a general acceptance of a systems framework, and a greater operationalization of procedures. The current controversy between the social work scientists and artists concerning research strategies is discussed. Three promising new perspectives—of morality, spirituality, and hermeneutics—are briefly interpreted.

We are ever looking to improve our helping actions and the techniques and skills through which we accomplish them. Our helping actions are determined, justified, and explained by our perspectives, or practice theory. These are our conceptions and perceptions of what, why, and how we act, diagnose, and treat, in our encounters with clients. We discuss our perspectives in such terms as theories, orientations, approaches, frameworks, paradigms, and helping models, terms we use to understand them.

An examination of our perspectives requires that we sharpen our minds and eyes so as to see things clearly and fully. We will not, however, look under a nearby bright light for the treasures that we lost elsewhere, but rather we will search where it is dark, or where we can expect the sunlight to come up. There we may discover lost or new treasures or rediscover old gems in a new light. We seek just and beautiful truths for and in social work practice—fair to the evidence, clear, cleanly stated, revelatory, and illuminating. We want such truths so that they may propel us into new pathways of a more effective practice.

The current state of affairs concerning practice theory for clinical social work will first be considered. The scene keeps changing rapidly and some of these changes will be identified. Several current trends and newly emerging perspectives are then to be discussed, as are several implications of these trends for clinical social work practice and education. No attempt is made to do a comparative analysis of the many and varied

existing theoretical approaches. We take this opportunity to tackle several significant questions, issues, and tasks about clinical practice.

It is hoped we will not fly like *Luftmenschen* in the upper abstract stratospheres, but rather keep our feet on the ground of practical realities. We do want to stick to the practical realities of our jobs in helping people with their psychosocial problems.

CLINICAL SOCIAL WORK LEGITIMATED

Clinical social work is in comparatively good shape today. We have been through an ugly period of severe political and ideological struggle, beginning with a rebellion against the so-called psychoanalytic therapy establishment by the social reformists and scientific behaviorists who flagelated the clinical social workers for being reactionary, unserving to the poor and minorities, and ineffective and unscientific. The battle continues, though on somewhat different grounds, with the psychodynamic artists currently striking back in an aggressive fashion. But there are clear signs that a reconciliation is taking place and that some win-win kinds of outcomes are emerging for both parties.

We now have increasing evidence that, in general, clinical social workers are effective and that most of our clients like us and find our services helpful (Condie, et al., 1978; Kitchen, 1980; Reid & Hanrahan, 1982). However, this evidence is not accepted by many of the powers that be, particularly the Reagan Administration, who are attacking the profession, seeking to emasculate us and to expel us from many welfare service positions. These attacks seem to be related to our social reform image and our association with the poor, minorities, and deviant members of our society, to whom we remained committed. But we are fighting back.

We are clearer now about the nature and purposes of clinical social work. Major contributions have come from the efforts by the Federation of Societies for Clinical Social Work and by N.A.S.W. task forces, to provide clear and operational definitions for licensing of social workers, for social work practice as a whole, and for clinical social work. Also helpful is the general adoption of ecological systems theory, particularly for clinical practice. There has been a substantial increase in clinical doctoral programs in schools of social work, which is associated with a veritable explosion of knowledge and major technical methodological advances in clinical social work. This is exemplified by the flood of publications in recent years, particularly in the recent, monumental, but flawed, *Handbook of Clinical Social Work* (Rosenblatt & Waldfooel, 1983). Clinical social work is more widely practiced than ever. Even with the shortage of jobs for the increased number of social workers, the employment of social

workers has rapidly expanded in private practice, health care, industrial social work, and work with the aged.

The recent definition of clinical social work, approved and legitimated by the N.A.S.W. (Clinical Social Work Council, 1984), states that it is "the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders." It adds that "the perspective of person-in-situation is central to clinical social work practice."

Clinical social work thus has come to have a clearer meaning of therapy with individuals, families, and groups that aids people in their life situations. The basic aims are to help people improve their psychosocial functioning through the combined use of their personal and social resources and to enable social structures to improve their functioning so as to provide the social resources that people need. Social work purposes include caring and protection of clients as well as changes in their behavior and in their social contexts.

As casework was a long time ago, clinical social work now is clearly more than psychotherapy, encompassing situational interventions and one-to-one therapy or talking treatment. The terms casework and social treatment now seem passé, even though some of us are not happy with the medical associations of the term clinical, and there are questions to be faced as to how to define its methodology and how to categorize its conceptual models and the psychosocial problems for which it operates.

