L. Shulman: Interactional Social Work Practice (Peacock Publ., Itasca 1991)

The Social Work Paradigm

Early in its development social work adopted a paradigm that currently dominates our profession. This paradigm was borrowed from the medical profession, considered to be a successful example for building scientific knowledge. The medical paradigm considered intervention as a three-stage process: study followed by diagnosis, and then treatment. Evaluation of treatment outcomes was added as a fourth stage designed to feed information back into the study process. Mary Richmond (1918), an early advocate of the importance of moving social workers from the status of "friendly visitors" to scientifically informed professionals, encouraged the adoption of the model.

This paradigm helped social work develop as a profession, and elements of the paradigm will probably always be central to our work. The argument advanced here is that there have been significant changes in our understanding of the helping process and the dynamic way in which workers and clients interact. These new insights suggest that a paradigm shift may be useful. This new paradigm would incorporate the best of what we have developed under the medical paradigm while providing a different model for viewing practice. Such a paradigm shift may already be under way.[2]

It's important to point out that I am not using the term *medical model*, as it is also sometimes used, to describe an illness and pathology orientation toward assessment of clients. Professionals will often tell me that they have abandoned the medical model, meaning that they focus on a client's strengths rather than limitations, and that they see clients in their social context. This is a common but narrow use of the term. I am referring to the medical paradigm that may still be employed by those who use a health rather than illness orientation for diagnosing clients. I believe that interest in a health and systems framework for understanding clients is a signal of the paradigm shift taking place. Even social workers who develop a social and community action approach to their practice, helping clients to organize (e.g., tenant associations in housing projects), may still be using the three-stage medical paradigm although they may emphasize diagnosing and changing the system and may substitute a different terminology.

Issues Associated with the Current Social Work Paradigm

What are some of the issues associated with the medical paradigm that might lead us to want to consider a paradigm shift? First, the paradigm suggests that the helping professional is somehow outside of the process he or she wishes to influence. The worker's interventions are viewed as the result of a sound study and diagnosis. When one examines actual examples of practice, as for example in an analysis conducted in one of my early studies of practice (Shulman, 1978), we see that, in reality, the worker's movements are as much influenced by the moment-by-moment

interaction with the client as by the treatment plan. In one part of this study, when we examined 120 videotaped hours of social work practice with individuals and groups, using a computerized interaction analysis system that I developed for the study, it was clear that the interaction between worker and client was reciprocal in nature. The movements of the worker influenced the responses of the client and the client responses influenced the worker, and so on throughout the session. Does a three-step paradigm adequately describe this interactional process? I don't believe it does, and in fact, I think it shifts our theory-building efforts and research away from a focus on the process toward a focus on the client apart from the process.

Evidence for this argument can be found in a review of our practice research that is influenced by our professional paradigm. Very few of our practice studies actually focus on what the worker says and does with the client. Although the current influences of behavioral and psychotherapy models have led us to examine method more closely, by and large, social work studies have ignored the interaction between worker and client.

In Fischer's controversial review of the social work practice literature (1973), he asked, "Is Casework Effective?" Fischer decided that the research had not supported the efficacy of our practice. What was overlooked in his analysis is that none of the studies reviewed examined what the workers were actually doing with their clients. The independent variables in the studies included how often they did "it" (e.g., frequency of contacts per week), the social worker's level of training when they did "it" (e.g., M.S.W. versus B.S.W. or untrained), or the modality of service used when they did "it" (e.g., individual, family, or group work).

What was not studied in any of the projects was what the "it" was social workers were doing. The operationalizing of the independent variable (social work practice) was never taken to the level that would have allowed us to distinguish between the effective workers and those who were not effective. We have all seen workers with similar professional degrees who were more or less effective. We were asking, "Is casework effective?" The question we should have been exploring was, "What is casework?" It's my argument that the question was not even raised because our paradigm did not lead us in that direction. Kuhn points out that among other things, a discipline's paradigm defines the important research questions (1962). The three-step diagnostic paradigm places greater emphasis on understanding the client than it places on understanding the process of interaction between worker and client.

