CHAPTER 11

ASSESSMENT AND DIAGNOSTIC UNDERSTANDING

Understanding is central to psychosocial treatment. As we indicated in the previous chapter, much understanding is intuitive. One immediately senses anxiety, anger, grief. Common knowledge of causative factors quickly brings explanations to mind. But one cannot rely upon intuition alone. Common knowledge is notoriously undependable. These constitute only a first step in the process of understanding, providing *hypotheses* to be checked out against reality. Through the psychosocial study—the fact-gathering process—the worker seeks to come as close as possible to securing an accurate picture of clients' inner and outer situations and the interactions between them. In assessment and diagnosis, the worker attempts to understand—to give meaning to—the picture in order to answer the question "How can this individual or family be helped?"

The terms *diagnosis, assessment,* and *evaluation* are sometimes used interchangeably. *Assessment* is occasionally used to describe the process that we call the social study. For some social workers, the word *diagnosis* suggests adherence to a "medical model" of casework. The concern is that those who use the term are placing responsibility—or even blame—for difficulties on clients rather than on their situations, that they are focusing on people's weaknesses—"illness," "pathology," "dysfunction"—rather than on strengths and capacities to cope with and bounce back from difficulties. It is reasonably argued that concentration on deficits is not only disrepectful to clients but also hampers our ability to help them find solutions. Some are concerned that the use of labels stereotypes and stigmatizes people, thereby ignoring each individual's uniqueness. It is further feared that diagnoses of clients artificially separate them from the social contexts in which they live, that attention will not be paid to understanding

the imbalance between people and their environments, and that potential opportunities for social supports will be overlooked. *Diagnosis,* some believe, supports the notion that the clinician imposes evaluations without participation by clients.

Concerns such as these would be true if one sought diagnoses of clients and their deficits alone. It is *not* true if one seeks to assess strengths and weaknesses of the person or family, of the situation, and of the circular interactions that constantly recur between the various components of the systems of which the client is a part. As far back as 1917, pioneer social worker Mary Richmond proposed a "no-fault," multidimensional definition of the diagnostic process that took into account person–situation interdependence:

> Social diagnosis . . . may be described as the attempt to make as exact a definition as possible of the situation and personality of a human being in some social need—of his situation and personality, that is, in relation to other human beings upon whom he in any way depends or who depend on him, and in relation also to the social institutions of his community.[1]

Our approach to understanding person–situation dilemmas has become more sophisticated as we have incorporated systems and ecological concepts that identify the complex interactions between people and their environments and that assess the quality of the fit between them (see Chapters 2 and 8). In a recommended and persuasive essay, Turner urges us to preserve the term and concept of "diagnosis," pointing out that it

> does not mean, as some of our practice texts imply, the assigning of labels; it does not mean the identification of pathology; it is not unidimensional; it is not keyed exclusively to the "medical model"; and it is not a process that by definition excludes the client from the helping process. Rather, for social workers, it suggests the conceptual act of formulating ongoing judgments for which we take professional responsibility and upon which we base our interventive activities with clients, be they individuals, couples, groups, families, or communities.[2]

With new information these judgments may shift, and as clients' own understandings evolve, new, mutually-arrived-at perspectives usually emerge.

Whatever terms are used, it is the point of view of this book that both the client and the situation are virtually always involved in the problem and must be understood, that it is in their interactions and interrelationships that many explanations can be found, and that the recognition of personal strengths and environmental opportunities is of paramount importance to diagnostic assessment.

CLIENT–WORKER PARTICIPATION

In the psychosocial approach, client and worker both participate in developing diagnostic understanding. Once clients understand the value of collaboratively searching for the reasons for feelings and behavior, they will often look for explanations and contributing factors. In individual or conjoint meetings, the worker also suggests lines of thought and often *tests hypotheses by asking for clients' reactions to them:* "From what you say, it seems as though Eric's bed-wetting began shortly after Julia broke her leg. I imagine Julia got extra attention during that time. Do you think there is a connection?" Or, "It sounds as if you were really furious at your mother for staying so long. Was it easier to take it out on Laurie?" Or, "Have you asked Frank to put the kids to bed or do you just wait for him to offer?" Or, "Do you think it is easier

in this family to express anger than other feelings?" When the worker asks questions such as these, it is important to make room for clients' thoughtful responses; often they can either refine or modify the hypothesis or suggest another.

In each of these illustrations, the worker's thinking started out being ahead of the client's. This is not always the case. Many clients spontaneously seek explanations of behavior and express their own thinking, to which the worker reacts. These explanations often show considerable insight. A woman who was considering leaving her recovering alcoholic husband said: "We are a bad match. I used to think everything would be all right after he quit drinking. But now I realize that his willingness to let me boss him around brings out the worst in me and makes it hard for me to respect him." At other times, client explanations derive from misinformation or are rationalizations and intellectualizations (e.g., "Her father's temper has no connection to Lucille's school problems; she ignores him," or "He would be all right if he took his vitamins," or "I think he has an oedipal problem with his mother") to which the worker may listen in silence or, when the timing is right, indicate some doubt: "Perhaps, but I think there is more to it than that." Or, "Are you truly satisfied with that yourself?" Or, "Do you really think that John is the only one who needs to make changes for the marriage to improve?" Or, "You know, you've read a lot of psychology, and sometimes knowledge of that kind can get in the way of real understanding. Right now it is your feelings about the situation that are important. Can you try to let them come and not bother so much about reasons and explanations?"

Even though the client is the best expert on what he thinks and feels and wants, ordinarily, and particularly at the beginning of treatment, the worker can be expected to understand some of the points more quickly and fully than the client. This is so for several reasons:

1. In situations in which they are closely involved, people are often blind to what they are doing and reveal by behavior many things of which they are not aware.
2. People tend to see other people's contributions to problems more clearly than their own, in part because they fear being blamed or finding "flaws" in themselves.
3. Although every situation is different in detail from all others, it is also true that human beings have a great deal in common, react in similar ways, develop in similar ways, and are exposed to many similar life events. Working over and over again with clients caught in successive dilemmas, not identical but nevertheless similar, enables the clinical social worker to understand the problems of new clients more quickly and more fully than would be possible without prior experience.
4. Knowledge has been accumulated by social work, psychology, and the social sciences that can illuminate human problems and that is part of the social worker's education. This consists of knowledge of biological influences, of the dynamics of human behavior and of human development, of family functioning and the social and physical environment, and of the various ways in which interacting factors in both past and present can create problems of pressure, deprivation, or dysfunction.

Clients' own assessments of their situations are nevertheless enormously important on many levels. This issue will be discussed in further detail in a later section of this chapter.