The traditional person-in-situation perspective has been a distinctive social work perspective and is now reaffirmed in what is known as an "ecological systems model" which expresses social work purposes and values, for interdependence, harmonious complementarity, and productive collaboration by the members or parts of a system to achieve common goals.

This ecological systems perspective has evolved into a basic conceptual framework or umbrella for our practice theories as well as for our behavior theories (Siporin, 1980, 1983b). Behavior theory is a set of descriptive concepts, theories, models, and principles about how people and collectivities develop, exchange resources with external sources, generate and resolve problems, weaken, and die. Practice theory consists of a set of assumptions, concepts, theories, models, propositions, and principles that are prescriptive for social worker action.[1] Practice theory is translated, converted, and then applied as a structure of ethical practice principles and of technical practice principles; the latter are derived from assessment, intervention, and evaluation theories.

Within practice theory, the ecological systems framework is utilized for the purposes of assessment, treatment planning, and evaluation of intervention. Based on this framework, certain practice principles have

emerged, for example, that problem-resolution requires a change in the interaction pattern or exchange balance between people and their life situations; that a basic helping goal should be to improve the adaptive fit between people and their situations; that helping interventions should be systemic in conception and have an impact at the crux or pivot of subsystem interface, so that they are both people-helping and system-changing.

In addition, there has been a substantial development of ecosystems theory itself and of its application in clinical practice (Germain, 1984; Germain & Gitterman, 1980; Hartman & Laird, 1983; Meyer, 1983). This is progress beyond the often-repeated notion that ecological theory is only a theory, without applications for practice procedures. We can instead recognize that we now have a viable, highly useful, and basic paradigm for social work, as well as for clinical practice. Goldstein (1983, p. 21) may be correct in declaring that the "interface" concepts of the ecological perspective are difficult to operationalize and even harder to research. However, the advances that have been and are being made with this framework warrant optimism that such further progress will take place.

THE CURRENT SCENE OF CLINICAL PRACTICE THEORY

As usual, we currently face a plethora of practice theories, all claiming to be the right and true path to the Holy Grail, Nirvana, Satori, or some other kind of heaven. However, the current scene concerning practice theory is in somewhat better order, and in more robust health, than it was a decade, or even five years, ago.

We now have updated and apparently improved models of psychoanalytic, problem-solving, existentialist, task-centered, and crisis-intervention approaches. The socialization approach, for example, now encompasses social skill training and family life education. But the old proverb says, "There is no goodness without badness," and in these changes in the new world of therapy, some negative aspects exist. As Strean (1981) has cogently observed, a number of the newer modalities are of questionable validity in claiming or seeking quick and painless results for serious, complex, and chronic difficulties.

The cognitive behaviorist approach, which includes rational emotive therapy, is particularly popular now, especially among academic types who can make use of its easy research applications (e.g., Beck, 1976; Berlin, 1983; Ellis, 1977). Many practitioners have come to recognize that its practice rationale and methodology, helpful as they are, are presently limited. It is clearly an insight-giving approach, psychodynamic in the sense that it is concerned with changing cognitions, in the form of maladaptive beliefs, expectations, and meanings, and thus with certain levels of personality change. Unfortunately, cognitive behaviorism seems to

focus mostly on the surface level of client statements and beliefs: "If I fail an exam, I am worthless," or "I interpret what happens to me by telling myself things that make me angry or depressed or anxious."

In comparison to this kind of simplicity, we have gained a renewed appreciation of psychoanalytic concepts and techniques, its soul-satisfying mythology, and its deeper insights into the high dramas of conscious and unconscious personality and interpersonal conflicts. The psychodynamic approaches, in varied psychoanalytic, existentialist, and psychosocial forms, constitute a different kind of cognitive therapy, with added experiential, subjective, intersubjective, and phenomenological dimensions (e.g., Arieti, 1974; Goldstein, 1982). Werner (1982) seems to occupy a middle (nonpsychoanalytic) position between these two camps.

For serious psychosocial problems, and particularly in regard to personality disorders, the psychoanalytic-psychodynamic model appears to be of equal or greater validity than cognitive behaviorism or other behaviorist approaches, on the evidence of clinical experience and on empirical research grounds.[2] The newer concepts and procedures about the experiencing consciousness, self concept, and object relations are of demonstrated practical value. One can agree with the conclusion of Altshuler and Rush (1984) that "cognitive and psychoanalytic therapies are more complementary and overlapping than mutually exclusive."

