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USE OF SELF: A PRIMER REVISITED

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ABSTRACT: Use of self is a concept that is universally accepted yet equally ambiguous. Melding the professional self of what one knows (training, knowledge, techniques) with the personal self of who one is (personality traits, belief systems, and life experience) is a hallmark of skilled practice. This paper synthesizes seminal works regarding the concept of use of self and suggests a five-category typology for defining and describing use of self in social work practice. Drawing from the literature and practice wisdom gleaned from the author's clinical, teaching, and supervisory observations, the article proposes that use of self can be operationally defined as: use of personality; use of belief system; use of relational dynamics; use of anxiety; and use of self-disclosure.

KEY WORDS: use of self; self-disclosure; counseling; clinical; therapy.

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Relationship has been hailed as the cornerstone of change. The therapeutic relationship involves a client or system and the worker's "self." Use of self is a concept that is universally accepted yet equally ambiguous. This article proposes five ways in which use of self can be operationally defined. The typology was derived from a review of seminal works regarding the use of self, coupled with practice wisdom based on twenty-five years of clinical experience, teaching graduate social work practice courses, and supervising both MSW students and graduates seeking clinical licensure.

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Use of self is what partially distinguishes us from other professions. Raines (1996) asserts, "One of the differences between social work and the other therapeutic professions is the degree to which we meet people who have suffered malignant deprivations and losses...only the provision of an authentic person will suffice" (p. 373). Years ago, Virginia Satir (Baldwin & Satir, 1987) challenged practitioners to move from being technicians (developing skills) and clinicians (using those skills, coupled with practice wisdom) to becoming magicians (using skills, practice wisdom, and self). That which distinguishes a clinician from a magician is the use of self. "Techniques and approaches are tools. They come out differently in different hands" (p. 19). Melding the professional self of what one knows (training, knowledge, techniques) with the personal self of who one is (personality traits, belief systems and life experience) is a hallmark of skilled practice. This melding process is often difficult to describe since we would diminish that which makes us unique by trying to define it (Edwards & Bess, 1998).

Novice, and even skilled, practitioners may reduce the concept of use of self to self-disclosure, but the literature and practice wisdom suggest it is much more. The theoretical definition of use of self is vague. What is it? What does it look like in the context of the therapeutic encounter? By describing the practice of use of self, behaviorally, by delineating an operational definition, a theoretical definition may be illuminated. Use of self has been primarily discussed in the clinical social work literature against the framework of the psychodynamic theories that have influenced our practice. However, less arcane applications of the use of self are helpful for working with those clients suffering the malignant deprivations and losses that Raines describes.

Drawing primarily from a literature review and clinical, supervisory, and teaching observations of the author, five operational uses of self are proposed:

- Use of personality
- Use of belief system
- Use of relational dynamics
- Use of anxiety
- Use of self-disclosure

USE OF PERSONALITY

Hans Strupp (as cited in Edwards & Bess, 1998), states that, "The person of the therapist is far more important than his theoretical ori-

entation." In fact, he argues, there may be no distinction between our theoretical leaning and our personal orientation since the theoretical orientation we choose reflects our personal world-view and our own formative experiences. Our own defenses influence our choice of theoretical approach or style. Elson (1986) adds, "The practitioner has only one tool and that tool is herself" (p. 3). Techniques are rarely separate from a practitioner's own style and behavior.

Coady and Wolgrien's study (cited in Edwards & Bess, 1998) characterized being "real" and "present" in a therapeutic relationship as:

Being authentic and honest
Personally identifying with client issues
Attending to impact of self
Using self-disclosure.

Mezirow (1990, 1991) has recognized the importance of "authenticity" (a genuine, empathic approach) to "perspective transformation." He describes transformation as "the process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world...and making choices or otherwise acting upon these new understandings" (1991, p. 167). Authentic dialogue in a supportive and accepting environment serves as a medium for self-exploration and change. Authenticity in a therapeutic relationship can assist a client in transforming perspective.

Use of our personality implies self-knowledge. Technical expertise alone does not help clients heal. As Satir reminded us, expertise plus use of self helps clients heal. The canon, 'Physician heal thyself' rings true for social workers: the therapist must heal himself in order to heal the patient (Palombo, cited in Edwards & Bess, 1998). Self-healing begins with self-awareness and self-knowledge. Development of self-knowledge can come through meditation, reflection, psychotherapy, supervision or consultation, and in being with clients. (Edwards & Bess, 1998).