THE ASSESSMENT PROCESS AND DYNAMIC UNDERSTANDING

How does the diagnostic assessment proceed? The total process consists of worker and client trying to understand:

1. What the trouble is.
2. What factors seem to be contributing to the trouble.
3. What can be changed and modified.

We evaluate *motivation* and *capacities* for growth within the *person* and *opportunities for change* in the social and physical *situation.*[3] Strengths as well as weaknesses in the person, situation, and *interactions* are prime considerations.

Diagnostic assessment occurs in two ways: First, as the worker listens in an interview to what clients are saying, he or she tries to answer the three questions just posed; in consultation with the client, what he or she does in the current interview will be determined by this understanding. Second, periodically during the total contact, the worker, with the client's participation, needs to look back over all that is known about the person–situation gestalt to answer these questions more fully in light of this total knowledge. When treatment is expected to continue beyond a few interviews, the first of these more extensive assessments usually occurs after four to six interviews. By that time, there is usually sufficient information gathered through the social study to arrive at a working basis for the major outlines of ongoing treatment, *subject to modification by later diagnostic reassessment.* The first diagnostic thinking is taken as a set of *working probabilities* to be constantly rechecked, extended, and modified, as additional information emerges during ongoing treatment and as the clients' feelings, attitudes, and circumstances change. *Treatment continually uncovers diagnosis.*

Dynamic Understanding To understand what the trouble is, the worker begins by scanning all the facts brought out in the psychosocial study. The diagnostic process moves from delineating *what* the realities of the client situation are to *why* the problems exist. In *dynamic understanding,* we look at the data of the social study to see which of the observed features seem to be contributing to the client's difficulties.

Worker and client together seek to understand the dynamics of the client's dilemma in terms of both current interactions and the effects of prior events, recent or remote, on client functioning. Assessments of individuals, couples, or families and their situations go hand in hand. We continually try to determine to what extent clients' problems lie within the situations, including family situations, that confront them and to what extent and in what way they are products of unusual needs within the personality of individuals or of flawed or underdeveloped ego or superego functioning. *One must understand the pressures people are under before one can have any opinion about the adequacy or inadequacy of individual or family functioning.*

We then try to establish interrelationships among the various factors that combine to create clients' discomfort or problems in social functioning. We are particularly interested in looking at the *ways in which these components interact.* In this process, a systems approach is again useful because the problem usually does not lie in a given failure in the personality or a specific lack or condition in the milieu but in the way that various weaknesses or idiosyncrasies in the total system interplay and affect each other. Similarly, strengths and potentials for solutions almost always reside in the person, the situation, and at the interface of the two. Because every factor in a system affects every other factor in that

system, the worker scans the field again, looking for interactions.

A Hypothetical Example Suppose 10-year-old Steve is doing poorly in school despite normal intelligence, and we know that he and his teacher are in constant conflict. Is the teacher critical of Steve because he is disruptive? Because he has been placed in a class for which he is not suited? Because his mother criticized her? Because Steve is from a different ethnic group than his teacher? Because Steve is big for his age, does the teacher think he should behave in a more mature manner than he does? Is she critical because the principal is pressing her about the reading grade average of her class? Only by talking with the teacher as well as with Steve can we get hints of what lies behind the strain existing between them. And only as we come to understand the interplay of pertinent factors in the situation will we know what steps can realistically be taken to ease Steve's discomfort in school.

It is also possible, as problematic as the interactions between the teacher and Steve are, that some aspects of the problem may reflect difficulties within Steve's family. Perhaps Steve's father has been very critical of his son and the boy has an expectation of being belittled and then adopts a manner that results in a "self-fulfilling prophecy"; in other words, he may "act up," smirk, or cower, provoking (not "causing") negative treatment by the teacher. It is further possible that Steve's mother, who resents her husband's attitudes toward the boy, becomes extremely solicitous of her son when he is criticized, with the result that by exaggerating the teacher's behavior, he can induce special favors from his mother. Additional explanations may emerge as marital strains between the parents become apparent, or it is revealed that Steve's father was never praised by his own father.

The possibilities are endless, but as the worker seeks explanations, he or she is also *assessing what aspects of the various systems and influences are most accessible to change*. Will working with the teacher on Steve's behalf help? Would it be better for Steve if he were transferred to another class? Is concern for her students one of the teacher's strengths after all? What are the capacities for change and growth on the part of each family member? Can Steve begin to understand his part in the difficulty? Can the parents be helped to see the situation differently? Do they want to resolve differences between them about their way of handling Steve, or reduce the tensions in the marriage, or understand factors in their own personalities that perpetuate the family discord? Which or how many of these approaches are relevant and which would be most practical and influential?

In the end, we are concerned with the interactions and the "fit" between people and their situations; we are looking for the points at which therapeutic interventions would be most effective. But to understand these we may have to examine many of the elements separately.

What Is Needed for Clients to Engage in Treatment?

We have discussed in some detail in Chapters 2, 9, and 10 general requirements of the worker and the treatment process to produce effective interviewing and engagement. However, our assessment must be finely tuned to the needs of the particular clients we are seeing. Some clients require very little sustainment (such as the Jones couple in Chapter 3); others (Mrs. Zimmer also in Chapter 3 and Jed Cooper in Chapter 20, although with very different diagnoses) require a great deal in order to feel trusting and at ease enough to participate. Some

clients like lively and even intense interactions with the worker; others prefer to maintain considerable space or even an aloof distance. Some clients, in individual and family sessions, find silences next to unbearable, yet others welcome quiet moments for reflecting or for getting centered. Some clients enjoy humor and find it gives them relief or perspective; others may find a light or jocular comment offensive. Often the worker intuitively senses the "comfort zones" of clients; in some instances, the optimal approach is not as apparent. But, in all cases, it is important for the worker to elicit feedback about the worker's approach. *Assessments of the clients and their situations are of little value unless we simultaneously evaluate what clients require in the treatment process in order to carry on their most effective work.*

One must also assess whether conditions of the agency suit clients' needs. The conditions to be considered include: the particular workers on staff, the availability of treatment hours, the frequency of appointments possible, the agency's flexibility in terms of long-term treatment or home visits, the fee schedule, and the location of the agency. If some conditions are not favorable, can changes be made to accommodate particular clients or should they be referred elsewhere?

Symptoms

In individuals, families, and societies, symptoms usually have a message value. They tell us that something is wrong somewhere. The symptom usually is not the ultimate problem, and often it is not or cannot be treated directly. Rather the symptom may serve as an SOS. Heart palpitations may indicate that one has heart disease, or anxiety, or that one has fallen in love! A fever usually tells us there is an infection somewhere in the body, but where or what kind needs to be determined; aspirin may lower temperature, but does not touch the underlying problem. A child's behavior difficulties may signal a learning disability, marital conflict, or family stress or dysfunction. Homelessness and drastic dips in the stock market point to serious social and economic dysfunction.

