



# Students' Perspective on Graduate Training



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*The first half of this chapter was written by Russell Hart while a first-year graduate student studying for an M.S.W. degree.*

Preparation for clinical social work, like training for many other professions, is a multifaceted and rigorous endeavor. ~~Not only does it require learning vast amounts of information on theories of human behavior and development, but it~~ also demands a knowledge of self and a quality of being and relating. One must have not only a head but a heart as well. The practitioner must learn to be critical and analytical in his or her thinking, along with learning how to sustain emotional contact throughout purposeful working relationships that are directed toward therapeutic change.

The demands of learning for action as well as mastery of this knowledge base present special difficulties. How one experiences and responds to the challenges and stresses of clinical social work education is dependent on such factors ~~as previous experience, level of maturity, and the age at which one enters the~~ educational process. That process can at times be a difficult and arduous task, yet it is not without its rewards.

This portion of the chapter will discuss several areas of particular concern arising from my experiences as a social work student. My comments are not only subjective but stem also from many conversations with other first-year students.

Social work students enter graduate school with some sense of competency, since all have been successful at the undergraduate level. All have been wage

earners, even if only on a part-time basis. Many have had social work experience. On becoming a graduate student, however, one enters unfamiliar waters. Previous feelings of mastery, competency, and familiarity are replaced by those of uncertainty and anxiety. Questions emerge, such as: What will be expected of me in this new environment? How shall I value my previous work experience? Will it be of any help here? How much can I realistically expect from an academic program when the task to be learned also involves the development of my emotional resources in the service of the helping encounter? Will the knowledge I bring be validated or will I be required to give up my previous frame of reference in order to incorporate new learnings? Will I be able to sift through all of the competing influences and choose for myself that which I think useful? Or will I be so inundated by ideas that I will lose my ability to discriminate? Will the skills I have be useful in this new endeavor, or will I have to give up hard-won gains, with little idea of what will take their place?

Additionally, the educational process requires heavy commitments of time and energy. Relationships and interests outside of school often must be put on hold—sometimes for long periods. Old routines are forsaken. One's personal life must be altered to meet the new requirements.

Most students enter social work education in their twenties, when issues of competency and independence still loom large. Any situation that might be experienced as a backward slide into a previous state of dependency is therefore threatening. Feelings of being overwhelmed can indeed result in regression and dependency. The demands of graduate education, in terms of time and energy, may well be viewed and experienced as a loss of control over one's life. When this occurs, much energy may become directed toward maintaining one's identity by a constant warding off of external influences in order to maintain a feeling of internal cohesiveness. The ways in which each individual mediates and negotiates this process differ. Judging from my own experiences, as well as from my observations of other students, there is often an initial sense of loss and a period of mourning. The mourning may first be expressed in the form of anger or resentment, or hostile acceptance. ~~The trainee frequently looks to the instructor or the supervisor for the "right answers" in order to reduce anxiety. Students may even compete to have the best interpretation or the best paper as a way to reaffirm their sense of competency. Others respond to the transition with excitement and exuberance at the opportunity to increase their knowledge, while still others fluctuate from one state to the other.~~

The process of learning about other people necessarily entails the risk and challenge of learning about one's self. Reviewing client cases and examining theories of human behavior cannot help but bring into awareness questions about one's own functioning. ~~It is almost impossible for the student to avoid examining his or her own life and relationships in light of new knowledge. In fact, this is clearly a necessity if learning is to go beyond mere intellectualization. Student trainees are likely to see their own families and significant relationships in a new light, and to begin to identify and question their own behaviors and motivations. Unresolved personal issues may emerge and require attention, while issues partially worked through at a previous stage of development may surprisingly reappear, much to one's chagrin. Such reactions involve an element of loss, for integration of this new material requires a giving up of previously held beliefs~~

about one's self. New insights replace gaps in self-knowledge. As Miller (1979) points out: "Clinical learning entails a loss of innocence as one of its hazards."

I recall, for example, a time when I had to set some strong limits on a ten-year-old boy who had difficulty separating at the end of our sessions. The memory of how pathetic and sad he looked as I coaxed him out the door is still vivid, along with the feelings of guilt and anger he evoked. In relating this incident to my supervisor, feelings of sadness suddenly emerged, much to my surprise. The situation afforded me an opportunity to examine my strong reactions and to better understand myself, as well as this particular worker/client relationship.