To enhance professional self-discovery, Edwards and Bess (1998) advise completing a professional inventory of self. Examining personality traits and behavior patterns would involve asking questions such as:

- Why am I in this field?
- What personal need does it fulfill?
- What traits do I bring to this field?

(E.g. "I am inquisitive about emotions." "I think in metaphor." "My avocation is..." "One of my natural attributes is..." "I get bored easily, so I...." "I am a natural nurturer.")

- What do I enjoy about this field?
- If a client resists my direction, how does it affect my behavior/ emotions/work?

Using our "self" means defining who our "self" is in the therapeutic encounter. In addition, being clear about what we cannot, will not, or do not like doing is important (Edwards, & Bess, 1998).

- What makes me uncomfortable in my work?

CLINICAL EXAMPLE

A worker was told during the workday that her mother had died, while in hospice care. Her supervisor advised her to tell her clients the reason for her now being unavailable for the next week. The worker, who was not particularly close to her mother, did not really want to share this information, but did so, at the supervisor's insistence that it was a way to establish authenticity and humanness in her relationship with clients. The clients responded in ways that made her even more uncomfortable, expressing effusive sympathy, engaging in role reversal wanting to "take care" of the worker, and asking more personal questions. All made the assumption that the loss was grievous, when in actuality, the worker had been adopted and her biological mother was the one who died. Later, in peer supervision, she reasoned that she could have still introduced empathy and genuineness into her therapeutic relationships without betraying her comfort zone.

Finally, answering the question:

- "If I were to do anything else other than social work, it would be....."

may illuminate aspects of personality that could be infused into the therapeutic encounter. Workshop participants asked this question have identified ways in which avocations are brought appropriately into the work. Examples include a would-be 'interpreter' who realized how she helped people find their own voice and 'language' in family sessions; a would-be nurse who used wellness concepts in her work; a would-be interior designer who assisted families in 'rearranging and redecorating' their lives; a would-be veterinarian who sought certification in animal-assisted therapy.

TOUCH

Use of personality may include a natural predilection to touch. Social workers have long been derisively described as being "touchy-feely" individuals. Social workers, as do other helping professionals, emphasize feelings and see value in touch. However, as with most interventions, context is crucial, timing is everything. Determining the appropriate use of touch in a relationship factors in the personalities of both worker and client (Beck, 1997), history of trauma, counter-transference reactions, sexual identity, age, and the needs of the client. Touch, after all, should only be for the benefit of the client. Nothing could grind the gears of a therapeutic relationship more than an inappropriate invasion of personal space.

According to Maizler (1997), the differential use of touch includes clinical, emotional and ethical issues in the following ways:

- Clinical: the body can store traumatic memories; the skin is the portal to the interpersonal world; the client or worker's need for touch reveals transference.
- Emotional: touch can be healing, can lower blood pressure, and can reduce interpersonal isolation, yet, it is not the function of the social worker to gratify physical needs of clients.
- Ethical: NASW Code of Ethics, Standard 1.10—"physical contact is to be avoided when there is a possibility of psychological harm to the client."

The official stance taken in the Code of Ethics (National Association of Social Workers, 1996), suggests that intervention with words, rather than touch, is preferred. The code does distinguish between appropriate and inappropriate physical contact, with the defining characteristic being the potential of psychological harm. For example, avoiding a proffered handshake could be insulting and damaging to a developing therapeutic relationship.

Strozier, Krizek, and Sale (2003), in a study exploring social workers reasons for use of touch, provide a thorough review of the complicated controversy regarding the use of touch in psychotherapy. The opposing philosophies range from touch as healing, to touch as traumatic. The ambiguous meaning that touch can carry argues for precluding its use yet, the lack of touch may be an intervention itself, communicating a power differential. Refusing to touch a client may indeed give the message that she is 'untouchable' or repulsive. The only thing that is commonly agreed in the controversy is that touch can have different meanings for different people.

HUMOR

Careful use of humor is another way of infusing our personality into the therapeutic relationship, but only if it comes naturally. The inappropriate use of humor could appear to diminish the importance of the client's issue and create a distance between client and worker. Conventional training instructs practitioners to keep an amicable professional distance from clients. Any attempt to become "friendly" with clients can be perceived as reflecting the worker's needs and insecurities. Humor can be construed as an avoidance or resistance mechanism.