Traditional psychoanalytic thinkers viewed an individual's symptoms primarily as evidence of internal unconscious conflict, such as between drives or impulses (the id) and the ego or superego. More recently, family and systems theories have alerted us to interpersonal features of symptomatology. Inner and outer phenomena are much more intertwined than was previously recognized.[4] Frequently, as will be discussed more fully in the family and couple chapters, *"antisystem" symptoms* (i.e., symptoms that a particular family or social system cannot tolerate) are required in order to force change. In some families, for example, a child's lie may be sufficient to upset the family balance and press the family into treatment; in other families, auto theft by an adolescent may be accepted with a "boys will be boys" attitude and, *if* there is internal pressure for change, the young man may have to "find" a symptom that will be more convincing or troublesome to get across the message that something is wrong.

It has long been known that "symptomatic treatment"—the direct effort to "cure" a symptom—too often is followed by development of another, sometimes more disabling, symptom. A woman successfully treated for chronic headaches believed to be psychogenic in origin may develop a spastic colon, for example. There is strong evidence that treatment for depression with medication alone is not as effective or lasting as when it is combined with psychotherapy that addresses personal or situational stresses.[5] Similarly, in family treatment we have learned that if one symptomatic child im-

proves, a sibling often begins to show signs of trouble. To the surprise of some people, it is not unusual for a spouse of an alcoholic to become depressed when the latter stops drinking. Along the same lines, a symptom often helps to maintain the balance of a relationship: A spouse may, consciously or unconsciously, pretend to be more dependent and helpless than he or she actually is to accommodate the other spouse's need to feel in control or superior; the relationship may be protected that way although at a price that compromises autonomy (which may result in other symptoms, such as depression). When symptoms are present, further exploration is required to understand underlying meanings and issues.

The Situation and Expectations

Average Expectable Environment, Negative Conditions, and Opportunities In evaluating the various features of the situational component, one can use the concept of an *average expectable environment,* where the term *average expectable* signifies "within the range of normally healthy experience."[6] It is where the actual experiences vary to a substantial degree from these expectable ones, especially where they vary in the negative direction, that the worker and client examine external factors that contribute to the client's problem. Serious *external pressures and deprivations include:* an income below the poverty line; homelessness; inferior housing; dangerous neighborhoods; day-in-day-out prejudice because of race, sexual orientation, age, or gender; inadequate schooling and medical care; lack of employment opportunities; exploitive or abusive working conditions; and many more. Many clients seen by social workers are subject to such extraordinarily noxious external conditions that it is remarkable they survive as well as they often do.

Even when they are not presented by the client as a major problem, employment, housing, and neighborhood factors can be important contributing factors to parent–child or couple conflict. The realities of the school environment—the opportunities for learning and for socialization, the respect for students, and so on—are of great significance for children. As we well know, social institutions such as the courts and police have negative as well as remedial or protective impact on the problems that occur in many communities.

On the positive side, one looks for *opportunities:* new employment possibilities or programs that prepare and/or train people for work; availability of safe shelters or better housing; ability to transfer to another school, the strengths of a skilled teacher, or location of a community center tutoring class; programs that provide a broad range of services to people with AIDS or other serious medical problems; advocates for legal problems, for women, and for others oppressed by discrimination; and the availability of self-help or therapeutic groups, among many others. (Resources and innovative programs are described in Chapter 8.)

Family and Personal Relationships Family connections that are reasonably satisfying and opportunities for friendships are components of an "average expectable environment" in the more personal realm. This does not mean these relationships are necessarily conflict-free, any more than "average" income is equated with affluence. These expectations vary according to cultural and other variables and must be viewed from the standpoint of general expectations and those of particular clients. An extremely authoritative husband may be "expectable" in Turkish culture, but he may be experienced as a distinct "pressure" by a woman brought up in this country or

even by a Turkish woman if she has lived here long enough to expect greater equality in marriage. If workers attempt to impose their own biases or try to promote equality, serious repercussions understandably may ensue. *The clients' own views of these factors is of paramount importance.* To what extent and in what way does each spouse experience stress?

Along similar lines, a teenage girl who recently immigrated with her parents from Puerto Rico may quickly be exposed to a peer group whose families have different values, are more lenient in certain expectations of behavior, and so on. When this creates intergenerational conflict in the girl's own family, it is not the worker's function to try to persuade one "side" or the other, but rather to help all family members understand the basis for dissension, to normalize (rather than to "pathologize") it, and to work on how to reach a solution that is respectful of parental concerns, of the teenager's struggles, and of each member's individuality.[7] Again, each family member must be assessed for his or her uniqueness and not viewed simply as a member of a particular ethnic group.

If parents are concerned about a child, the worker can assess the quality of the parents' functioning only in light of the realities of the child's behavior that confront the parents. What is living with this son or daughter like at the moment? Is the child so withdrawn that he or she is hard to reach? Is the youngster provocative in a hostile way, "expectably" arousing parental anger? Is the child's behavior publicly humiliating to the parents? If the child is ill, how much of a strain does caring for him or her cause? Are parents deprived of sleep? Are there constant demands? Any tendency to feel more sympathetic toward children than adults will be counterbalanced when one attempts to put oneself in the place of each family member and carefully assess that person's circumstances and burdens.

In any sort of problem, the worker must evaluate the pressures to which clients are responding, as illustrated in the hypothetical case of Steve, discussed earlier. *An individual's problems never stand alone.* It is also the exception rather than the rule to find pressure in a single spot. As the chapters on family and couple treatment will describe, there are usually people in either the immediate or extended family systems who are part of the difficulty and are also part of the solution.

In response to stress in the family or personal arena, one again searches for *opportunities:* Within the family, who is able to give what is needed? Who can take leadership in resolving problems or finding creative solutions? Is there a relative or friend on whom a depressed adult or disabled person might depend? Is there a young adult in the family or friendship network who might help a troubled adolescent? Are there resources for socialization or social supports in the larger community? Peer groups? Church or neighborhood organizations that provide spiritual or recreational connections?

Whatever situational problems are within or outside the family, one must assess not only whether the pressures are relatively ordinary or extraordinary but also whether they are *transient* or *enduring.* When assessing the many multidimensional processes in the external situation in interaction with individuals and families, the worker and clients must try to determine which are the most salient influences and which are most accessible to intervention.

The Personality System

Motivation, Hope, and Capacity In individual, couple, or family treatment, we almost always assess personality dynamics

and characteristics as well as external pressures and opportunities. The more complex the treatment, the more we usually need to understand about the workings of the personalities. Among the important factors to evaluate is client *motivation*. How much interest is there in making changes or working toward certain goals? Usually there is motivation for some changes and not for others. Motivation is closely linked to the degree of *hope* that change is possible. The worker's role in both eliciting motivation and supporting realistic optimism is discussed in other chapters, especially Chapters 9, 12, and 13. It is important here to emphasize the significance of these in the overall assessment.