There is a danger that one may become overly vigilant and critical as a result of this type of self-exploration. Like the medical student who seems to contract whatever disease is being studied that week, so too the social work student may wonder—half in jest, half seriously—if he or she is not borderline manic-depressive. How does the individual learner explain this tumultuous state of affairs to oneself and to others? Reactions are not always so extreme; however, there may be times when one feels that there is either something wrong with one's self or with the educational process, without being clear about exactly what it is.

Clinical work requires that our clients' behavior be carefully observed and analyzed for the purpose of determining how best to help them achieve their goals. Differential diagnosis involves the use of labels and the planning of treatment procedures. At such times the sense of the client as a whole person, as another human being, can be temporarily suspended. When this happens the trainees may feel that they too will be examined in this way. If a clinician can observe what clients cannot see in themselves, then the same may be true for the student/teacher/supervisor relationship. This can be anxiety provoking, particularly when the student is feeling confused, overwhelmed, and struggling to maintain a cohesive sense of self. The student's fear of being in some way like the client can be either exacerbated or decreased by the way in which the instructor or supervisor listens to and responds to questions. The development and use of psychological terminology provides one way of warding off feelings of powerlessness and lack of control. When this happens, classifications are apt to be used pejoratively.

Students differ widely in the ways in which each negotiates, mediates, and copes with the process of change involved in applying what is learned about human behavior. It is difficult for those actively involved to assess how much stress is inherent in the very nature of clinical social work education. Thus, while important but beyond the scope of this chapter, questions about the role of the school and the agency in containing or exacerbating students' anxieties must be considered.

The first year, challenging and tumultuous as it is sure to be, provides the opportunity for growth and increased self-awareness. Adaptation over several months to a highly demanding and challenging situation adds to the learner's sense of achievement and self-esteem, especially when one looks back from the vantage point of examinations successfully completed.

Mastery and adaptation gradually but ultimately take place in the field, in the actual meeting with the client, where theory and application come together over time. Depending on the depth of experience of each individual trainee, there is initially some feeling of helplessness, born of lack of knowledge and skill. As one student stated: "When I first started, I needed my supervisor to tell me what to

do from session to session. I felt really lost." From other conversations I heard a common theme: Students assumed that they were expected to present their supervisors with the process recordings of perfect interviews and to have each case expertly assessed and mapped out. It was also evident that there was great fear of making mistakes, alienating the client, or doing harm.

When one of my clients did not show for his appointment three weeks in a row, I was sure that I had somehow increased the client's ambivalence about treatment, despite my supervisor's assurance that I had not. It can be difficult initially to judge how much power and influence one has in the therapeutic situation, when feelings swing quickly from omnipotence to incompetence. Was I accepting enough? Did I push too hard or too little? Did I miss the "real" issue? Should I share my feelings or maintain a sense of detachment? If I knew more and were more skillful, would I be able to turn this case around or move it along faster? If the client had an experienced therapist would he show more improvement? Neither classroom readings nor supervisor seem to offer information and direction fast enough during this frustrating initial period.

Practice inevitably begins before knowledge and performance have solidified. Guilt may result from the feeling that one is practicing on the client and the belief that someone more skillful could have done better and speedier work.

Client demands which overburden the trainee's existing knowledge can be experienced as an assault on self-esteem. One student, conducting her first home visit, was greeted at the door with: "Oh not Not another young worker. I wish they'd send me someone with experience."

I remember one session early in the year when one of my recently assigned clients poured out an overwhelming amount of material. Later, talking with my supervisor, I said: "He just kept pouring out information and material and I didn't quite know what to do with it all. I tried to make sense of it, tried to slow it down. I ended up making process comments, but he kept on talking." Despite the ~~fact that I had some previous experience and some general ideas about how to~~ handle such situations, I never felt sure that I would not get totally confused and disoriented by the quantity of material, or be unable to control its flow.

One of the most difficult elements to contend with in the beginning is this onslaught of intense human emotion—both clients' and one's own. Multiproblem families and individuals suffering from serious traumas and deprivations can overwhelm the student with intense sadness, depression, and anger. In fact, during a first-year class discussion of current issues such as poverty, welfare reform, racism, unwed mothers, battered children, alcoholism, and divorce, silent ~~thoughts rear through the room: How will I deal with all of this? And with what~~ means? How much can I expect from myself in dealing with this? How much will be expected of me? Will I learn enough while I'm here to even make a difference?

