Back to the Future:

The Great Schism in Social Work and Science

About How to Help Clients

A Last Lecture

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Overview

My last lecture will begin with an overview and history of the two overarching models of helping in social work practice and examine the tension between them. Next is an overview of key findings from empirical research about the client outcomes of those models, asking "*What treatments provide the most help for diverse clients and their presenting concerns?* My lecture will conclude with key ingredients from empirical evidence and practice wisdom for helping that works in a brief review of the state of the art.

My lecture has three learning objectives for participants:

(1) Describe the historical, philosophical, and environmental roots of the Diagnostic and Functional traditions, their basic assumptions, and the tension between them in clinical social work practice.

(2) Recognize the footprints of those traditions and the tension between them in social work practice today.

(3) Explore the empirical evidence both for and against those traditions in light of client outcomes.

Roughly 50 years ago, seven social work organizations - representing caseworkers, group workers, community organizers, medical social workers, psychiatric social workers, school social workers, public welfare workers, and social scientists - merged to form NASW, taking seven years to accomplish their task (Beck, 1977). And - as each of the founding seven social work membership organizations brought its unique history, practice culture, and helping perspective to the bargaining table - an additional year was required to craft common language for social work practice (Bartlett, 1958). Protracted negotiations portend a fragile alliance and, in roughly the time that it took to establish, NASW began to unravel. An eye witness to history, Phillips (2000) recalls that clinical social workers lost faith in NASW and began to form independent state societies for clinical social work as NASW adopted social action as its primary organizational mission.

But clinical social workers fought to a standstill themselves over how best to help clients long before that, and contemporary perspectives on how to help clients are still haunted by the ghosts of that war. For example, one view of helping, drawn from *Research on Social Work*

Practice, championed the development of protocols and algorithms for clinical practice, based on expert consensus and the best available empirical evidence, to serve as social work standards of care for presenting problems linked to differential DSM diagnoses:

> *Numerous studies indicate that guidelines* [for clinical practice] *can increase empirically based practice and improve clients' outcomes. Guidelines for social work practice would also promote more informed client decision making, improve clinical training in schools of social work, encourage more cost-effective and accountable practice, and help codify current knowledge in controversial practice areas. The National Association of Social Workers should institute a guidelines development program and ensure that guidelines reflect traditional social work values and the best in available scientific evidence and practice experience. . . [because] few of the practice decisions social workers make are empirically rationalized (Rosen, 1994)*. (Howard and Jensen, 1999, p. 283).

A second view of helping, drawn from the lead article in a volume

of *Clinical Social Work Journal*, argued that clinical practice is a transactional art that should be practiced with an eye to the client as a *person*, not the client's diagnosis:

> *Kohut (1971) has suggested that by carefully attending to the demands of the transference, by providing optimal empathy to the selfobject needs, the therapeutic process can proceed to build internalized self structures. The assault on the self, caused by the crisis of chronic illness, requires an experience near empathic experience to restore and maintain self-esteem and self-cohesion. Kohut's (1977) theory of self-psychology is based on the concept that when the needs of the self are not met, fragmentation occurs and defenses become more primitive. . . The therapeutic relationship becomes one of the crucial components toward attaining cohesion over fragmentation and vitality triumphing over despair*. (Garrett and Weisman, 2001, p. 130).

The tension between these two models of helping reflects the great schism between the Diagnostic and Functional traditions of clinical social work practice. Those two knowledge traditions rested on

assumptions so different that a commission formed to bridge the chasm between them collapsed (Kasius, 1950). Lessons for the future lie in the past.

The Diagnostic Tradition of Clinical Practice

The Diagnostic tradition of clinical practice took form in 1917 with Mary Richmond's publication of *Social Diagnosis*, a blueprint for clinical practice with persons with problems. The basic assumption of *Social Diagnosis* was a model of helping that cast social workers as experts and agents of change. *Social Diagnosis* instructed social workers to help clients by gathering facts, assessing people and problems, exploring solutions, and selecting the best intervention to achieve them. In university-based schools of social work, educational policy for direct-practice education[1] still bears the imprint of Richmond's directive.