Capacity for "normal" or *optimal functioning* and for *change* must be evaluated. In many cases, the client's assessment is better informed than the worker's; in almost every situation, worker and clients together gauge these matters. For example, is the person employable? Retrainable if necessary? Does a high school student have the ability to go to college? Can an elderly woman function alone at home after discharge from the hospital? Does a husband have sufficient role flexibility to take on or share child care functions when his wife becomes ill or gets a full-time job? Some fairly well-functioning people want to make intrapsychic or behavioral changes or modify their situations but cannot seem to do so because of extreme rigidity. Others with more severe personality deficiencies but greater flexibility are sometimes better able to make substantial gains in treatment. The capacity for change, therefore, is not entirely contingent on the seriousness of the clinical diagnosis.[8]

Average Expectations When assessing the personality system, it is again helpful to use the concept of "average expectations." Flexible norms that exist within every cultural group define expectations of how an individual with a "healthy" personality will act and react. These expectations create a theoretical frame of reference against which one can view the functioning of any individual. It is important to keep in mind that this is *theoretical*. It does not imply a *stereotype* of expectations of how a "healthy" individual will or should function. Wilson Bentley, who spent a lifetime studying snow crystals, took over 6,000 pictures of snowflakes. Out of this number of pictures, he was unable to discover two that were identical. In his discussion of Bentley's research, John Stewart Collis wrote: "The variety is inexhaustible, but very often (though it would be rash to say always) the foundation of a hexagonal shape is adhered to, so that each is a little star with six rays crossing at an angle of sixty degrees."[9] People are a bit more complicated than snowflakes, but they too have both infinite individuality and common patterns!

Personality is so complex that one has to view its functioning in a systematic way in order to understand and to assess its strengths, its weaknesses, its potential. Just as one scans the field of the client's milieu, the various systems of the person–situation gestalt, so one can assess the data of the social study that concerns the person. Psychoanalytic, ego psychology, and object relationship theories provide a picture of the "patterns," the basic structures and functions of personalities, from which individual variations grow. The worker is helped to recognize the patterns quickly and carefully by keeping in mind general knowledge of the major aspects of personality and its functioning. Rereading the overview of the personality system presented in Chapter 2 can be useful at this point.

The Tripartite Personality Structure When assessing the personality system, inferences made about the qualities and

interactions of *id, ego,* and *superego/ego ideal* become important. We know that personality functioning must be evaluated in conjunction with situational circumstances because, as we have repeatedly said, *individual characteristics—strengths and deficits—cannot be accurately assessed without a full appreciation of the social context in which these are observed.* It is also always important to view personality in terms of developmental phases. Nevertheless, it is also true that many features of personality, particularly of adult personality, are enduring and have been with the person for many years, beginning in childhood.

Among the many questions one may ask when assessing personality are: Is there evidence of dysfunctional residues of primary process thinking, or have secondary process functions developed fairly successfully? Is the ego able to regulate and control impulses when necessary? Do emotions frequently "drown out" intellectual functioning? Does the person seem capable of mature, loving relationships in which there is tenderness and constancy? Is there the capacity for consideration and realistic trust of others? Is the person relatively consistent in his or her feelings, or is there an unusual amount of ambivalence or mood fluctuation? Are there unresolved hostilities or overly intense attachments to parents to the extent that these interfere with current family or other relationships? Is the person able to stand up to others when necessary and pursue goals with vigor, or is there extreme inhibition or destructive aggression?

An extremely important question is: Is the individual able to see things as they are, or is there constant distortion? Is the person generally able to test perceptions and plans for action against reality before coming to conclusions about them? Or is there a consistent tendency to distort or make untested assumptions? How sound is the person's judgment? Is self-image fairly accurate or does the person over- or underestimate actual abilities? Does the person have adequate self-respect? To what extent is the individual clear about his or her identity? Can his or her own opinions, values, feelings, and sense of purpose hold up even in the face of criticism? Or does the person stubbornly maintain a point of view even in the face of information that disproves it? Mastery and competence are extremely important in assessing how well people can cope and get things done. How able are they in affecting or interacting with other people or functioning within the various systems with which they are involved? Are social skills poorly or well developed?

Is *intelligence* average? above? below? Is thinking overly concrete when abstract concepts are required? Are there gaps in the way thoughts are processed? Are memory and concentration on par with expectations? One must be especially careful in assessing intelligence because it is easy to confuse the results of educational level or cultural background with basic intelligence. Sometimes people with very limited education have been well schooled in life experience and demonstrate keen understanding of the world and human relationships. Functional intelligence is often diminished by depression, anxiety, distraction, and other emotional conditions. If assessing intelligence appears to be a problem, a more definitive evaluation can sometimes be made by psychological examinations as long as the well-known limitations and cultural biases of these are considered.

Assessing *ego defenses,* described in detail in Chapter 2, is *very* important. Which defenses does the person rely upon most? Are they functional or dysfunctional in terms of the person's relationships and life situation? Are they serving healthy or

pathological psychological ends? Are they rigid and entrenched or flexible when circumstances require?

One sometimes hears the term *ego strength* used as if the ego were some kind of composite force that could be measured as a unit. Rather, as discussed in detail in Chapter 2, it is a series of functions and qualities of many different and interpenetrating dimensions. Perception is accurate or inaccurate, judgment is sound or unsound, self-image is appropriate or inappropriate. One may be highly competent or relatively incompetent, function more or less autonomously, have good or poor capacity for object relationships. Only the control functions of the ego may be strong or weak. One may say about the ego as a whole that it functions well or poorly, but this description is not as useful as a delineation of *which* aspects of the ego function well, which poorly, and when poorly in what way.

Superego–ego ideal qualities are also important. Is the person overridden with feelings of guilt or shame? Is the person overly critical and overly self-punishing for what most would think of as minor transgressions? Is there an extreme tendency toward embarrassment or humiliation? Are there lacunae, spots where standards would be expected but are absent? What is the quality of the person's self-standards? Are aspirations commensurate with background and life roles? Are they realistic and stable? Are there indications of inconsistencies, such as those sometimes characteristic of narcissistic or borderline personalities?

In evaluating the client's superego–ego ideal functioning, the worker considers both the general structure of the superego, its relative strength or weakness in the personality, and the quality of its demands, the level of its demands and the consistency of the standards it supports. Particularly in this aspect of the personality, assessment is made in the light of ethnic background, class, education, regional differences, sexual orientation, and variations in age. Clients sometimes have multiple reference groups from which ego ideal aspirations are derived: They are exposed to the general culture, which upholds one set of aspirations, and to family and peer cultures, which may be quite different. Is there conflict among these demands?

The extent to which the worker needs to assess personality qualities and functioning varies a great deal with the predicament about which clients are seeking or willing to accept help. Assessments are arrived at by deductions from the picture described by clients about the problem, the situation, and themselves as well as from direct observations of the clients and their functioning in individual and conjoint interviews.