Some clients, seeking instant relief, endow the trainee with omnipotent powers, and it is difficult not to accept the role of all-knowing and powerful worker. The propensity to take on too much responsibility for the client's problem is an early pitfall: The client who wants the worker to magically bring about desired changes and the trainee who wants to prove himself form a partnership that is doomed to failure. It is often equally difficult to allow clients to make their own mistakes, or to see them backslide, without feeling responsible. The situation

can raise feelings of anger and doubt that alternately can be turned inward and diverted toward the client for his or her refusal to get better.

There is also the experience and awareness of knowing that, no matter how much investment is made by both therapist and client, the amount of change is likely to be partial and provisional. The goal in this case becomes not "well" but "better."

An emotionally deprived eleven-year-old boy became quite dependent during the course of our individual sessions. He wanted more time with me, wanted gifts from me, arrived at the clinic a half hour early, and even came during school vacations when he knew I wouldn't be there. Sometimes this became rather upsetting. Never having worked with children of this age before, I did not know what to expect. His verbal skills and level of awareness were below age appropriateness and my inability to engage him in any more than a three-sentence conversation outside of play activity became painful. Not to know directly what he was feeling or what he wanted rendered useless my usual way of relating and being helpful. It was hard for me to see that our meetings served any useful purpose. In addition, I found this child's growing attachment to me both gratifying and frightening. It gradually became apparent that I could never undo his earlier deprivations—a rather sad awareness. Yet it was evident from his changed behavior in school and at home that our relationship was therapeutic. However, given his poor family situation, even with the aid of community supports, there were definite limitations to what treatment could provide.

It is the gap between expectations and experience, with its resulting discomfort, that forces the student to question, to pore over process recordings, to read and reread clinical literature, and to look to the supervisor for support, encouragement, and direction.

The paradox is that this discomfort resulting from a felt lack of knowledge needs to give way to a feeling of being comfortable with the ambiguity, complexity, and limitations inherent in the therapeutic encounter. Or, one might say, there is a need to become comfortable with the uncomfortable, the vague, the uncertain. Theories and constructs can point the trainee in the right direction by providing frameworks from which to understand behavior, but the frameworks are only guides—they are not the most important element in the therapeutic process. The relationship between the client and therapist would appear to be the key element in which treatment is grounded. The more the trainee is able to give up having "right answers," the more able will the trainee be to see, hear, and feel in the client's presence, and the more will the trainee be likely to get in touch with the unique qualities of the interaction and to learn that "right answers" emerge from the interaction of treatment.

Students can then begin to rely more on their own personal resources in conjunction with classroom learning and supervision; this leads to more autonomous functioning and less dependence on the approval of the supervisor. A search for easy rules and technical guidelines is replaced by the exhilaration of searching for and discovering the client's perspective and understanding significant interpersonal data that facilitates treatment objectives. As energy is redirected from preoccupation with one's own uncomfortable feelings, it may be used in a more creative fashion. One begins to hear the content of the client's messages as well as the underlying feelings, while processing one's own emotional and mental

responses. The ability to hear, to feel, and share the client's pain as it occurs without being devastated by it, becomes an essential part of this task.

After the first few months of training students begin to speak in less uncertain terms and with greater excitement. There is an interest in genuine sharing of one's work with other students. The themes in informal meetings and classroom discussion begin to change. "What am I supposed to do?" and "What's the right way to approach this?" become "This is how I handled it" or "This approach did not work. What do you think went wrong?" The questioning occurs at a deeper level—from a desire to know rather than a fear of failure. Theoretical constructs are not as likely to be offhandedly dismissed as irrelevant nor as likely to be swallowed as absolute truths. Rather, each new learning is more apt to be weighed for its relative merits and application to the individual case. The limitations of treatment as well as one's own limitations can be more easily accepted, as one becomes freer to examine the existential stance of each client and able to consider one's interventions without being defensive. The phrase, "It may be my issue . . ." becomes a common statement as trainees consider their own countertransference responses rather than fearing them.