Despite these cautions, humor can have its place in therapy. It can be normalizing. Humor can provide the intimacy essential for a developing therapeutic bond. In fact, the ability of a client to use humor can be seen as a diagnostic clue (Dewane, 1978). Bitel (1999) describes maintaining a sense of humor as one of four prominent themes of group work. The other three are empathy, accessibility to a range of emotions, and full use of self. One might argue that full use of self would include maintaining a sense of humor.

A final use of our personality, using those experiences that make us unique, can also contribute to the authenticity of the therapeutic relationship. This concept became clear to me in the following example:

> While exploring interpersonal difficulties a client was experiencing, I spontaneously offered something my mother used to say (giving her full credit(!). Sessions later, the client referred back to the aphorism, saying, "What was that saying your mother had? It really summed it up for me!

It seemed that we had strengthened our therapeutic bond through the sharing of maternal wisdom. Sharing colorful metaphors, and even significant influential figures in one's own life, is certainly an authentic use of self and reflects an empathic understanding of client issues.

In a poignant description of lessons learned from her own neurological illness in her work as a therapist, Elliott (2000) describes the therapist's life experience and interests as an instrument which is played expressively in the therapeutic encounter. She posits: "When language alone is not enough to move the therapeutic process forward, other working knowledge in the therapist's life can be brought to bear as a powerful evocative force in therapeutic change" (p. 321). She goes on to substantiate the use of the expressive self as grounded in the neurosciences.

In sum, the therapist's personality and personal experiences should be the filter for all professional knowledge. "No tech-

nique...should ever be applied to a therapist's own work if it feels in the slightest incompatible with the therapist's sense of self" (Edwards & Bess, p.99). Professional training that admonishes therapists to assume a professional mask, or present a blank screen image (Elliott, 2000)—in other words, to sublimate "self"—is in direct contradiction to establishing an authentic relationship.

USE OF BELIEF SYSTEM

Consider this example:

Two people are taking a walk on the open road after a light rain. One person stops every few feet to move unearthed worms to the safety of the nearby grass. The other walker looks on bemusedly.

The earthworm person has a belief system that says: 'All things are worth saving, we are all connected, it is up to me to help an unfortunate creature who, because of man's concrete jungle, has lost its way. The worm is sentenced to die.' The other person has a more fatalistic view, believing: 'After a rainfall, earthworms come out of the ground and they die. It is part of the evolutionary process. My efforts here would be fruitless and might interfere with the natural order of things. The worm is destined to die.'

The same two people (social workers, of course) later are confronted with this case: A middle-aged woman seeks counseling for admitted unresolved grief. Fifteen years ago she gave birth to twins, one was stillborn. She named and buried the baby, never telling the other child of his twin sibling. The remaining child undergoes religious confirmation in which a name is to be chosen. The child (unknowingly) chooses the name of his deceased sibling. This event disturbs the mother to the point of seeking mental health assistance.

The Earthworm counselor will approach the case with a social constructionist, transpersonal belief system (Cowley, 1993) that allows that there are no coincidences in the world. Everything fits together in some inexorable way. Her use of self will allow the mother to explore and reframe the event as a gift. The Fatalistic counselor will approach the woman with a belief system that will enable the mother to accept that the death was meant to be, to grieve as we all must, and to explore ways in which she can find meaning, and go on.

Neither is right or wrong. Probably both would be helpful. Each counselor must identify how her own belief system enters into the therapeutic relationship. Each must identify the client's belief system to see where it fits with her own. The nexus of belief systems may enable the therapeutic relationship to grow, the therapeutic process to evolve, and change to occur. Undoubtedly a balance is needed in using one's belief system without imposing one's own values. The therapeutic process exists to enable the client's own healing potential to occur and not as a forum for a clinician's proselytizing.

A strengths perspective emphasizes that people have what they need to heal (Saleebey, 1996). The therapist unleashes that potential

with a skillful use of the intersecting belief systems of both client and self. The world-views approach to counseling (Sue & Sue, 2003) advises that all interaction be couched with the client's world-view in mind. The worker's world-view is also an essential part of the equation and would be necessary toward building a skillful use of self. Therapists might answer these questions to work toward using their own belief system in a positive way.

- What is my view of how the world works?
- What traumas or life crises have shaped my world-view?
- How do I solve personal dilemmas?