The renewed positive valuation of the psychoanalytic-psychodynamic approaches is confirmed by large numbers of students and younger social workers who seem more ready to take on the tasks of self-awareness and self-discipline involved in learning such an orientation to clinical practice, including undergoing personal therapy. At the same time, there is a felt need for a personality theory and therapeutic approaches that go beyond the psychoanalytic overemphasis on the unconscious, beyond psychic determinism and psychosexuality and that is more concerned with self concepts, identities, and self-esteem.

We also have several new breeds of therapy floating around, some adopted in typical faddish fashion and gathering social work disciples. These include neurolinguistic therapy, hypnotherapy, strategic therapy, sex therapy, life model, divorce meditation, and so on. We seem more tolerant of the appearance or existence of these many models, including of the somewhat quiescent, radical, crisis-intervention transactional analysis and gestalt approaches. There also are the remains of functional casework, which are kept unburied and distinct from the existentialist trend in social work by the loyal members of the Otto Rank Society. Our tolerance for these approaches is in keeping with the characteristic social worker tolerance for the avant garde or deviant, in the hope of constructive results. This tolerance is supported by the recognition that, as adapted by social workers, these theories take on certain commonalities: a common core of social work purposes and values, a systems framework,

and a concern with both person and situation. Highly individual styles and eclectic, pragmatic theoretical and technical orientations, rather than a monotheistic, cultist conformity, are thereby encouraged.

Family therapy continues to be very popular, with workshops drawing well year after year and with a continuing outpouring of books and journal articles, from structural to strategic, Milan, "ordeal," and other points of view, being produced. Students in schools of social work continue to flock to courses on family and marriage therapy, which provide substitute forms of personal therapy for a number of them (Siporin, 1981). Here also there is a general acceptance of a systems perspective and a trend toward technical eclecticism and theoretical integration.

INDIGENOUS SOCIAL WORK MODELS

A great deal of ferment, experimentation, and creative impulse is thus evident. But there is a puzzle here that is difficult to explain. With the exception of the towering figures of Hollis, Perlman, and Satir, clinical social workers have not personally formulated or come to represent a specific social work school or model of therapy. This applies to such currently prominent therapeutic figures as Aponte, Strean, Spark, Gerda Schulman, Palombo, Papp, and Hoffman. Though most of these people have maintained a social work identity, they largely are identified with psychiatric or psychoanalytic models associated with psychiatrists such as Bowen, Minuchin, Sager, and Bloch. The cognitive behaviorists, on the other hand, rely almost exclusively on psychological theorists and researchers. Social workers seem to be highly individualistic yet also group-oriented.

There are several social work models that may emerge from their present incomplete states, such as the life model, as in Germain and Gitterman's (1980) formulation, Shulman's (1979) mediating model, and Reid and Epstein's (1977) task-centered, procedural model. The "integrative model" of family therapy, well presented by Sherman (1981), Scherz (1972), and Leader, 1976, as elegant and useful as it is, has somehow not had general professional recognition or status. There also has been little recognition of the impressive achievement of Stuart's (1980) "Helping Couples Change," which is a helpful integration of psychodynamic, sociobehavioral and social learning approaches, with a heavy research base. However, Stuart has not helped himself by downplaying the psychodynamic elements in his work.

Germain's (1983, p. 50) suggestion that "practitioners lack the time and financial arrangements to participate in formulating technological frameworks" is questionable. We can look for a spurt of development in this regard from some of the graduates of our clinical doctoral programs,

a few of whom may actually become the scientist-practitioners that we need. But the profession needs further emancipation from its characteristic passive-submissive relations to father figures, particularly psychiatrists or psychologists. We can learn much from and with them, but they are not our real fathers. We have a rich conceptual and theoretical heritage, of which we should consciously and chauvinistically make better use.

ON EMPIRICISM, RESEARCH, AND PRACTICE

Another bit of progress to be noted about the current scene is the increasing operationalization of helping methods and concrete specification of procedures. This is first a response that marks an acceptance of an increasingly rationalist *Zeitgeist;* it represents a movement away from the rather wooly-headed, "touchy-feely" orientation of the contracultural sixties and seventies. Second, there is the result of the behaviorist influence toward explicit objectives; toward empirical, quantitative procedures to achieve and evaluate them; and toward contracted, concrete tasks that can be completed in short-term service programs. The third influence is the bureaucratic demands for accountability concerning economic and efficient service provisions.