I do not mean to imply that uncertainty vanished within the first year, but rather that, with the accumulation of experience and success, one began to respond with greater enthusiasm, independence, and autonomy.

With better understanding of theory and practice, more penetrating questions emerged. When therapeutic understanding was no longer something to be feared, but rather to be used in a judicious fashion, the question of its differential use arose. Questions were ultimately linked to the development of one's own ideas about how people change and were more frequently involved with examining one's own values.

Because social work trainees are taught to consider the individual, along with his or her environment and adaptation to it, difficulties inevitably arise in defining the roles and boundaries of the social worker as psychotherapist and as social activist. Where, for example, could one's energies best be used? How much time should one spend on changing the conditions and institutions from which clients' problems stem, and how much attention placed on helping the person to make a more effective adaptation? It is hard to refute the belief that individual treatment frequently offers only Band-Aids to those whose problems result from societal inequities of opportunity and resources. During the first year the student usually settles for helping clients gain more power and control over their lives by removing psychosocial obstacles.

Too often questions such as by which route such obstacles might best be overcome are put aside in order to master the more immediate tasks at hand. Ideally, social work affords an opportunity for three methods of prevention: community organization, social reform, and psychotherapy. Yet, for the first-year clinical student the reality is simply that we are only making small improvements. How best to make those improvements lies at the core of the questioning, and is carried over into the second year. Sorting through one's beliefs as to how best to impact on the client population is a process which hopefully does not end after graduation, for the requirements of clinical social work are broad and vast enough to incorporate numerous ways of thinking and modes of responding. I entered my second year of training convinced that there is no one "right way" and that the

pitfalls inherent in the present state of social work knowledge and skills are well charted.

#### References

Miller, Roger. "Clinical Learning as a Developmental Process." Delivered at St. Edmund Hall, Oxford, August 22-26, 1979.

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*The second half of this chapter was written by Hessa Kadet while a second-year graduate student studying for an M.S.W. degree.*

On entering the field the student is quickly faced with questions about the boundaries of clinical social work. One soon learns that members of the profession struggle for a shared definition and a shared identity. The trainee who enters the profession, having chosen a clinical focus and requested a particular type of field work placement, may find that his or her identity is initially defined more by the type of practice than by the social work profession as a whole. This struggle for professional identity seems to parallel the profession's evolution and subspecialization into the broad-based profession that it is today.

The development of a positive professional identity is a particular challenge for the clinical social work trainee who is learning skills in a setting such as a hospital where a traditional medical model or mental health hierarchy exists. In such a setting medical staff may be providing primary care, and interdisciplinary lines are likely to be sharply drawn which classify psychiatrists as the clinical experts. Clinical social workers with expertise in psychosocial assessment and treatment, innovative program development, teaching, research, and publishing are essential role models cherished by students in such settings.

~~One enters graduate training having already made some choices about those aspects of social work of greatest interest, but one soon learns that the boundaries between clinical social work, program planning, and policy are really quite fluid. The need to deal with immediate needs of clients, as well as to change the institutional structures that have contributed to them, soon becomes apparent. It is within the context of a relationship through contact of one human being with another that needs for treatment and prevention are identified. In thinking about any case one inevitably moves to considering the need for advocacy and social action.~~

~~For the student clinician the relationship between client and worker seems paradoxically both professional and personal. Feelings, thoughts, and actions that occur before, during, and after meeting with clients may be subject to intense scrutiny. Understanding one's reactions based on one's own life experience, attitudes, vulnerabilities, and subjective distortions often requires great investment of~~

Three years after writing this article I find myself in substantial conflict with it. While I realize its intrapsychic orientation reflects the new clinical knowledge I was acquainted with and immersed in as a student, I feel it fails to pay equal attention to the influence of race, class, and sex on clients' lives.—Hessa Kadet

emotional energy. Open and safe classroom discussion of experiences and ideas and supportive supervision in the field are a help. In retrospect, it seems that a great deal of anxiety is endemic to clinical training since working with people experiencing significant pain, deprivation, loss, illness, and stress evokes feelings which are often difficult to understand. Thus many students who have not already been in therapy find the need for it.

Prior experience related to social work is an asset as it gives the trainee a sense of confidence and competence which helps especially during the early part of training, but the unlearning or reexamination of existing knowledge and skills is common, whatever experience one brings to training.