Satir's (Baldwin & Satir, 1987) words remain prophetic:

> If I believe people are sacred, then when I look at their behavior, I will attempt to help them live up to their own sacredness. If I believe that people are things to be manipulated, then I will develop ways to manipulate them. If I believe that patients are victims, then I will try to rescue them. In other words, there is a close relationship between what I believe and how I act. The more in touch I am with my beliefs, and acknowledge them, the more I give myself freedom to choose how to use those beliefs (p. 24).

USE OF RELATIONAL DYNAMICS

A relationship is reciprocal—it takes two to have one. Genuine closeness and intimacy between the therapist and client must be developed for therapeutic change to occur. (Palombo, as cited in Edwards & Bess, 1998, p. 95). Alexander et al. (1946) coined the therapeutic process as providing the "corrective emotional experience." This description implies both experience and emotion, on the part of all participants, in the process. The therapist's own vulnerability, own humanness, is part of the process.

Heinz Kohut (as cited in Cooper & Lesser, 2002) is credited with establishing "empathy" as a clinical concept, stressing that empathy is more than just "feeling" for the patient. In self psychology literature, the therapist's empathy is the "scientific tool of psychotherapy" (p. 124). Being understood by another person (the therapist) gives the patient the affirmation so vital for establishing other meaningful relationships. (Ibid.) The relational dynamic of the clinician-client dyad exemplifies a use of self that is internalized by the client and translated into other relationships.

Integration of personal self and technical self implies tension between being a regular person in a real relationship and being a disciplined, "non-judgmental" professional. (Hoffman, cited in Edwards & Bess, 1998). Professional training commands clinicians to be non-judgmental. However, being non-judgmental does not necessarily mean being non-reactive. A counselor is a "mediator of reality" and thus should not remain totally detached. It is impossible to be genuine and human and remain objective.

Focusing on the "here and now" in the therapeutic interchange facilitates growth. Acknowledging immediate reactions can provide the "in-vivo" learning essential to change. "Therapeutic neutrality" is a myth. Neutrality can suggest victim blaming and limit strength seeking. This difference between an authentic response and a "neutral" one can be exemplified by two similar but distinct counselor reactions to a shocking revelation by a client:

> "I wonder how that behavior was perceived by others?" [neutral]
>
> and
>
> "Were people shocked at your behavior? I would be! [authentic]

Therapists using a feminist model, or self-in-relation approach to counseling, might be more inclined to use the second example, a willingness to model and share self in a move toward empowering the client. "The movement toward mutuality in a relationship is central to healing and empowerment." (Cooper and Lesser, 2002, p. 129). Self-in-relation theory posits four components of a successful client–worker relationship: mutual empathy, relationship authenticity, relationship differentiation, and self-empathy (Ibid.). All speak to the therapist's skillful use of self. Feminist approaches would support the concept that for a woman to become empowered she must have a strong positive relationship with another woman. Yet this "ethic of mutuality" in the therapeutic relationship does not mandate self-disclosure. (Cooper and Lesser, 2002, p. 131).

In the field of adult education (Knowles, 1980) it is universally accepted that adults learn from one another and from experience. Social work, as a derivative profession, can build on its knowledge base using the adult education concepts. The therapeutic process often relies on psycho-educational techniques. Modeling or teaching interpersonal skills can be part of the ongoing interaction (relational dynamics) between worker and client. A therapist modeling her own reaction to a situation can serve to provide the client more information with which

to make future decisions. Rehearsing or role-playing problem-solving scenarios, for example, demonstrate the use of another type of relational dynamics.

TRANSFERENCE/COUNTER-TRANSFERENCE

The concepts of transference and counter-transference are an extension of relational dynamics but often are inexplicable because they are unconsciously driven. Traditionally counter-transference was viewed as an undesirable by-product of a therapeutic relationship. The challenge to this view is a current assessment that considers using personal reactions to facilitate the therapeutic progress.

"Transference" describes a process in which the client, usually unconsciously, displaces onto the worker patterns of behavior and emotional reactions that originated with significant figures from the past (MacKinnon & Michels, 1971). Counter-transference is the subsequent worker reaction to aspects of the client as if he or she were an important figure from the worker's past. Clues to counter-transference have been listed by Raines (1996, p. 366) as negative and positive manifestations of both over-involvement and under-involvement with the client. A contemporary view proposed by Aron (as cited in Edwards & Bess, 1998) defines these processes as "reciprocal transferences"—all parties in a relationship have transferences, and all also have counter-transference, (reactions to the other's personality). Thus, responses to each other should be called reciprocal transferences.