Variable Expectations Forming an opinion about whether or not a person's functioning is within the "average expectable" range or varies from it sufficiently to be problematic is not easy. As indicated in Chapter 2 in the discussion of role expectations, there is no single model of appropriate or realistic or healthy (or whatever term is chosen) functioning. This is influenced by many variables: age, sex, class, ethnic background, religion, educational level, geographic location, and social role, as well as idiosyncratic differences. Acceptable aggressiveness or assertiveness for a person of one background is defined as overaggressiveness for a person of another. People of different backgrounds normally emphasize different defenses and have different norms for expressing sexual feelings, tenderness, anger, and so on. Concepts of appropriate male and female ways of acting are very differently defined in different parts of the world. Even the level of psychosexual maturity expected of men and women varies among different cultures.[10]

Fortunately, in this country, recent years have seen some shifts in stereotyped expectations of male and female personality styles. Heretofore, in general, men were discouraged from the expression of many of the "softer" feelings: sadness, fear, and to some degree even tenderness. Strong, sometimes disabling defenses (repression, intellectualization, etc.) were often required to subdue normal emotion. This is still true, but less pervasively so. Women, on the other hand, were, to one degree or another, warned against the demonstration of assertiveness, to say nothing of aggression. Sometimes women were taught to seek their ends by devious behaviors, through manipulation or seduction; often, however, these were either unacceptable or ineffective, and women sometimes developed depressive symptoms because opportunities for healthy assertion and achievements were blocked by social expectations. Cultural background still plays an important part in gender expectations.[11]

The general atmosphere within which an individual is reacting and particular antecedent events are also significant to personality assessment. In periods of turmoil, such as when students and others are enraged by events such as unpopular wars, police brutality, prejudice against various ethnic groups, abuse of gays and lesbians, unbearable neighborhood conditions and the like, it would be a grave error to think that the passions unleashed indicated abnormal character traits of the participants. Campus and community rioting may sometimes attract people with poor impulse control or hitherto contained fury seeking release, but many normally well-balanced individuals also find themselves enraged beyond endurance or may determine that aggressive action is essential to foster change. As can be seen, assessment of personality factors is far from simple. It requires not only knowledge of the general nature of personality but also finely tuned judgments about the interacting influences of situational realities brought together in the social study.

Disentangling Interactions How does one assess complicated personality characteristics? One applies clinical judgment to knowledge of the ways in which clients interact with others, including the caseworker, and handle their own affairs. Again, it is impossible to evaluate components of the personality properly, except as they are seen in the context of an individual's situation. One must take into account the whole gestalt. For instance, one cannot judge whether a reaction of anger or anxiety is normal or excessive unless one knows the realities behind it. It is one thing to be plagued by the fear of losing a job in normal times when one's performance is adequate and quite another when there is a recession or one's performance is marginal. It is one thing for a client to accuse his wife of belittling him when in actuality she does constantly criticize and devalue him and quite another for him to distort her remarks, projecting onto them his own devalued self-image or experiences he has had with others in his life. Feelings of depression may be part of a particular physical illness syndrome, a reaction to the loss of a valued friend, a response to a dysfunctional marital relationship, or, in the absence of any such provocations in reality, evidence of a bipolar or depressive disorder.

This disentangling of the reverberating interactions between external realities and the individual is a complicated task. Sometimes, however, the worker can bring general knowledge to bear on the situation. For instance, the worker often knows what a given neighborhood is like, or how a particular doctor reacts to patients, or what the eligibility procedures in the local public assistance agency are. General knowledge of this type, however, has to be used with cau-

tion. Sometimes the doctor, public assistance interviewer, or school principal has not acted in a specific instance in the way prior knowledge would lead one to expect. Direct observation is more certain. It is simplest when it has been possible in the social study to observe the interplay with the externals directly. Here lies the great advantage of the worker having direct contact during the social study with the principals in any interpersonal problem, and of the home visit, and of couple and family interviews from which so much can be learned. But even insights thus gained are not infallible and sometimes give the worker a false sense of certainty.[12] Things that have been "seen with my own eyes" and "heard with my own ears" carry great weight, but they are also subject to misinterpretation by the worker because of countertransference and other subjective judgments.

Another method of disentangling the objective from the subjective is to evaluate the circumstantial detail that the client uses to support opinions and reactions. Does the situation described bring the worker to the same conclusion? Insofar as the worker's own perceptions and judgments are realistic, he or she can then evaluate the client's reactions. One reason for emphasizing the importance of self-awareness in worker training is to reduce biases, or at least to bring them near enough to consciousness to alert one to possible sources of error in judgment.[13] As discussed in Chapter 9, a worker's own subjective responses to clients can sometimes provide useful information for personality assessment.

Repetitiveness provides another useful clue in assessing behavior, for if an individual has a tendency to over- or underreact, to distort, to deny, to intellectualize to excess, and so on, it will not occur in a single instance only but will show itself again and again. If the same type of seemingly unrealistic response arises several times, and particularly if in each instance it occurs in reaction to *different people,* the chance is very great that a dysfunctional personality factor is involved. This illustrates the special value of knowing the client's history when the nature of the problem requires particularly careful assessment of the personality. Since psychosocial workers believe that much of the personality structure is shaped in early life, it is expected that repetitive patterns will often show themselves clearly in the life history and in interactions with family of origin members. Specific symptoms or evidence of affective, personality, or psychotic disorders in the client's past are of great significance. Current or past substance abuse and experience with battering, incest, childhood sexual abuse, and so on also are important leads to understanding present personality functioning.

Family Systems Theory, Complementarity, and Communication

In problems of interpersonal adjustment, such as marital or parent–child problems, one person is in a sense the other person's situation, and vice versa. The term *complementarity* is sometimes used to describe these characteristic patterns.[14] As noted earlier, the action of one person upon another takes effect only in the form in which it is perceived by the other. For example, Susan may use a complaining tone because of fatigue, but if her husband Joe perceives the tone as anger, he reacts to it as such. Susan's response, in turn, may be silence, or martyrlike murmurings, or explosive retaliation, depending upon her personality, the earlier experiences of the day that have set a mood, her perception of Joe, her notion of the requirement of the role in which she is functioning, the pressures she is

under, and a variety of other factors. Joe's next response is subject to similarly complicated influences.