My first year of classroom work emphasized the social aspects of human development. This shifted in the second year of training with the introduction to theories of psychopathology and the impact on the treatment process of severe psychological disturbance.

The concern of the first year with a lost sense of competence gives way in the second to questions about one's potential. Feedback from supervisors and teachers remains crucial to the development of confidence about one's performance. At the same time responsibility for one's own learning increases. It becomes easier to identify particular areas of difficulty, rather than waiting for the supervisor to do so. Supervision, essential to clinical learning, creates an atmosphere in which the experience, expertise, and support of the supervisor helps the trainee develop perspective as well as understanding of the treatment process. I found learning easier when the supervisor was able to generalize rather than personalize the clinical learning process. This created an atmosphere in which I felt safe to disclose doubts and openly acknowledge feelings of confusion. Respect for individual learning style and value differences convey the sense of a mutual endeavor, especially when reviewing clinical material and the questions it raises. Supervisors are extremely important, providing the type of acceptance and expectations which make it easier, in turn, to accept clients and help them struggle with difficult, anxiety-provoking events.

The following three vignettes illustrate the way in which clinical learning raises issues, questions, and anxieties which promote learning.

*Insight Isn't Everything.* A thirty-seven-year-old single black woman employed as a teacher, struggling with depression and long-standing dissatisfaction with many areas of her life, was referred to a trainee at the beginning of the school year. The client was intensely involved with her mother, against whose moralistic, perfectionist, friendly but distant manner the client judged herself inadequate.

During the initial interview the trainee felt a sense of rapport and excitedly looked forward to working with the client. After this initial meeting the client called the clinic director to request a more experienced therapist, noting that while the trainee was "very nice" she felt the high fee she was required to pay was not commensurate with the trainee's level of professional experience. The trainee was disappointed by the client's request which dovetailed with and confirmed her own concerns about her level of competence and ability to help. She personalized the client's concerns and quickly undervalued and overlooked the rapport felt in their meeting. With the benefit of supervision the trainee, recalling her feelings for the client, was able to telephone her. In supporting the client's wish to find a

more experienced therapist, the student recommended that rapport be an equally important element in her choice. In the course of this telephone conversation the client decided to return to work with the trainee, and they did so until the end of the academic year. Initially a ten-week contract was made, based on available insurance coverage, but when this was exhausted the client chose to continue seeing the student, even though she had to pay for sessions until insurance coverage was reinstated.

In the early stages the relationship felt very tentative because of the client's difficulty in expressing feelings, particularly about painful issues. The student overfunctioned and bombarded the client with "insights" and "interpretations" in an effort to demonstrate her knowledge. Over time, and with the benefit of supervision, the trust and confidence of both student and client grew. The client was able to express more feelings and a growing acceptance of herself enabled her to separate from her mother.

During the course of their work the client said that it was her expectation that the trainee, a white woman, would be judgmental, particularly around sexual issues; it was such fear, rather than lack of experience, which led her initially to request another therapist. The interest expressed by the trainee's phone call meant a great deal to her and led to her decision to return. Thus she taught the trainee how intrinsic concern for one's clients' best interests sets the stage for change.

*The Nature of the Relationship.* A twenty-seven-year-old single white fireman came to the clinic after the breakup of a relationship with a woman whom he continued to idealize. He had become deeply involved with this woman in a three-month period and hoped that they would marry. He described a great dependence on others in order to maintain positive feelings about himself. At work and with women he related with a bravado style, which masked his fear of abandonment. In a similar way he idealized the trainee, noting how good she was at what she did, and experienced her as quite powerful, describing meetings as "having gone ten rounds with Ali." After three months, work was interrupted by the trainee's vacation. During the meeting prior to this break, the client commented in a bravado manner that it was too bad he didn't have a few days off as well so that he could go away with her. Shocked, flustered, and concerned that somehow she had unwittingly invited this kind of remark, the trainee quickly proceeded to recite the boundaries and limitations of the therapeutic relationship. She reminded the client that they had an agreement to meet at a prescribed time and place to discuss what he chose to discuss and to focus on him.