It is not accidental that the early leadership of the psychotherapy research, which focused on the communication and relationship skills of the therapist, was provided by the group building upon the paradigm shift in psychotherapy advocated by Rogers (e.g., Truax, 1966). It was the new interaction-oriented and client-centered paradigm that sent these researchers in this direction.

It is also interesting to consider the model building which sprang from our interest in general systems theory, sparked by the pioneering work of Gordon Hearn (1958, 1969). This view stressed the importance of understanding clients in dynamic interaction with the systems around them (family, group, agency, etc.). However, most early models did not include viewing the worker–client interaction in the same way. It was as if the worker were outside of a dynamic system, looking in.

A second issue related to the use of the medical paradigm is the dominance in our theory-building efforts of a suggested dichotomy between a worker's professional and personal self. Professional objectivity was valued as the quality that allowed the helper to divorce him or herself from subjective feelings, attitudes, and beliefs that might negatively influence practice. A premium was placed upon presenting a professional self upon which the client might project, such as in the process of transference. The notion of maintenance of a professional stance was an important one in that it protected against a worker "acting out" his or her own problems with the client, allowing personal prejudices to influence the process, or responding negatively, which might occur in association with countertransference.

Unfortunately, this view created a dualism in the minds of many professionals between their personal selves and their professional selves. Rather than attempting to develop a synthesis of the two, in which each professional makes use of his or her personal self in implementing the professional function, many in the field believed professionalism required the suppression of one's feelings. One result of this offshoot of the paradigm has been the development of a stereotype of a professional without genuine feeling for his or her client. If one argued that spontaneity in sharing of worker affect in the disciplined pursuit of one's professional function was at the core of the helping process, then a paradigm that incorporated this concept would more accurately describe the helping process.

In my early studies (Shulman, 1978), sharing of personal thoughts and feelings by the worker was a skill that correlated highly with developing a good working relationship and effective helping, as perceived by clients.[3] As one client put it in her comments on a questionnaire: "I like my worker. She isn't like a professional, she's like a real person." In my training work with thousands of helping professionals over the years they consistently reported that their practical experiences had taught them the importance of integrating their human qualities into their interactions with clients. However, many felt they had to hide their work from their colleagues, who would have considered them "unprofessional." These professionals would be aided by a paradigm in which the human interaction between worker and client was central to the model.

In my own study of the practice of family physicians with their patients, I found that the physician's attitude toward the patient (positive, neutral, or negative) was an important predictor of the outcomes of patient comprehension, satisfaction, and compliance (Shulman & Buchan, 1982). In spite of the fact that the physicians were sure that their professional stance insulated them from the effects of their "personal" feelings, their patients clearly perceived these attitudes and were affected by them.

This variable was added to the study design when a physician serving as a key informant during the instrument development stage said, "How will you account for those patients I schedule for the end of the day, because if I began the day with them it would be ruined for me?" As I pursued the meaning of the question, it became clear that the physician's paradigm of practice would not allow him to admit to me, or himself, that he really did not like these patients. He could, however, accept a question on his attitude toward patients worded as "positive, neutral, or negative." Active exploration of physician attitude toward patients in my training efforts with family practice residents yielded important insights into medical as well as relationship issues connected to the feelings of the doctors. A more accurate paradigm for medical practice itself would be one that also understood the reciprocal nature of the interaction.[4]

It has been argued thus far that a paradigm that guides professional social work practice, teaching, and research exists. This paradigm has added to our understanding and the professionalism of our practice. It has also been argued that significant advances in our knowledge of clients, their systems, and the helping process may have prepared the way for a shift to a new paradigm, which incorporates more effectively new understandings and practices. Such a shift, if it takes place, will only be accepted by the field if the new paradigm provides answers to troublesome anomalies, suggests more productive directions for our research, makes it easier for us to teach new professionals how to practice effectively, and creates a closer fit between our theories and models and the day-to-day realities experienced by professionals in the field. One such paradigm is described in the next section and elaborated on in the chapters that follow. Others will certainly emerge to compete for the acceptance of the field. This is a healthy process for the development of any profession.