In consequence, there has been a positive and increased use of planned, explicit, systematic, observable procedures in order to achieve explicit, specific objectives and to assure the maintenance of gains in an accountable though questionably "scientific" helping process. The craft of clinical social work has become more sound, while enabling a broad range of operational procedures and practitioner styles.

One positive feature of this trend toward operational procedures is the formulation of ethical and technical practice principles. There is a growing agreement with Harold Lewis's (1982, p. 57) view that "principles direct the practitioner. . . . The practice principle is the most powerful intellectual tool in a profession's practice." Thus, we see a rapid development of a body of technical practice principles that are theory oriented, based on practice wisdom or research, and directly applicable across a variety of practice situations (e.g. Stuart, 1980, pp. 370–371).

Social work and casework used to be considered an ethic and a philosophy in search of a practice or, as Cohen (1958, p. 1) stated, "humanitarianism in search of a method." We have developed a helping methodology (what also is mistakenly called a technology, as if our clients were things to be operated on). In the past, our values were ritually recited, like a catechism, as was done with Biestek's (1957) principles of the casework relationship, and then shut away in a holy ark. Today our value system is being operationalized and concretely applied in the helping process.

We recognize today that the relationship principles, for example, of individualization and acceptance, are ethical practice principles, which actualize our value system. Specific behavioral referents, criteria, and purposes have now been identified, so that we can observe and teach these principles. They guide the procedural actions of a worker to accomplish specific helping objectives, as in conveying our respect for the worth and dignity of a client, affirming unique individuality, or supporting the client's ability to make his or her own choices and decisions. They complement the more outcome-oriented technical procedures, so that we can be both efficient and humane in our dealings with clients.

This trend toward greater and more explicit formulation and operationalization of principles and procedures has its negative as well as its positive aspects. It is to the good in helping practitioners to be more realistic about their purposes and about what they can accomplish. It also is to the good in making for a more purposeful, explicit, task-oriented, effective, and efficient practice. An increasing number of useful standardized assessment instruments have been developed and are being used in practice. Monitoring and evalution of intervention activities are now more accepted as essential elements of the helping process, along with assessment and treatment.

However, the pressures for quantitative, logical, linear, overt behavioral approaches; for the pervasive, standardized computerized report forms; and for immediate, short-term, reportable, and therefore accountable results, all impose severe limitations and distortions. These features have become oppressively restrictive, mechanistic, and reductionistic, and they have brought about an expectable counter-rebellion.

SCIENTISTS VERSUS ARTISTS

The current controversy between the psychodynamic, experientialist, qualitative research advocates and the scientistic-behaviorist research defenders in regard to both research and practice is a complicated one, with many issues arising on several levels (Geismar & Wood, 1982; Gordon, 1983; Heineman, 1981; Hudson, 1980; Raynor, 1984, Ruckdeschel & Farris, 1981; Scheurman, 1982).The reverse beating on the scientists that is currently being administered by the psychodynamic artists and antiscientism faction represents a counter-revolt out of a felt need for certain kinds of experience and practice that may be called supra-rational, intersubjective, or transpersonal; this will be discussed later on.

We are now just coming out of a period in which a strong effort has been made to turn clinical practice into a science. This effort has not really extended to community organization or to policy development or administration. Social work, particularly clinical social work, is an

art, though we would like it to be a scientific art. In general, science tells us what to know, and art tells us what and how to do. Neither social work as a whole, nor clinical social work in particular, can be a science. It is and can be a better scientific art, based on valid data, with theories, principles, and techniques that are tested and verified in systematic and public ways.

The behaviorist-empiricist era has already resulted, as recognized above, in important positive gains for clinical social work. But it is completely unrealistic to believe that many clinical practitioners will make use of experimental, controlled, AB, ABA, ABAB single subject research designs or quantitative, statistical procedures in helping a client with a crisis situation. As Kirk and Rosenblatt (1983, p. 556) point out, there is very little clinical research reported in the literature, and "most clinical practitioners are unlikely to become well grounded in both research and practice."