CLINICAL EXAMPLE

A student was working with a combat-wounded veteran with Post Traumatic Stress Disorder (PTSD). She shared with him that her husband had a spinal cord injury and used a wheelchair. In supervision, she discussed that her self-disclosure was a way to demonstrate her understanding of disability to the client. In the next session, the client asked her outright why she shared the information about her husband, "Did you want me to have sex with you since he can't?" The student was stunned.

In supervision this student was able to see that her attempt to establish therapeutic rapport had backfired into a "reciprocal transference" nightmare. She readily admitted that although she ostensibly thought the disclosure was for the client's benefit, she also felt that his disability was minimal. To reduce his self-pity, she was trying to "one-up" him and show him what a real disability was. Her secret message

was that if anyone deserved pity, it was she! He obviously got that message.

USE OF ANXIETY

The therapeutic relationship can be intense and anxiety provoking. Most growth or change involves some anxiety. Powell (1992) reassures us that counselors' negative feelings are normal, and he identifies sources of counselor anxiety. Most anxiety stems from wanting to do a good job and insecurity about one's own competence.

Mueller and Kell (as cited in Taibbi, 1995) have identified three styles of coping with anxiety among clinicians: approaching, avoiding, and binding. 'Approaching' is the willingness to accept anxiety as a natural part of growth and change and provides an impetus for problem solving. 'Avoiding' people see anxiety as a problem in itself that becomes overwhelming and paralyzing. Those that cope with anxiety by 'binding' use over-control, denial, and distancing.

Corey (2004) suggests that anxiety provides counselors an opportunity to examine their internal dialogue and challenge self-defeating assumptions. Moderate anxiety leads to honest self-appraisal. An honest self-analysis by a social worker would examine anxiety within in the clinical situation.

- Do I talk more/less when anxious? Do I withdraw?
- How do I experience the anxiety in a therapeutic encounter? Is it visceral, mental, emotional?
- Do I seek collegial assistance immediately?
- What exactly makes me anxious in my work with clients?
- Am I talking more than doing?
- What techniques should I use?

Approaching anxiety by the acceptance of risks and a willingness to be vulnerable and open to exploring "self' (Edwards & Bess, 1998) can move the therapeutic relationship forward and simultaneously model problem-solving for a client.

Rigid adherence to sterile techniques and a "tabula rasa" approach to therapy may be a safer more comfortable approach, but to be authentic we need to take the risk of giving up that safety to promote healing." Aron (cited in Edwards & Bess, p. 248) states "...One way of thinking about the quality of our 'expertise' is that it is part of our function as analysts to allow ourselves to be and to prepare ourselves to be emotionally vulnerable with our patients."

CLINICAL EXAMPLE

> A worker was seeing a family of three: mother, father and 12-year-old daughter. The daughter demonstrated age inappropriate behavior by sitting on her mother's lap, playing with her mother's hair, interrupting conversation, as a toddler would do. Attempts to engage the parents in curbing the behavior were to no avail. The worker finally said to the girl, "I'm very uncomfortable with you sitting on your mother's lap. I want you to sit in your own seat right now."

Using her anxiety the worker simultaneously taught the girl what was appropriate behavior and modeled for the parents how to handle attention-seeking and inappropriate behavior.

USE OF SELF-DISCLOSURE

Perhaps the most discussed aspect of use of self is self-disclosure. Raines (1996) asserts that it is impossible not to self-disclose in some way or another. The décor in our office reveals something about out interests (Elliott, 2000). Having a family picture on a desk is self-disclosing. In a thorough review of the literature on self-disclosure, Raines presents six guidelines for the use of self-disclosure grounded in the interpretative (psycho-dynamic) roots of the social work summarized as follows.

1. Self-disclosure must lead to growth; it should deepen the capacity for insight and for relationship. In other words, it should be for the purpose of furthering the therapeutic alliance. It is ultimately and predetermined for the client's benefit.
2. If self-disclosure occurs at the beginning of the engagement process, it is more likely to fall under the client's right to know and less subject to interpretation. Again, it may be used to solidify the therapeutic relationship. Timing is everything.
3. It is disclosures within the current therapeutic relationship that are predominant in relevance to the therapeutic work. Self-disclosures in the "here and now" are more likely to further a therapeutic relationship in contrast to self-disclosures about the therapist's life outside the office. (This concept is akin to the previous discussion of relational dynamics.)