An Interactional Paradigm of Practice

The interactional paradigm was described by William Schwartz in an entry on group work practice published in *The Social Work Encyclopedia* (1977). He described his model as an interactionist approach. The article in which he first described his theory was called "The Social Worker in the Group" (Schwartz, 1961), and was extracted from an unpublished doctoral dissertation (Schwartz, 1960). Although Schwartz was widely known as a group work theorist and the founder of what was later termed the "reciprocal model" (Pappel & Rothman, 1966), his interest was in developing a theory of social work practice that would describe the profession in action in its many different settings and differing modalities of practice (individual, family, group, community).

Schwartz drew heavily on social interactionist theorists and philosophers (Baldwin, 1911; Dewey, 1922; Follett, 1926; James, 1958; Mead, 1934; Parsons, 1937) as well as social work theorists such as Lindeman (1939), Pray (1949), and Hearn (1958). Lawrence Frank (1957), from the field of psychotherapy, was another important influence. In particular, it's interesting to note his roots in what is still termed the *functional* school of social work, whose founders, Jessie Taft and Virginia Robinson (Taft, 1942), contributed many crucial constructs which have achieved wide acceptance in practice today. Three of the most important include the impact of time on practice (beginnings, middles, and endings), the importance of empathy in the helping process, and the power of clarity of agency function.

It was the functional school, physically located at the School of Social Work at the University of Pennsylvania, that first challenged the medical, or diagnostic, paradigm. Taft and Robinson drew upon the ideas of Rank, a disciple who broke with Freud, to develop some of their central notions of change. These views were not well received in a field dominated by Freudian psychology. In addition, social work was attempting to enhance its professional status by borrowing the paradigm of practice employed by psychiatry. Advocates of the functional approach found themselves excluded from the mainstream of the field. They were not invited to present at conferences, and the peer review process worked to exclude their publications from journals.[5]

Schwartz turned to the rich literature of the social interactionists, social philosophers, and early social work pioneers in developing his own synthesis, which he termed the interactionist model. (I have changed the term *interactionist* to *interactional*. This places the emphasis on the process rather than on the person. Others have at times called it the "mediating" or "reciprocal" model.) Central to the paradigm was a view of the helping relationship in which a self-realizing, energy-producing client with certain tasks to perform, and a professional with a specific function to carry out, engage each other as interdependent actors within an organic system (1971). He focused his attention on the ways in which each person in the system "reverberates" as all of them act upon their respective reasons for being there, with their tasks changing from moment to moment. The relationship is a circular, reciprocal one, with each party (worker and client) affecting and being affected by the other.

Starting with this paradigm of practice, one's energy is directed toward understanding the client in a moment-by-moment interaction with the worker. A premium is placed on the worker's ability to understand his or her function in the helping process and the ways in which implementation of that function assists the client to actively play his or her part. Functional clarity, often obscured in the field by the use of jargon (e.g., words such as *enhance*, *facilitate*, and *enable*), becomes a prerequisite for effective action.

Another principle associated with an interactional paradigm is the centrality of method. Method is the way in which the helping professional puts his or her function into action. A premium is placed on our ability to describe in some detail exactly how our professional role is implemented. Communication, relationship, and problem-solving skills are the tools workers use to implement their function. Developing skills without harnessing them to a clear sense of one's function will result in ineffective practice. A worker skilled in the use of empathy has to know which feelings to empathize with in pursuit of what purpose. The empathy skill,

caught apart from the structure provided by clarity of purpose and worker function, will not contribute to the helping process.

Finally, understanding the worker–client interaction as a dynamic system taking place within a larger dynamic system (agency, community, society) leads us to a holistic approach to theory development and research. All these core ideas are described and illustrated in the balance of this book.