If one studies a series of such transactions, one finds that similar patterns in interaction can characterize the behavior of whole families. In most cases in which there are problems of social functioning or even severe individual stress and symptomatology, dynamic diagnosis must include evaluation of interactions with family members and other significant people. This involves understanding of the way in which one person's attitudes and behavior set off or provoke certain responses in the other, the extent to which this is consciously or unconsciously purposeful, and the extent to which unrecognized complementary needs or defenses are being expressed in the process. In family and marital conflict, the worker may make serious treatment errors if he or she is not aware of complementarity in various relationships in the family. Some so-called father–daughter marriages or mother–son marriages, relationships in which there is inequality based on gender or other factors, "sadomasochistic" couples, adult children who continue to live with their parents in very dependent or "symbiotic" relationships, alcoholic families, and many other complementary relationships are complex and delicately balanced, requiring careful assessment before treatment goals are determined. Sometimes a worker may find that serious trouble has emerged in a family where a previously existing complementarity has been disturbed.[15] In some such cases, where there is the possibility that the upset balance may result in emotional breakdown or suicide, for example, serious consideration must be given to the possibility of helping to restore the previous balance. Family relationships are frequently the means by which individuals with rather serious handicaps in functioning are enabled through complementarity to function at a reasonable level of personal satisfaction, social effectiveness, and stability.

Just as individual behaviors and attitudes repeat themselves, so interactions among family members become patterned and entrenched. Particular behaviors are predictably followed by certain reactions, which foster other repetitive responses, and so on, in circular transactions. When these represent persistent dysfunctional family styles, a family member may become symptomatic or problems may arise between the family and systems that surround it, thus bringing the family to the attention of clinical social workers.

In any social or interpersonal system the quality of communication determines and, in turn, is affected by the nature of the relationships among the people involved.[16] When communication is dysfunctional—when people *persistently* send confusing, contradictory, or incomplete messages, for example, or inaccurately receive messages from others—this can be viewed as both cause and effect of problematic relationships. Communication and interaction are intertwined. In most cases in which there are personal or family adjustment problems, one needs to assess communication patterns and, if they are dysfunctional, try to determine what interferes with clear communication and what these patterns tell us about the relationship. We ask ourselves such questions as: Are certain ego defenses interfering with full expression of attitudes, desires, and reactions? Are defenses interfering in reception of these by another? Are nonverbal behaviors contradicting verbal statements? Do poor communication patterns reflect realistic or unrealistic fear of retaliation or abandonment? Is lack of autonomous functioning revealed by unclear statements made by family members to one another? Are either words or gestures being

misinterpreted because of variations of meaning related to sociocultural factors?

The four chapters in this book devoted to family and couple treatment discuss assessment of interactional and communication patterns in greater detail.

Use of the Past

Previous life history, as we have said, often reveals repetitive patterns. These can be immensely valuable in helping the worker to understand "causation" in the developmental sense of how the person came to be the way he or she is. Knowledge of early family relationships is particularly helpful in understanding the level of psychosexual development and autonomous functioning and the nature of parental attachments, superego–ego ideal development, many qualities of the ego, and the basis for anxieties that give rise to ego defenses. Traumatic events in a child's early years—death of a parent, placement in an institution, and so on—or ongoing neglect or unavailability of "good enough" parenting sometimes adds to our understanding of certain developmental deficits and personality disorders. Family history can also help to explain intergenerational patterns of behavior and interaction; a genogram may reveal that alcoholism, depression and suicide, violence and abuse, incest, or other problems have recurred throughout the family system through the years. It is also important to evaluate sharp discrepancies in the way an individual functions at different times in life; these can provide excellent clues to the ways in which situational factors affect a particular person.

Psychosocial caseworkers always have thought in terms of *multiple* causation, recognizing the *circular effect* of interacting contributing factors in the present and those derived from the past. Transactions of the past are incorporated in present personalities and relationship patterns, thereby influencing the nature of the current interactions; the past thus lives on to modify the present. This systems point of view is in contrast to linear thinking, e.g.: "Jane is depressed because she was raised by a domineering mother." Rather, Jane's depression may be understood in part as her particular low-key personality's reactions to a controlling mother and alcoholic father from whom she felt little comfort and who discouraged independent development. Self-esteem was further influenced by the fact that she attended a small rural school with no girls her age to play with and received poor instruction from a teacher who lacked warmth or sensitivity to children. In order to get some relief, at age 16 she married Henry and moved to an urban manufacturing area where she knew no one and felt very out of place. Henry, like her father, developed a drinking problem. Her father died, and her mother discontinued any communication with her after Jane refused to leave her husband and go back to live with her mother and mentally handicapped brother. Jane had four children within five years. When the oldest child was seven, the factories in the area closed and Jane's husband was out of work for almost a year. For a few months, Jane had an extra-marital affair that she took few pains to conceal from her husband; when he discovered it, for the first time he beat her severely. Jane made several efforts to leave her increasingly destructive marital relationship; on one occasion she found adequate housing and received public assistance, but she returned to live with her husband because, she said, she felt sorry for him. A few months later her mother contacted her after many years of estrangement; Jane became clinically depressed and was briefly hospitalized.

This abbreviated case history can only be fully appreciated in "no-fault" systems

terms, as a network of circular and evolving interactions over time in which the issues of cause and effect as such become irrelevant. All people in this tragic situation affected and were affected by past and present actions of others, which, in turn, were influenced by conditions in other impinging systems and every individual's reactions to these. Again, part of the assessment process requires a determination of where treatment interventions would be most effective. *Therapy is most successful when it addresses those aspects of the system that are most accessible to change, not necessarily those that seem to be the "sickest."* In the case just described, some short-term work with Jane's husband, who was quite shaken by his wife's depression and feared losing her, resulted in his making significant behavioral changes; Jane, in turn, became more optimistic about her marriage and after several months of couple treatment, the relationship improved. Jane continued to work on finding more loving ways of relating to her mother. As these interactions improved, her relationships with her husband and children were positively affected, in part because her internalization of her mother's interactions with her had afflicted her self-esteem and close relationships.

Often, by acquiring a different understanding of past experiences or different attitudes toward them, people begin to interact differently in the present and thereby help not only themselves but also others who are part of the same family or social system. Again, a change in one part of a system inevitably impacts the other parts.

The Client's Own Assessments

We want to reiterate that although the worker is trained to understand human behavior and relationships, he or she alone cannot properly assess the dilemmas people bring to treatment. The clients' own evaluations of their troubles are of utmost importance for many reasons:

First, clients are the ones who know what they think and feel, what the circumstances are like for *them,* what has helped or has not helped in the past, and so on. Over and over again, we ask: "What have you tried?" "Does this explanation seem accurate to you?" "What are you hoping to change?" *Understanding is based in large measure on the meaning of the situation to the client.* A worker may not want to see an adult daughter continue to live with and care for her aging parents instead of becoming more independent, but the assessment of the situation as well as the treatment goals are contingent on the *client's* preferences and values, not the worker's. The worker's respect for the value of self-determination is basic to the assessment process.

Second, client motivation and self-esteem are enhanced by the worker's confidence in clients' ideas and opinions: the expectation that understanding is within their reach, not something that is delivered from "on high" by the worker.