> *Practice content must include the following skills: defining issues; collecting and assessing data; planning and contracting; identifying alternative interventions; selecting and implementing*

[1] Although this language has been obfuscated in subordination to an emphasis on practice competencies in the most recent iteration of CSWE educational policy and standards, the basic themes remain constant. See http://www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx

appropriate courses of action; using appropriate research to monitor and evaluate outcomes; applying appropriate research-based knowledge and technological advances; and termination.(Council on Social Work Education, 1994, p. 102)

Reflecting American pragmatism and can-do spirit, Richmond's protocol for practice was an expression of confidence in people and the profession. Although the United States at the turn of the century was a crossroad of popular beliefs and assumptions about knowledge, the Enlightenment was the source of social work's basic faith in human development. Separated by the Renaissance from the middle ages, in which the course of each human life was fixed in accordance with God's timeless plan, the Enlightenment's lesson was progress and change.

The optimism of the Enlightenment reflected a break with past assumptions about the nature of knowledge. The Christian middle ages assumed that knowledge was God-given and *revealed*. In the wake of the Enlightenment, as science exposed nature's hidden secrets, people came to believe that knowledge was *discovered*, and industrialization and advancing technology proved the pudding.

If the physical world could be understood, altered, changed, social workers assumed that no less could be true for individuals, society, and human institutions, as evidenced in the American and French revolutions, viewed as democratic eruptions of inexorable human progress. Thus infused with progressive assumptions, *Social Diagnosis* championed the systematic pursuit of knowledge for practice. To discover knowledge, Richmond turned to science and its rigorous methods. For social workers, this meant acquiring independent evidence to support or challenge impressions and hunches about cases. For the profession, *Social Diagnosis* meant systematic observation, description, and classification. In the progressive blueprint for helping, science was the key to the future.

If *Social Diagnosis* was a prescription for building knowledge by helping one case at a time. (Richmond recommended a learning caseload of at least two families, with a ceiling of four), it also prescribed an overarching helping procedure. For the layperson, diagnosis means naming disease. But Mary Richmond viewed diagnosis as a systematic method for selecting the most effective intervention for a particular case.

Knowledge in the Diagnostic tradition meant knowing what treatments produced what outcomes with what people and problems. Skills in the Diagnostic tradition meant assessing people with human concerns, using the findings to select the best treatment among many contenders, and carrying it out.

> *The [worker] . . . endeavors to have the client give relevant facts and amplifying details about the difficulty for which he is seeking help. . . The treatment plan, however, is based on knowledge of the relevant factors . . . its character, the degree of pressure it is creating, its onset, and possible ways of handling it. The caseworker attempts to gain sufficient information to be able to assess the nature and weight of the <u>reality</u> pressures in the individual's situation. Such an inquiry may cover such points as finances, work, health, living arrangements, attitudes and behavior of others involved in the problem; it also includes consideration of the client's ideas or plans* . . . [but] *The subject matter - the content - of the discussions, although client initiated, is held within boundaries and given direction by the worker* . . . [as] . . . *The*

> *casework field is currently attempting to clarify and describe various types of treatment according to goal and to indicate the range of techniques appropriate to each classification . . . Treatment at this level utilizes a range of techniques, in various combinations; the dynamics of the particular case determine which techniques, and in what combinations, are most appropriate.* (Kasius, 1950, pp. 15 - 18).

The Functional Tradition of Clinical Practice

Twelve years after *Social Diagnosis* was published, pessimism rooted in depression-era economic and social conditions shaped a very different view of how to help people. The social work historian Mary Burns describes the Functional practice environment:

> *The next six years were a bitter contrast to the previous decade. Unemployment rose steadily until over fourteen million persons were out of work; the industrial plant stood idle much of the time; the farm situation deteriorated to the point of chaos; and the banking system of the country neared collapse. Suffering was acute, as provision for financial assistance of the unemployed was*

> *totally inadequate to the size, intensity, and duration of the emergency.* (Burns, 1958, p. 91).

Resources were limited, caseloads ballooned, and jobs were elusive. Face-to-face with a nation in peril, the Functional response was retrenchment and a redefinition of the social work role. Its' manifesto was published in the inaugural issue of the *Journal of Social Work Process* and, in this [edited] quotation from our social-work past, the substance and subtext of the Functional view still speak to the present in Jesse Taft's words.