The proponents in this controversy seem to slight the need for both quantitative and qualitative research efforts to arrive at different types of truths related to different kinds of problems and situations. Also, an older model of clinical social work research has been sadly neglected. It has been beautifully described by Hollis (1983) in a remarkable paper called "The Way It Really Was." She clarifies the use of a collaborative group and very public process by the early social workers in the development of psychosocial practice theories and procedures, the body of which came to be called "practice wisdom." This involved the use of case studies, collegial group thinking and discussion, and a responsible, rigorous, dedicated effort to discover and test out a number of important practice concepts and principles, such as client self-determination, the importance of understanding and using the environment, and the client-worker relationship. Hollis indicates that this was a

> valid scientific approach . . . based on observation, recording, thinking about the observations, experimenting with the new ideas and trying to be as honest as possible about whether they did or did not work. (p. 9)

Another important aspect of this controversy is the evident confusion that the empiricists slip into about the concepts of practice and research, and their effort to turn practice into a research activity.[3] Thus, empiricists declare that practitioners have to observe objectively, think logically, measure problems and treatment actions, observe and determine baselines, consider the validity of a sample, test for significant association of dependent and independent variables, monitor and evaluate intervention. Therefore, in this view (prevalent among research teachers, though identified as a type of research model, by Kirk and Rosenblatt,

1983, p. 554), "every case should be a research project," with the use of "research techniques as therapy." Such a conceptual confusion constitutes a classic kind of arrogant put-down of clinical practitioners.

It is counterproductive to categorize as research activity the use of such skills as logical thinking, systematic activity, and respect for the rules of evidence. One can grant that certain kinds of reasoning are similar in practice and research. But the thinking skills are used for different purposes, processes and outcomes. For example, analogical, metaphorical, symbolic, tacit, and parallel (nonserial) modes of thinking are much more prominent in clinical reasoning and the pattern-recognition and computational processes are also very different. Measurement is truly an essential aspect of practice, but qualitative measures can be as valid and objective as quantitative ones, and quite a number of things exist and work in this world that we cannot measure.

In such unhelpful attitudes and blind misunderstanding of clinical thinking and actions expressed by many empiricists lie the major reasons for the way student clinicians are turned off by research courses in schools of social work. This is aside from the general lack of relevance of statistical techniques and research findings for clinical practice. Research findings, like theories, need to be made relevant for practice purposes by being identified and translated into practice principles and criteria for their use. Very little of this has been done.

A further error is made in placing the rationale, principles, and procedures of treatment evaluation in a box of courses called research, that is separate from the box of courses we call clinical practice method. Such separate courses distort the teaching and learning of practice method and encourage the misguided teaching of practice method and techniques under the rubric of research, especially by faculty members with little or no agency practice employment, who are "researchers." This also retards the adoption of empirical evaluative procedures by clinicians as necessary components of practice. Practice method and research method should be taught as conceptually different and distinctive undertakings, and practice method needs to be taught so that it includes but is not limited to the reasoning skills that also are used in research.

PSYCHOTHERAPEUTIC AND SITUATIONAL INTERVENTIONS AND BEYOND

Many doom-crying social workers declare that because of the renewed concern with intrapsychic personality issues, we have traitorously turned away from our social reform mission. It would be more accurate to observe that the ecosystems perspective and its practice applications have helped us to focus better and more comprehensively on both person

and situation and on their inter-relations. Instead of the sharp duality between social structural and personality structural concerns, there has been a steady cumulation and evolution of knowledge and skill, for intervening in the social structural systems of clients, as well as for working with them individually and in groups.

The psychoanalytic era was a necessary period in our history in providing major needed learning for social workers in understanding and assisting the individual person with personality issues. But social workers also have been building a solid knowledge and competence for modifying the social milieu and the life situations of clients. It is true that social work therapists have given little theoretical significance to such situational interventions as social resource provision. They prefer the image and ideal of making deep interpretations of the unconscious to individual clients in private tête-à-têtes. They do not appreciate that their left hands actually have been busy developing situational intervention theory and procedures, though in the guise of such forms as family, and other therapies.

There is a continuous trend toward the development of such situational interventions, even though we admit that situation theory itself has had inadequate theoretical formulation. For example, during the 1940s, there was a substantial development of industrial social work. After World War II, there were successive periods of concern within social work for sociocultural content of renewed development of marriage and then family therapy, as well as of continued growth of social work with groups.