It was only after the session, with some distance and thought in supervision, that the trainee could see that what she had quickly interpreted as a seductive invitation could be understood as an expression of the client's sensitivity to loss, felt more intensely when anticipating the trainee's absence. Undervaluing the meaning of the relationship, the trainee recited the rules of the relationship without exploring the feelings behind his comments. The client was intellectually aware of the limitations of the relationship. What he responded to were feelings evoked by being left by someone with whom he had shared many doubts about himself.

But *why* must the boundaries of the professional relationship be maintained? Over a period of the next several weeks, with reading and classroom discussion on the role of trauma and the repetition compulsion and talks with

supervisors and other trainees about the treatment process, a deeper understanding emerged. A great deal of clinical learning occurs retrospectively. Process recordings reveal themes and issues missed during the session, leading the student to wonder impatiently when listening, hearing, understanding, and responding usefully will all occur *during* the session.

The compulsion to repeat trauma, although at first seen as a deterministic concept, became extremely useful when viewed as an attempt at mastery, making clear the way in which clients may unwittingly invite responses that reactivate old wounds. Once such patterns become apparent, the therapeutic relationship can be used to talk about, understand, and experience new and more effective ways of dealing with such painful experiences. Ultimately one realizes that it is the special nature of the relationship which allows the client to feel and to reflect rather than act.

*Getting Close to One's Self.* A chronically troubled adolescent began attending an out-of-town college. Separation from home and academic and social demands precipitated what she described as urgent inner feelings of fragmentation, suicidal impulses, and anger directed at other students who seemed to be adjusting well while she was "falling apart." Fear that she would throw a pair of scissors at her sleeping roommate led her to the college infirmary and eventually into treatment with me. Her history was marked by chronic depression, significant tragedy and loss (including her adoptive mother's death two years earlier), frequent suicidal ideation, and a suicide gesture at age fifteen.

It was difficult to tolerate this young woman's pain, feelings of worthlessness and hopelessness, and her long silences during meetings. I felt an urgency to do or say something to remove or at least reduce her sense of disconnectedness from life. Frightened by her suicidal thoughts, it was difficult not to feel responsible for this young woman's life and to fear that one wrong comment or action during a session or telephone call would prove to be a fatal error. After every session the client would leave the office with a pained grimace and hurried gait. Although at fleeting moments a beginning connection with this young woman was felt, she subtly conveyed her anger that treatment provided ~~very little relief.~~

The meetings, increased in frequency to three times a week, just didn't seem to be helping. I felt that either I wasn't doing enough or was doing something wrong, and I was certain that a more experienced clinician would not be in this predicament. The client was not getting better and I found it difficult to deal with my own feelings of anxiety, helplessness, and responsibility. The client's comment that after meeting with previous therapists or college advisors who had provided "no solutions" she had considered killing herself to show them how insensitive they had been was repeatedly recalled, so that I began anticipating sessions with a feeling of nervousness and dread. Perhaps most difficult to tolerate were negative feelings toward the client, which brought to mind doubts about my potential capacity as a clinician and my very choice of the field.

Supportive supervision, personal reflection, and a framework for understanding the client's developmental needs provided the perspective and distance required to conceptualize and tolerate this difficult clinical learning experience. Several essential issues and ongoing learning tasks emerged. First, I recognized the way that my urgent need to change the client's perception of herself was being communicated, and I gained an understanding of the meaning of this to the client; that is, her intense feelings were as intolerable and unspeakable to me as

they were to herself, and this increased the client's fears that her feelings were indeed destructive and could therefore not be expressed. This miscommunication was also impeding the development of my empathic understanding. When I began to recognize intellectually the part played by empathic listening in *containing* acting out, I began to hear my client's expressions of helplessness and despair. This freed me to explore the meaning of her suicidal thoughts. With the help of the classroom work and readings it became easier to accept the emotions evoked by this suicidal, angry young woman as transference phenomena rather than evidence of failure. In addition, it became easier to appreciate the way in which this client's difficulty expressing disappointment and anger stemmed from significant earlier losses. Thus it became clearer how a client's manner of relating may result in the worker accepting responsibility for the client's life and reinforce the expectation that all needs will be gratified in a therapeutic relationship.

Even when the trainee is endowed by the client with special skills and qualities, one's fears about not knowing enough may be easily touched off because much self-esteem is invested in being able to be helpful to everyone. This tendency is closely related to over-responsibility and dovetails with the trainee's personal struggle to determine what she or he can and cannot do.