> *The intensely psychiatric, psychological, and subjective phase of interest in . . . clients . . . seems to be passing, along with the shift from intensive, indeterminate casework by the private agency to the highly functional administration of public money . . . That social casework cannot become a science is taken for granted by virtue of its practical basis . . . Too often we have to admit we know not what to do. . .*
>
> *In my opinion, we already have [a foundation of professional skill] if only we can relinquish our too great sense of responsibility*

> *for the client and his need in order to concentrate on a defining of what we can do and a refining of our knowledge and skill in relation to the carrying out of each specific and accepted [agency] function. . . The social worker. . . must be able to accept the results. . .whether or not they go against his natural human desire to help. . .he must respect the process and limitations inherent in work with other people. . . The help that occurs, if any, must be left entirely, instead of partially, to chance. . .* [and left to the client!] (cited in Robinson, 1962, pp. 206-226).

If Taft's revision of the social work role embodied retrenchment, *the helping relationship*, a slippery construct illuminated by Virginia Robinson, promised renewal. This became the centerpiece of knowledge in Functional social work practice.

> *Of relationship, the most incomprehensible phenomenon in human development, little has been written. . . [but, it] has been taken for granted as the fundamental background and reality of human development. . . [There is] an inevitable tendency on the part of the client to seek and accept an emotional relationship to the worker . .*

. *in which to solve a problem.* (Robinson, 1936, pp, 115-151).

Where the Diagnostic position prescribed an objective and systematic approach to social work practice, the Functional position viewed helping as a subjective interpersonal experience - an unfolding process without substance or form - in which luck and the client govern helping outcomes. In the language of Kenneth Pray . . .

> *[R]elationship is itself always a process - a dynamic, fluid, developing process, never static, never finished, always chiefly significant for its inner quality and movement, for its meaning to those it engages, rather than for its form or status of outcomes at any instant in time*." (Cited in Dore, 1990, p. 365).

The Human Dimension of the Great Practice Schism

According to one version of history, the great practice schism was a struggle for ascendency between two systems of knowledge imported from Europe (Kasius, 1950). According to a second version, the turbulent environment of social work practice under economic depression, world war, and recovery engendered the schism (Burns, 1958; Eisenberg, 1956). According to third version, the roots of the

schism were deeply-human and personal. After earning her doctorate at the University of Chicago, Jesse Taft began searching for social work employment. The high-school graduate she sought as her mentor was found withholding, unhelpful, and rejecting. What transpired is described by Taft's best friend, colleague, and biographer.

> *In search of advice on job opportunities she made an appointment with Mary Richmond who in her position in the Russell Sage Foundation in New York was at that time the authority on social casework in the country. Her qualifications apparently did not impress Miss Richmond who told her that she would need training in a good casework agency under a competent supervisor, suggesting Johanna Colcord. Jesse Taft was in no mood to consider subjecting herself to a beginner's position as a learner under anybody.* (Robinson, 1962, p. 44)

If bad blood started the schism, a foreign infusion may have deepened the rift. The interpersonal tension between Taft and Richmond had its counterpart in Vienna, where Otto Rank, Freud's protégé and once favorite, fought with his mentor (Klein, 1981). After Rank broke

with Freud in 1924, Rank sailed to the United States (Rudnytsky, 1991), where an entranced Taft heard him lecture. (Robinson, 1962).

Employed as a clinical "child psychologist," Taft asked Rank to become her psychoanalyst, but Rank demurred, claiming no room in his schedule was full. Ever intrepid, Taft resolved to approach Rank once again. This time, Rank agreed to psychoanalyze Taft, and Taft become Rank's colleague, biographer, and champion.

Wounded by Richmond but welcomed by Rank, Taft launched an attack Richmond's model of social work practice:

> *[A]s diagnosis and treatment are concepts taken over bodily from medicine or psychiatry . . . they represent an attitude toward the client which seems to us fundamentally antagonistic not only to functional practice but to social work itself. The client in our belief is not a sick person whose illness must first be classified, but a human being, like the worker. . ."* (Taft, 1944, pp. 8-9).

By mid-century, the tension between Richmond and Taft had become a schism between two views of knowledge for practice:

> *In the diagnostic model, the practitioner carried primary*

responsibility for the outcome of the intervention; correct interpretation of case material resulted in the selection of the right intervention and led to a positive outcome. In contrast, [the Functional model emphasized] the central role of the client in his or her change. . . [in the context of the helping relationship]. . . It was the client who made the ultimate choice between growth and change, or stability and, possibly, stagnation." (Dore, 1990, pp. 363-364).