This trend accelerated during the social reform era of the 1960s and 1970s. Social workers then learned a great deal about social resource provision and development, the use of brokerage and advocacy procedures, organizational and policy development and change, community organization, and social welfare agency and program administration. More recently, social network therapy and work with social support groups have had extensive development. Even the social work behaviorists helped to generate learning about working with situational procedures of behavior extinction and acquisition, and about reinforcement contingencies and schedules, in conjunction with therapeutic activity to help clients learn needed social skills, or to modify dysfunctional attitudes and behavior.

Great strides have thus been made in developing a rich and varied body of practice theory and a rich interventive repertoire for clinical work with people and their life situations. Again, it is true that we do not have one overarching theory for understanding personality or situations, or for personality change or situation change.

One can question, however, the need for and feasibility of overly unitary theories, such as psychoanalytic personality change theory once

claimed to be. A major advantage of theories and practice principles is that they can be applied to the very great variety of problems, people, and situations that make up our practice. And we do have a unifying ecosystems framework within which these midrange theories can be contained, made consistent, and applied appropriately and differentially in actual helping situations. At the same time we can grant that our behavior and practice theories do need further development.

Every advance though, successful as it may be, uncovers new gaps and needs. At this time, there is a renewed emphasis on and effort to develop theory and skill concerning certain dimensions of the individual person, of the individual's identitites and memberships in group and community. Also, we seek to understand better and to help with these subjective and intersubjective relationships, within the individual and interpersonally, with others. Thus we have a new set of perspectives in the process of emergence. They invite our participation to help realize their promising contributions to the enrichment of clinical practice. Three of these are discussed here in an introductory way.

MORALITY, SPIRITUALITY, AND HERMENEUTICS

One branch of development is the emergence in recent years of a new or renewed moral perspective for social work practice (e.g., Joseph & Conrad, 1982; Keith-Lucas, 1977; Levy, 1976; Lowenberg & Dolgoff, 1982; Reamer, 1982; Siporin,1982,1983a). This trend is associated with an increasing awareness that many of the problems of our clients are moral-ethical in nature and that they are concerned with value conflicts and ethical dilemmas, as well as with deviance and transgressions that have harmed themselves or others. Difficulties in social functioning are more understood as disorders of moral action and relationships, rather than as those of mind or emotion. Also, the moral-ethical dimension is recognized as an essential and central one for human development and functioning.

This trend is part of a larger societal movement. Many people are frightened by the moral chaos of our times, by rampant violence and crime, and they desire a more secure moral order and community (see Yankelovich, 1981). They now wish to conduct themselves in accordance with the normative principles and practices of right living and right relationships with other people. There has arisen in this country what is called a "post-Watergate morality."

For many years, this moral-ethical aspect has not been given much attention in the morally relativistic and libertarian thinking of helping professionals, including social workers. Today, in understanding well-functioning and dysfunctioning people, social workers are moving away

from an overconcern with narcissistic and borderline personalities to a renewed emphasis on the moral character of the person, the importance of social norms in accordance with which the person has to live, and a focus on the person's value system of moral/ethical beliefs and philosophy.

It follows from such a realization that therapy itself is a moral enterprise, concerned with morality and ethics, their principles and their application in helping practice and in for the lives of clients. Much of therapy is thus seen to involve helping people to choose their ways of life in the light of ethical principles, so as to do good and to act rightly and justly.

Such a moral perspective does not sit well with some clinical social workers who have shied away from an explicit moral conception of their work and who adhere to a traditional and hard-won attitude of not seeing needy people as either worthy or unworthy of assistance. Nor do they wish to be morally judgmental, especially in religious terms, of the client as a person. Many social workers, however, have confused the need for acceptance of people and for tolerance of constructive deviance with indiscriminate approval of all kinds of deviant conduct and life styles. A different moral philosophy is evidently needed to correct such an unhelpful orientation.

Our desire for greater therapeutic helpfulness in meeting actual client needs will stimulate direct exploration of the moral aspects of practice. We need to work out ways of avoiding moralistic attitudes, while maintaining our acceptance of and tolerance for constructive deviant behavior and for serving as moral agents with and for clients and their collectivities. We need better ways of actively helping clients to face and deal with their moral-ethical obligations and responsibilities, their related and overt or covert anxiety, shame, or guilt feelings, and the processes of forgiveness and reconciliation. Such helping activity is indicated to aid clients in resuming or maintaining full membership and optimal social functioning in their groups and communities.