The Common Elements of a Practice Theory

In any effort to develop a unified, empirically based practice theory for a profession, the first step involves focusing on the core elements that apply to social work practice in any setting, with any population employing any modality of service (individual, family, group, or community work). We have to observe clearly what it is that social workers bring to their work that identifies them as members of a single profession. In past efforts to identify these unifying elements, we have focused on common knowledge and values, a unified code of ethics, and a shared interest in the psychological and social issues facing clients. While all of these elements contribute to the unity of a profession, they do not address commonality of method. What we know and value, our ethical injunctions, and our interest in both person and situation are all important contributors to our activity with clients, but they are not substitutes for a clear definition of what is common about what it is we actually do as we put knowledge and values into action.

A unified practice theory should provide us with the tools for recognizing a social worker in action, as he or she works with an individual seeking counseling in a rehabilitation agency, leads a group of patients on a psychiatric ward, helps a family in a counseling agency, or organizes tenants in a housing project. Although the purposes and processes in each of these encounters may be different in many ways, a unified practice theory should help us perceive the commonalities in the methodology employed by each practitioner. In addition, if our profession is unique, we should be able to observe the unique qualities of social work intervention as compared to other professions. In the next part of this section, I will provide an illustration of the common elements of such a theory, focusing on the interaction between persons (worker and client) in context over time. This discussion is followed by a section that illustrates how this common core is differentiated into the variant elements of practice.

Person in Interaction

Many person-related factors may influence the outcomes of practice. For example, the client's motivation may have a powerful impact. The degree of stress the client experiences or the nature of the problem may prove to be strong predictors of outcomes. The client's acceptance of a problem and ability to use help may also make a difference.

Person-related factors may influence a worker's interaction with clients. A worker's background, education, and training; stress from heavy caseloads; or the nature of the problem (e.g., sexual abuse) may take its toll on worker motivation, attitudes, and behaviors with clients. These person-related factors are examples of common elements of a practice theory that may influence all clients and workers in their interactions.

Starting with the assumption that worker and client personal variables influence the interaction, the next step is to examine worker skill. To illustrate the theory elaboration process I will use two core skills employed by workers with clients. These are the skill defined as *clarifying role* and the empathic skill called *articulating the client's feelings* (Shulman, 1978, 1981, 1982).

Clarifying role is a skill in which the worker explains, in simple, nonjargonized terms, his or her role in the proceedings. This statement is the worker's attempt to answer the following question from the client (even if the question is never directly asked), "How will you help me?" The emphasis on directness and the restriction on jargon is important because of the unfortunate tendency for professionals to use language that obscures rather than clarifies our role (e.g., enhance social functioning, facilitate individual growth and development, and strengthen egos). Clarification of one's role is an important element of the crucial contracting work which must take place if a framework for productive practice is to be developed.

Articulating the client's feelings involves the worker becoming so *tuned in* to the client's inner feelings and concerns that he or she is quick to respond directly to indirect cues in their presence.* For example, when a mother says her daughter has been going through a tough time with the breakup of a marriage, articulating the client's feelings might sound like this: "And it hasn't been an easy time for you either." It is crucial that the comment by the worker be genuine in that the worker must really be trying to feel the mother's pain.

These are two examples of core skills, which one might expect to see in the practice of any social worker, in any setting, with any client, working in any modality of service. They are examples of constant elements of social work practice. The actual elaboration of the role of the social worker, and the kinds of client feelings the worker will empathize with, are all variations on the common themes. For example, a social worker in a family counseling agency might articulate a role that reflected the purpose of the agency and the family counseling modality of service. The feelings of the client, which are relevant to family dynamics and family counseling, might be articulated by this social worker. Another social worker, working in a community organization agency, might elaborate a different role because he or she contracts with tenants in a housing project. The hidden feelings in first sessions might relate to the tenants' fears of retribution by the housing authority.

One could easily argue that these two skills are also important for any helping professional, for example, teachers, psychotherapists, doctors, nurses, or physical therapists. I would agree. The difference between