4. Self-disclosure is most appropriate when the client is least able to obtain consensual validation of reality or when the client's identity is most able to allow the therapist his or her own individuality. Thus, self-disclosure is directed toward those who need it most or those who don't need it at all. It serves as reality testing for the former, and reality validation and authenticity to the latter.
5. Self-disclosure must be justifiable on rational grounds, and not subject to the whim of the therapist. Is the benefit worth the risk? Has a positive outcome been demonstrated as a result? Is it reasonable and customary?
6. Self-disclosure should never occur without first analyzing what and how much of the responses belong to whom. Know thyself.

The use of self-disclosure has decidedly generated controversy in the field. The three common objections are: self-disclosure switches the focus from client to worker, it interferes with the transference process, and/or it is unnecessary (Raines, 1996). The previous example given where the worker shared her mother's death with clients exemplifies the shift in focus from client to worker.

Raines argues that it is only fair to answer client questions early in the engagement process, in order to establish rapport. He claims it falls under the rubric of a "client's right to know" (Guideline #2). Suggested responses to clients' direct questioning are: "I'll be glad to answer your question about my _____(religion, marital status, sexual orientation, ethnicity) but maybe more important is what you are feeling when you would like to know my _____. What concerns you about it? Are you concerned that I might not understand if I am not _____?"

The argument taken with this stance has been that a client's inquisitiveness early in the relationship is almost always a resistance or doubt about the worker's competence. Answering questions will not alleviate the client's anxiety (Strean, 1997). When does the client's "right to know" end? Does answering a question outright early in the therapeutic engagement set a bad precedent? Counselors who feel a need to answer questions directly may be trying to alleviate their own anxiety about the clinical situation, to avoid rejection, disappointment, or anger on the client's part.

The counter-stance is that perhaps not all client anxiety and doubt is masked by personal questions. Perhaps being courteous and answering a client question outright does not represent counselor anxiety. Sometimes a question is just a question.

CLINICAL EXAMPLE

> The therapist's last name was the same as a well-known local news celebrity who had died years before. At the end of the initial session, the client asked if the therapist was related to the broadcaster. The therapist acknowledged that indeed the broadcaster was her husband. The client shared how he had enjoyed his work and missed his perceptive commentary. The therapist thanked the client, saying, "People are usually afraid to say anything".

Could it be argued that this interaction was less than positive for both parties?

The client's right to be understood and the client's right to know can intersect. It probably is a good rule of thumb to always explore WHY a person has asked the question, but it may be fair to answer it. e.g. "No, I am not gay, but I'm wondering if you think because I'm straight we won't be able to work together. If so, can you tell me some of your concerns?"

Raines advises that we should not be rigid in our approach to answering questions. He suggests a host of responses including:

- Responding with a question
- Silence
- Interpreting the question
- Answering the question

Sharing life experiences in resolving a similar dilemma is appropriate if indeed it is for the client's benefit and is not perceived as the "right way" to solve a problem. Another caveat in sharing personal information is to beware of the "you know" phenomenon. A client might then say, "Well, you're divorced, you know how it is to be single." "You had cancer too, you know how it is." In such a case, it would be important to use self-disclosure as a way to explore how indeed "it" may be different for the client. Additionally, using one's own unique cultural influences and ethnicity is one example of self-disclosure that demonstrates willingness to include and respect diverse cultural influences. Acknowledging values emphasized in one's background or explaining cultural rituals encourages a reach for common ground between worker and client.

Undoubtedly, self-disclosure is one of the most controversial tools in the social work skill repertoire. When considering self-disclosing, the

guiding rule of thumb as always, is: "Is this for the client's benefit or mine?" The previously discussed example of the student who disclosed her husband's disability reminds us of this rule all too well.

SUMMARY

Use of self is a powerful concept paramount to skilled practice of the social work profession. Five operational applications of use of self have been delineated that can be demonstrated in the context of the therapeutic encounter. Using these categories, the ambiguous concept of 'use of self' may become clearer. Within these parameters, clinicians may be more comfortable in using the most effective tool they possess—themselves.

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