A second branch of development, to which social workers also have given little attention until now, concerns the spiritual perspective. This is related to the moral view in that the spiritual is essentially moral in nature. The spiritual element of the person (Hardy, 1979; James, 1978; Joseph, 1984; Macmurray, 1936) is the aspect of an individual's psyche, consciousness and unconsciousness, that is also called the human soul. It is in terms of the spiritual dimension that a person strives for transcendental values, meaning, experience, and development; for knowledge of an ultimate reality; for a belonging and relatedness with the moral universe and community; and for union with the immanent, supernatural powers that guide people and the universe for good or evil. This spiritual aspect of the person is not subsumed or dealt with in psychoanalytic ego theory or in cognitive theory, though it has a place in Jungian and exis-

tentialist therapies (Assagioli, 1965; Frankl, 1962; Jung, 1933; Krill, 1978; Peck, 1978).

Religion is one means and context for the expression and satisfaction of these spiritual aspects, strivings, and needs. It consists of a system or creed of beliefs, values, myths, symbols, and practices, including a faith in this creed and in a God. It is to the divine God figure that individuals relate themselves as the source and representation of ultimate reality and power.

The religious system of beliefs, precepts, and practices generally has an institutional structure, of communal denominations and congregations, in which people become members and take on religious roles, identities, and relationships with others. As Joseph (1984) clarifies, religion has important functions for believing individuals: it is socially integrative; provides emotional support, hope, and consolation; fosters an acceptance of authority, for order, discipline, and responsibility; confers a sense of identity; sacralizes norms and values; enables expiation of guilt and conversion experiences; provides symbols and rituals that support significant life experiences and transitions. Joseph also clarifies that these uses of religion may have either constructive or dysfunctional consequences.

At present a major religious revival is taking place in this country and in other parts of the world. Many people are searching for spiritual meaning and an ontological significance in their lives, mostly in religious but also in nonreligious terms and forms. For some, it may involve a concern with mysticism, occultism, faith healing, meditation, paranormality, or psychedelic drug experiences. For others, it means returning to traditional religious institutions; joining esoteric, charismatic, or fundamentalist cults; or belonging to new kinds of religious communities. There also is a reawakening of a nonsectarian, "civil religion" that has been developed in this country (Bellah, 1982; Krauthammer, 1984). This has important functions for citizens and the social order, in their relation to country and government. It includes a faith in a God We Trust, a sacred American history; sacred symbols, such as the national flag; heroes and heroines; a morality of civic rights, obligations, and virtues; and ritual holidays and celebrations.

The religous movement is beginning to make its appearance felt in professional social work thinking and education for practice, with a rediscovery of a tradition of religous concerns within social work (Johnson, 1956; Loch, 1910; Neibuhr, 1932). At the recent professional symposiums of the N.A.S.W. and at C.S.W.E. meetings, increasing attention has been given to these interests.

There is a recognition of the major discrepancy that exists between the religious beliefs, practices, and memberships of clients and of the general neglect of these matters in clinical assessment and intervention.

This discrepancy is prevalent, even though a substantial number of social work agencies and schools operate under the auspices of religious institutions. It further is being recognized that this spiritual-religious dimension is a significant factor for individual, family, and community functioning (Argyle & Beit-Hallahmi, 1975; Joseph & Patrick, 1980; Meystedt, 1984; Yinger, 1957). There is therefore a trend toward exploration and discovery concerning these spiritual and religious aspects of the people, their families and communities, as well as their implications for practice and education.

A third perspective is emerging out of the desire to gain better ways of understanding the subjectivity and consciousness of the person, as well as how better to relate to the person in his or her full humanity, including the moral and spiritual dimensions described above. A promising approach is the evolving discipline of hermeneutics (Bauman, 1978; Bernstein, 1983; Howard, 1982; Ricoeur, 1981). The latter is attractive because it offers a way of arriving in nonpositivistic, nonscientistic terms at moral, spiritual, and rational truths about clients and their reality. Developing from a long theological tradition of biblical studies, and from existentialist, phenomenological, analytic, and other philosophic orientations, hermeneutics has been translated into an epistemological, philosophic approach and applied to the social sciences, the humanities, and now to helping practice.