Fast Forward: The Past 50 Years

Social work has labored to manage its factions and schisms for the past fifty years, because feelings get hurt in the clash of ideas. A commission formed by the Family Service Association of America to mend the Diagnostic and Functional rift was unable to do so (Kasius, 1950), and to define a common base of social work practice without splintering NASW, the Subcommittee on the Working Definition of Social Work Practice was forced to seek refuge in the diplomatic language of noble abstractions (Bartlett, 1958). In social work education, that compact launched a search for a unifying theory or model of direct social work practice, one that could synthesize Diagnostic and

Functional values, knowledge, and methods without alienating the amalgamated profession's companion group-work and community-organization practice traditions and social-policy positions. This produced a generic curriculum for social work practice with a functional direct-practice center.

> *In the years since the functional model was developed . . . its basic concepts have become an integral part of social work practice, often without real awareness of their origins. In almost every contemporary social work practice text, a practice approach is described that includes functional principles such as the client's right to self-determination, the understanding of individual difference, starting where the client is, the evolving nature of client assessment, the important role of relationship in the helping process, and a recognition of time as an organizing component of the intervention process*. (Dore, 1990, pp. 369-370)

If Dore was correct that Functional knowledge became the centerpiece of social work theory for practice, a turbulent environment soon tipped the balance. Primed by the pump of the federal government,

the marketplace for clinical social work surged during the heyday of the community mental health movement, catalyzing a succession from NASW. But in the 1980's public policy turned to the right; the federal government ended direct funding to mental health centers, and state government and the private sector began to take over. Speaking from the citadel of federal retreat, NIMH staffer Morris Parloff (1982) put clinical social work on notice that Diagnostic knowledge would become the coin of the realm in the 21st Century.

> *Research evidence on psychotherapy outcome is both extensive and positive. However, the evidence is not responsive to the question, "What kinds of psychotherapy are most effective for what kinds of problems?"* (Parloff, 1982, p. 718)

Titled, *Psychotherapy Research Evidence and Reimbursement Decisions: Bambi Meets Godzilla*, Parloff's proclamation triggered a new round of conflict (for a review, see Tyson, 1995), and schools of social work began training a new breed of social workers - brash with training in behavioral research and statistics - to challenge and overthrow the functional establishment, polarizing social work education

and social work practice (Austin, 1998; Fraser, Taylor, Jackson, & O'Jack, 1991; Glisson, 1995; Karger, 1983; Marino, Green, & Young, 1998; Rosen, 1994; Thyer, 1996).