A great deal of self-scrutiny is required to develop clinical skills. One confronts painful, demanding, confusing, and sometimes frightening situations in which one attempts to "use" one's self in helping another. The relationship as the medium of change may be understood only intellectually in the first year of clinical training. By the second year, with deepening understanding and appreciation for the complexity of the client/worker relationship, its value and use take on greater meaning. Supervision, class discussions, and reading can help to contain and bind the anxiety produced by clinical learning. This provides the framework in which the trainee can view the individual in his or her social situation, against the gradual development of the client/worker relationship. Clinical experience and self-scrutiny, needed to sort out who one is from how one is experienced by clients, make social work training an affective, self-involving learning experience and not a purely academic one. Tolerating feelings and anxiety in oneself and in others is an essential task, a process of change that can be exhausting and excruciating, but also exhilarating. This is particularly true when the student is involved in a program that has grown out of a real need, identified in direct clinical work with individuals and families, and that illuminates ideas about preventive intervention.

*Moving from Case to Cause.* Rape Crisis Intervention, through which I worked with a woman experiencing the trauma of rape, was founded at a Boston hospital and directed by a social worker to provide immediate and followup medical and counseling services to rape victims and their families. The program involves collaboration, coordination, and consultation with police and attorneys and the sharing of knowledge about medical, legal, and psychological issues faced by rape victims and their families. Twelve followup crisis-oriented counseling sessions were offered to help mobilize coping abilities and social supports.

**CASE EXAMPLE.** A twenty-three-year-old single white nurse, Ms. A, was seen in the hospital emergency room two hours after she was raped in the basement laundry room of her apartment building in the early afternoon. Immediately following the rape she returned to her apartment where her roommate reported

the attack to the police before accompanying her to the hospital. Ms. A, an articulate woman with many interests, strengths, and a wide circle of friends, had moved to Boston two months earlier.

In the emergency room Ms. A was composed and able to focus on those issues of greatest concern to her. These included her fear that the rapist would return to her apartment and fear of walking alone at night. She was anxious, fearful, and preoccupied with whether or not to tell her mother she had been raped. Since she was afraid to do so, she requested that her mother receive counseling in the event of an anticipated visit.

In the initial counseling sessions Ms. A reported no difficulty sleeping or eating. Increasing her involvement with schoolwork seemed to help her regain the sense of control that had been threatened by the assault. Ms. A was committed to taking legal action but was anxious about the court process. She was relieved to learn of the availability of a witness advocate to help her prepare for this. However, when the man concerned was arrested two weeks later while raping a seventh woman, he pleaded guilty to all seven charges, thus precluding the need for Ms. A to appear in court.

In later counseling sessions Ms. A became tearful and anxious around discussion of her mother and chose as the focus of the counseling contract to work on deciding whether or not to tell her mother about the assault. She viewed her mother as fragile and in need of protection, particularly since the death of a close family friend one month earlier. Ms. A had already told her mother by telephone that she had been robbed in the laundry room but had not mentioned the rape. When this omission was explored Ms. A described her uneasiness with the prospect of discussing prior sexual relationships, which she felt would inevitably be revealed in the telling.

Ms. A's own feelings of vulnerability and helplessness resulting from this assault seemed to be transferred to her mother. The theme of the client's difficulty centered around her problem in acknowledging and expressing her own dependent longings to friends and family. She feared that expression of such feelings would result in loss of affection from others. At the third counseling session Ms. A said she had called her landlord to report the need for additional locks on the building, adding that she hoped she would not be labeled as a "troublemaker." I suggested that perhaps she found it hard to accept her angry feelings about the rape and supported the steps she was taking to protect herself.