The hermeneutic approach seeks to apprehend, interpret, and explain the objective truth of knowledge, reality, people, and action in terms of subjective and intersubjective human meanings and felt experience. The understanding, and avoidance of misunderstanding, are considered to take place in transactional processes of mutal self-reflexivity and empathic acceptance; through unbiased, mutifaceted perceptions; concentrated or unfocused attention; reciprocal, complementary expectations; and open, dialogical relations between people. In such conscious relations and dialogue, consensual meanings and truths are arrived at. Hermeneutics reconciles the duality between subject and object and between the subjective and objective. Principles and procedures for this mode of knowing with therapeutic purposes are just beginning to be formulated and tested.

A knowledge thus gained is what Polanyi (1958, 1966) called a "personal tacit knowledge." This is an intuitive, comprehensive, and holistic understanding of reality, including its often hidden, sublimal, and emergent aspects. Polanyi suggested that such knowledge includes a "comprehension by indwelling" of people and things, in processes of personal involvement and empathic encounters with others.

This approach has important implications for our relationships and dialogue with clients. These concepts and procedures give conceptual and

linguistic expression to what social workers characteristically try to do and describe doing through the use of such inadequate terms as empathy, compathy, acceptance, and support. A hermeneutic effort at interpretive understanding and experiential comprehension enables us to join with clients in the tacit knowledge of the client's authentic history, situation, intentions, and behavior. In addition, it enables us to work with clients to actualize the potentials of their life experiences, and thus help them construct new facts and truths, new objective and subjective meanings and realities, and new patterns of action needed for optimal self-realization and functioning.

A hermeneutic perspective can complement the logical, rational, linear approaches to knowledge and truth. Both perspectives are needed to apprehend the complexity of data we gather and the processes we use to arrive at different orders of reality. And both are needed because, as Bruner (1964) stated, "knowing in the light of reason and knowing in the light of experience are surely only two of the candles with which we light the darkness."

CONCLUSIONS

We began our discussion of the theories of clinical social work practice by recognizing its current robust state. We clarified that a new ecological systems conceptual paradigm has emerged for social work practice and thus for clinical social work. We touched bravely on the current controversy between the empirical, behaviorist scientists and the nonempirical, psychodynamic artists. It is suggested that practice is essentially an art, though we wish it to be a scientific art; that research and practice need to be clearly distinguished conceptually; and that practice method should be taught as such, rather than as research, in the schools of social work.

Several forms of advance were noted in the cumulative development of theories and procedures for personality and situational change. We also identified and explored new perspectives for clinical practice, in terms of morality, of spirituality and religion, and of hermeneutics. These new perspectives can better aid social workers to arrive with clients at moral, spiritual, experiential, and rational truths upon which to base their choices for right action and living.

Social workers seek knowledge, of truth, beauty, and justice, not only in words, in practice theories, and in proclamations, but also in actual practice. As Kirkegaard (cited in May, 1961, p. 12) pointed out, "Truth exists for the individual only as he himself produces it in action." Social workers are doers and very action oriented. They are therefore particu-

larly qualified to help clients arrive at authentic understandings and actions about themselves and their life situations that are more apt to resolve their problems.

Related to this point is the old proverb that says, "He who knows himself, knows others." Good social work clinicians always return to the need to be self-aware and self-knowing, for authentic dialogue with and true understanding of our clients, as well as for effective helping. So do we seek to know and interrelatedly to act, to establish, interpret, and also create, with our clients, just, beautiful truths and new realities.

REFERENCE NOTES

1. Siporin (1975, pp. 74–78, 105–115) distinguishes and explains the nature of behavior and practice theories, and of ethical and technical practice principles.
2. This conclusion is based on ambiguous results of the reviews of research on outcome effectiveness of different therapeutic approaches, especially on the treatment of personality disorders. See such reviews in Griest, Jefferson, and Spitzer (1982) and American Psychiatric Association Commission on Psychotherapies (1982). The very great conceptual and methodological difficulties in doing outcome research are emphasized in both books, and the results are confounded by the observation that most psychotherapists are eclectic in actual practice. For discussion of this latter point, see Parloff (1980). For empirical research evidence of the validity of psychoanalytic therapy, see Masling (1982).
3. For examples of this empiricist confusion of research and practice, see Fischer and Hudson (1983) and Schinke, (1983). A notable exception is Thomas's (1983) emphasis on the differences between single subject research and clinical service and his suggestions for their co-existence.
4. For an application of the hermeneutic approach to psychoanalytic theory and practice, with a categorization of psychoanalysis as a "hermeneutic discipline," see Atwood and Stolorow (1983).

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