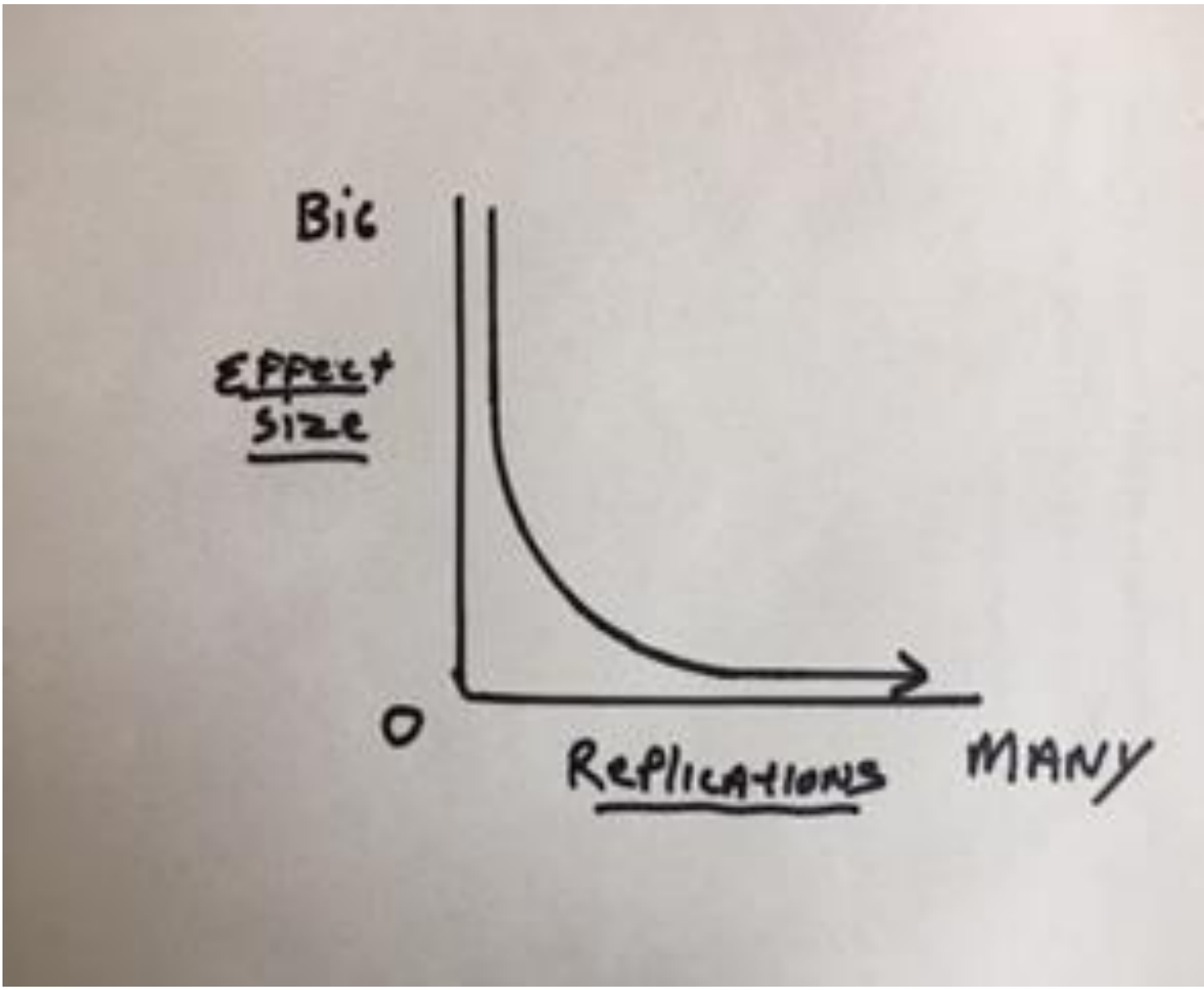
Back to the Future

I want to use a broad brush to paint a picture of what's known about how people help people, using helping outcomes research as my palette. For many years, randomized controlled clinical trials (RCTs) have served as the "gold standard" in helping science. RCTs are "experiments, and the "horse race" is the basic logic behind them. In order to answer Parloff's question - *What kinds of psychotherapy are most effective for what kinds of problems?* – RCTs try to operationalize and compare them in standardized units –the "effect size" – of change.

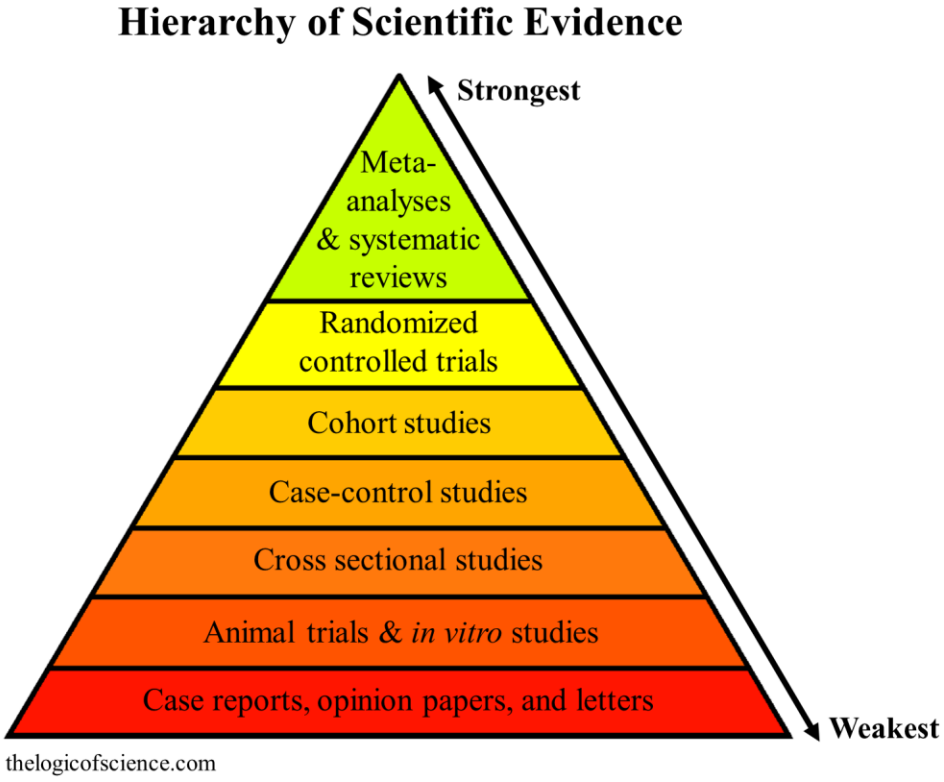
That's no easy task, because – as of a few weeks ago – there were about 20,800 Google Scholar citations addressing the outcomes of psychotherapy, and 102,000 Google Scholar citations addressing the outcomes of social work practice. As that's an awful lot of territory to cover, we're going to need bulldozers and headlamps to answer our question. And to complicate things even further, there's a big problem