Third, it is important that clients become *experts on themselves* because this helps them to develop the tools to make changes, to make new choices, to relate differently to others, to find solutions. Thus, for both ethical and practical reasons, the spirit of mutuality is essential not only to establishing goals but to achieving the fullest understanding of what is wrong and why. Too often in mental health circles assessments are made by the therapist or in case conferences without sufficient input from clients. Or worse, the client's point of view is unappreciated or even ridiculed.

CLASSIFICATION

Another step in biopsychosocial diagnosis is classification or categorization, recognizing that a characteristic or set of characteristics

belongs to a known grouping about which generalized knowledge exists. Three types of classification or categorization have so far been found by psychosocial workers to have particular value for treatment: health, problem, and clinical diagnosis.

Health

The *medical classification,* or diagnosis, often has implications for personal and social consequences, which are guideposts to casework treatment.[17] For instance, a childhood diabetic may need help with feelings that he or she is defective and with resentment at the deprivations of foods or activities that friends can enjoy. An adolescent athlete whose knee is permanently injured may consequently lose status as "star" of the high school team or have to give up a dream of making the major leagues. After a diagnosis of heart dysfunction, a successful businessman may have to limit his activities and give up strenuous interests and outlets, some of which he had engaged in to distance himself from his unsatisfying marriage. A person with multiple sclerosis is confronted with the certainty that physical functioning will become increasingly impaired over time, and this fact will have practical and emotional implications not only for the person but for all members of the family. The man who has had a serious stroke or certain kind of injury is placed in a regressive and dependent condition, requiring him to relearn previously automatic processes he had mastered as an infant, such as speaking and walking. Catastrophic illnesses—terminal cancer, kidney failure, AIDS, etc.—have tragic meanings to individuals and loved ones. Knowledge of the implications of various physical disorders and disabilities and the adjustments they require immediately provides the worker with information for the overall assessment once the medical diagnosis has been made.

Problem

A second type of classification refers to problems addressed by clinical social workers including: parent–child difficulties, homelessness, wife battering, sexual or physical abuse of children, delinquency, substance abuse, ambivalence about pregnancy, incest, terminal illness, suicidal ideation, various kinds of family dysfunction and marital conflict, situations involving adult children of alcoholics, adult survivors of sexual abuse, among many others. Each of these problem categories tells us something about the difficulty and can become the focal point for assembling data about the trouble; from there one can formulate hypotheses. The problem category informs the worker and suggests treatment steps that may have to be taken. To demonstrate how one problem category may aid the worker's assessment and suggest possible treatment approaches, we include the following example.

Wife Battering In this discussion, we expand upon the category of spousal battering (95 percent of which is committed by men against women[18]) to include violence in unmarried and same-sex couples. When clients present battering as the difficulty or when it is uncovered in the exploration of other concerns, immediate decisions are required. The most critical questions have to come first: Does the woman who has been beaten require a safe house of some kind? If there seems to be serious risk, will the woman need to go to a relative, friend, or shelter? Are children in danger? Should a court order of protection be secured?

While these questions are among the most urgent, and may require prompt action or location of resources, simultaneously the worker must begin to assess the seriousness of the beating and determine whether there has been a history of battering. If so, for how long? How often? How severe? Are alcohol or

drugs involved? If so, does the couple see substance abuse as a problem? Are there guns in the household or readily available? Does the batterer assume responsibility for his violence and indicate a wish to stop? Does he appear to have the capacity to be introspective and in touch with emotions other than anger? Does the wife want to save the marriage? Does she say she wants to separate but see herself as powerless? Does she believe she has any influence—positive or negative—on the marital interaction and the escalation to violence? Has the couple heretofore denied violence, to themselves and/or others?

What strengths can be assessed in each spouse and in the relationship? For example, are fairness, loyalty, and caring apparent despite the abuse? Is there stability in job performance, in caretaking of the children, and so on? Are there strong family, friendship, or community supports? Are there external pressures contributing to the situation, deriving from unemployment, poverty, extended family problems, repeated experiences of prejudice and hostility from others because of ethnicity, race, or (in a same-sex couple) sexual orientation? Did either or both of the spouses come from households where there was family violence?

Would this couple be willing and able (without out-of-control blaming and anger) to have conjoint sessions? Or is the situation so severe that couple treatment clearly will not work and might even endanger the woman? Even if the couple wants to work together on the marriage or on some kind of resolution (such as about children if they separate), it still may be wise to see each spouse separately at least once to get the most accurate account from both partners; otherwise, information and attitudes can often be drowned out by defensiveness, fear, blame, or anger. Would the husband be willing to join a group that helps batterers to find alternative responses to anger or panic, to improve communication patterns, and so on? Would the wife consider a group that would provide support and help understanding her role in continuing in an abusive relationship, or aid her in the examination of difficulties with self-esteem, assertiveness, communication, and so on?

In cases of wife battering (which is far more prevalent than many realize), the worker has to pay special attention to *countertransference* (because the worker's capacity to participate effectively in the treatment relationship is an important part of the assessment). Physical violence is extremely distressing. It may seem difficult to feel empathy for a person who abuses others. Sometimes it is possible to get to underlying dynamics of the violent behavior (e.g., feelings of powerlessness, low self-esteem, unlovability, fear of losing love, difficulty expressing "softer" emotions, fear of intimacy), but such exploration is possible only if the batterer feels regard and caring from the worker. Often such men have particular difficulty with trust. One must also beware of countertransference reactions to couples in which change seems unlikely, which can be the case when patterns are deeply entrenched. It can be exasperating when the abuser is unable or unwilling to give up violent behavior. The worker may feel impatient with a wife who keeps returning to her battering partner, even though practical avenues for leaving are available. In any event, workers must assess and reassess their own countertherapeutic responses.

Some clinicians assert that conjoint sessions are contraindicated for couples experiencing violent behavior, that couple meetings imply an equality between the spouses. Some believe that a "no-fault" systems stance holds the victim as responsible as the perpetrator when, in fact, the physically stronger partner is usually the batterer, has more power and control over the rela-

tionship, and is the only one who can make changes that curb the violence.

However, we believe that cases of battering require *differential diagnoses,* just like all other interpersonal situations. It is true that some batterers will not change, even if they want to. It is also true that some batterers are out of control, and their wives are in incredible danger; in such cases it is obvious that conjoint work would be contraindicated and the goal of treatment would be to help the wife take all steps possible—legal and personal—to protect herself. As with all other situations described in this book, in our view it is never fruitful to blame or "pathologize" anyone in trouble; it *is* necessary, however, to assess realistically each situation, to elicit the clients' perspectives, and to share our opinions with them.