Ms. A related childhood experiences which seemed to play a part in her response to the rape. After her father's long illness, requiring multiple hospitalizations, and death when she was seven, Ms. A had assumed "adult" responsibilities at home, relied on herself a great deal, and described a "give and take" between herself and her mother, who worked long hours and was unavailable much of the time. She recalled wishing for a sibling, perhaps to share the burden of responsibility. Into adulthood Ms. A idealized her deceased father and had an intensely ambivalent relationship with her mother. The helplessness experienced during the rape reactivated memories of former crises, such as her father's death, and conflicts about dependency and sexuality. Ms. A seemed to feel both the wish for and fear of overprotectiveness by her mother at a time in her life when she was struggling to separate and assert herself as an independent sexual adult, able to take care of herself. During the course of counseling Ms. A's sense of autonomy

began to be restored. She decided to discuss the rape with her mother and accepted her right to her own sexual life. She also dealt effectively with her landlord, who was reluctant to accept responsibility for providing adequate protection for his tenants. For me, this case helped make clear the work which clinicians need to do with the community and professionals (other than those directly involved in delivery of mental health services) in order to institute preventive services.

*The "Right Way."* Students quickly become aware that warmth and concern, while essential elements of clinical work, are not enough. The challenge lies not only in understanding clinical material but learning how to use it.

There is an urgency and impatience inherent in this type of learning, especially when progress or solutions are elusive. Faced with complex, confusing interactions, one hungers for techniques that would structure the treatment situation and contain anxiety. Theoretical frameworks are eagerly sought but, though helpful for this purpose, they tend to interfere with listening and hearing what the client is trying to convey. Developing tolerance for ambiguity, uncertainty, and complexity is one of the hardest tasks for the beginning clinician.

Students frequently enter clinical training with the unacknowledged but powerful assumption that there is a "right way" to talk with clients and that this is what they will be taught. This can lead to fears that one's comment may be an irremediable mistake and anxieties about exposing one's work to others. The lack of detailed case material in social work literature forces the student to sift through highly theoretical material, which is often difficult to operationalize. What becomes clear in the process of clinical learning is that how we talk with clients depends on our willingness and on our capacity to hear by engaging in a mutual effort to understand.

The trainee's struggle to develop his or her own style becomes easier as experience increases and training progresses. Exposure to the live or videotaped work of a variety of experienced practitioners helps the student relinquish the notion of a "right way," even though one continues to try out, at first self-consciously and later with greater comfort, the styles of supervisors, teachers, and peers, by "borrowing" the wording of a question or response. Slowly the three-minute response becomes more concise.

The realization that the same clinical situation may be handled in different ways by different clinicians, each with an individual style, theoretical orientation, previous experience, and intuitive response, can result in the trainee's feeling alternately liberated and overwhelmed by possibilities.

*A Piece of Work.* The choice of the social work profession implies some concern for the lives of others, a commitment to human potential and growth, and an investment in helping the client. On a less altruistic note, it is also intensely personally gratifying work. Both conscious and unconscious factors operate in choosing the profession of social work.

During social work training there is a tendency to assume too much responsibility for clients' lives, particularly at the outset when the trainee's wish to help, with the tremendous amount of self-esteem invested in being able to do so, clouds the mutual nature of the professional endeavor.

The ending is an inevitable part of any therapeutic relationship. It is a time when the work that has been done is reviewed along with considering the work that may remain. It is a bittersweet time when the outcome, the meaning, and im-

portance of the relationship gratifies and saddens. It is a time when whatever result has been accomplished may be obscured by unrealistic expectations. As even with a positive, significant outcome, one confronts the limitations of the kind of work.

The ending of the relationship will be experienced differently with each client, depending on the degree and nature of the involvement and the individual's previous experience of loss and separation. But termination that is based not on the resolution of the client's problems but rather on the trainee's completion of time at the clinic or agency presents special issues for both. The client may feel angry that this occurs before his or her problem is resolved and may even wonder whether she or he contributed to the trainee's decision to leave. Students feel guilt and sadness on leaving clients before the work is completed and frequently respond by overfunctioning during the last several weeks of placement in an effort to achieve quicker results. The student must respond to the client's feelings about termination while confronting his or her own reactions to the impending change or loss of relationships with clients, peers, supervisors, and teachers.

Trainees become increasingly aware of their expectations of the ending process. The urgency and need to hear the client express a full range of feelings, particularly anger, may be thought to ensure that the client's experience has been therapeutic. It is at termination that the trainee appreciates most the client as a teacher. Learning to identify that a piece of work has been done, even if it does not provide total relief from distress, and to be at peace with it, is a major task for any student. The limitations of two years of clinical social work training also become clearer. Thus one leaves school with an appreciation for the part that ongoing education and experience play in developing clinical knowledge and skills.