with the “truth” in the body of “science” we look to for answers. The effect sizes in science – and helping science in particular - appear to be shrinking (Lehrer, 2010).

How much are the effect sizes shrinking in science? According to Lehrer, they’re shrinking like this.



Not surprisingly, there's debate about why there's so much shrinkage in what we know about how to help people, but the most common answers are these: (1) There's a lot of human bias in the scientific method; (2) there's a lot of human bias in what gets published as knowledge in print; and (3) the size of practice effects regress toward the mean. That's why – despite the frequent claim that RCTs are the "gold standard" in helping research - science has revised its hierarchy of knowledge by subordinating RCTs to systematic reviews of the research and meta-analyses, and that hierarchy looks like this.



Systematic reviews and meta-analyses are the headlamps and bulldozers I want to use to wrap up this lecture, drawing on the work of Wampold and Imel (2015), who recently completed a systematic review of 710 meta-analyses of 12,511 RCTs published through 2013. Here's what they found.

- The *absolute efficacy* of psychotherapies has a large effect size that ranges from .75-.85, suggesting that the average client receiving psychotherapy will be better off than 75%-85% of untreated clients. Whether or not a client receives psychotherapy explains about 14% of the variability in client outcomes in experimental settings.
- The *relative efficacy* of psychotherapies appears to be moot. Across treatments for depression, anxiety disorders (including PTSD), and substance use disorders, for example, the effects of varied treatments are equivalent. The differences among them only explains about 1% of treatment outcomes in experimental settings.

- The best available evidence suggests that psychotherapies are about as *effective* in community settings as they are in clinical trials.
- The preponderance of the evidence suggests that the individual practitioner has a much larger effect on client outcomes – in the range of 3 percent to 7 percent, with considerable variability - than the method or modality of treatment.
- The *relationship* between the worker and client has a larger effect on client outcomes that the treatment method or modality.
    - Client ratings of their agreement with the worker about the goals of treatment – e.g., client-worker *collaboration* – predict about 11 percent of treatment outcomes.
    - Client ratings of the *empathy* of their worker predict about 9 percent of treatment outcomes.
    - Client ratings of their *alliance* with the worker explain about 7.5 percent of treatment outcomes.
    - Client ratings of the worker's positive regard explain about 7.3 percent of treatment outcomes.

- Client ratings of the worker's genuineness explain about 5.7 percent of treatment outcomes.

A Harkness Synthesis of How to Help Clients

- In order to help, both you and the client have to show up.
- Tell your client what's going to happen, and explain how you work.
- Form a partnership with the healthy parts of the client.
- Recognize the client's pain and provide some relief.
- Establish some goals, and align yours with the client's.
- Tell a story that builds hope and sheds light on the problem.
- Build and manage working relationships charged with affection.
- Build client mastery and success.
- Collaborate on new ways to experience the self and the other, the self and the world.
- It's easier to add than subtract in human development.
- It's not always good to work harder than the client, but it's not always bad.

- You can’t give every client your all, but you can give your all for one client.
- Don’t be afraid to love and hate clients, but don’t hide it either.
- Read deeply and widely until something makes sense, and then read some more.
- Attend professional trainings and workshops.
- Obtain case consultation and supervision.
- Invite client feedback.

Implications for Social Work Education and Practice

I’ll leave that for you to decide. I’m retired, and I don’t want to overreach or wear out my welcome.

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