With some couples where physical abuse has occurred, it *is* possible to promote an open dialogue. In our experience, many such couples have a long history of failure to communicate with each other, to share personal meanings and emotions. However, the worker may need to establish ground rules, to remain sympathetic yet adopt a strong, firm leadership role. For progress to occur, *it is necessary for batterers to be held responsible for their behaviors.* The worker must indicate in a very definite and straightforward manner that *there is no real chance for change or for the marriage unless the violence stops.* Battered women, too, usually need to be helped to become aware of their options, of their strengths, of their own needs, and of their fears of taking stands for themselves. One does not necessarily deal with all the above dimensions in every case of battering, but each of them needs to be in the worker's mind as possible matters for consideration.

A similar type of tentative outline of dimensions for assessment and treatment possibilities can be made in relation to any problem category; in some situations, the outline for evaluation is even more complicated than the one just given, and in others it is far less complex. A given client or family may have several types of problems, each with its own diagnostic and treatment requirements.[19]

Postscript on Mrs. Harris, a Battered Woman It will surely be encouraging to the reader to learn that Mrs. Harris (whose initial interview appears in Chapter 10, pages 279–80) did return to see the worker. After three meetings, the contract evolved, and with some suggestions from the worker about how to approach her husband (e.g., without blame, asking for his help), Mrs. Harris invited him to join her in sessions. He came to the first meeting seemingly resentful and bitter. Before the beating had even been mentioned, he blamed his wife for being too easy with the children and spending too much time with friends; he complained that she let her mother strongly influence her. Was he, the worker asked, interested in working together with his wife to improve things? "I'm here, aren't I?" he responded. Deliberately, the worker waited to determine whether either the defensive Mr. Harris or the self-effacing Mrs. Harris would raise the question of the beating. Finally, as he seemed to feel a little more trusting, Mr. Harris said, rather sheepishly, "I guess my wife told you I hit her." (This, the worker thought to herself, could be a good prognostic sign.) The worker asked, "Have you thought about what led you to take such an action?" Mr. Harris responded with more blaming. The worker persisted: "Do you really believe that anyone could *make* you do something like that?" Mr. Harris shrugged but seemed to get the point. Shortly afterward, the worker added: "I get the sense that you did something against your better judgment because you have little confidence that you can get through to your wife any other way. Is that right?"

After Mr. Harris hesitatingly agreed, the worker went on: "Do you believe for a minute that she can get your true message that way?" Mr. Harris shook his head. The worker followed up with: "What would you like her to know about how you feel?"

During three months of once-a-week couple treatment, both were able to speak of their loneliness and hopelessness in the marriage. Mrs. Harris indicated that she never got the feeling that she mattered to her husband. Mr. Harris said he felt he always came last with his wife: after the children, her friends, and her mother. With difficulty and some help, Mr. Harris acknowledged that his abusive behavior, verbal and physical, was contrary to his idea of the person he wanted to be (his ego ideal). Mrs. Harris recognized that she did not show the same affection to her husband that she did to the children and to her friends. She explained that it was not because she did not love him, but she thought *he* did not love *her*. She said that she had come to realize that she had tolerated the beatings because somehow, at least at those times, she felt he cared.

When the couple terminated, there was much more openness and warmth between them. Both Mr. and Mrs. Harris believed that physical violence and avoidance of meaningful communication were now behind them. Six months after treatment ended, the worker made a follow-up call and learned from Mrs. Harris that, although the marriage was not always a "Hollywood romance," no further beatings occurred; when tensions mounted they talked problems out, and things were "better than I ever thought they could be."

Clinical Diagnosis

Social Work Use of DSM The *clinical* classification, or clinical diagnosis, is a combination of terms derived from psychiatry and used to designate certain major personality syndromes or configurations. In recent years, the revised editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association, have been used widely by social workers.[20] The DSM classifications reflect the "state of the art" as judged by respected clinicians and researchers. Although social workers have had broad experience with personality assessment and psychosocial evaluation, so far they have no typology that begins to compete with the DSM. Classifications in recent editions of the manual are based on more extensive field trials than those in earlier editions were; the systematic descriptions of various disorders and inclusion of diagnostic criteria undoubtedly have improved reliability.

Social workers often have responsibility for making diagnostic decisions and formulating treatment plans based on these. It has become essential, therefore, that they be familiar with the typologies and standards of current practice. As members of multidisciplinary treatment teams and when collaborating with other professionals, social workers need to be able to share in a common language about diagnosis so that they can communicate with colleagues. Increasingly, DSM has become the official reference manual in mental health facilities. Agreement on nomenclature is now far greater than before, resulting in less confusion about terms being used. Furthermore, social workers have had to familiarize themselves with the DSM system because managed care and insurance carriers generally require them to provide a DSM diagnosis to be eligible for reimbursement.

A Broader Person-in-Situation Classification Urged Unfortunately, social work lacks a systematic typology that classifies problems encountered by social workers, a

system that simultanously grasps the complexities of the personalities in interaction with their situations. In a thought-provoking article, Kirk et al. strongly urge social workers to work toward the development of a classification system that suits their needs and reflects their mission and values. Instead, they point out, "Because DSM is so widely used in mental health practice, the American Psychiatric Association's system of naming and classifying mental disorders has *unofficially and by default* had significant effects on diagnosis in clinical social work."[21] [Emphasis ours.] Social workers, they believe, "do not need a new jargon that stereotypes clients."[22] Rather than the DSM medical model, they assert, social workers need to develop a system of assessment that ensures the systematic consideration of factors required to evaluate the problem and personality in the context of the situation. A classification based on research that could precisely identify information that clinicians need to understand the person–situation gestalt would be welcome and could lead to a far more illuminating method of assessment than the unidimensional DSM system.

DSM purposely takes a generally atheoretical and descriptive approach to clinical diagnosis with the intent of making the manual useful to clinicians of various theoretical orientations and to researchers. Its value is seriously curtailed for psychosocial workers, however, not only because the significance of interpersonal or other external influences is neglected, but also because psychodynamic and etiologic theories are ignored. Many social workers have not found DSM useful in treatment planning, in assessing family difficulties, or in reflecting the complexity of the problems clients present.[23] As illustrated in the case of Mrs. Zimmer in Chapter 3, we often view personality disorders in part as an outgrowth of early deprivation and flaws in ego development. The effects of the client's milieu on the diagnosis must be evaluated. For example, a woman with a dependent disorder may marry a domineering man, in which case the traits of both may be reinforced by marital complementarity.

Or paranoia may be aggravated by a sadistic family environment, by abusive discrimination, or by various sociocultural factors; if these are not considered, the clinician may recommend inappropriate treatment. For example, the belief that one is being persecuted could be absolutely true or based on realistic expectations; or the so-called paranoia could be based on a belief system common to the client's reference group; or, because of language or cultural differences, the clinician may misunderstand what the client really means and assume there are ideas of persecution when there are none.[24] Further concerns about DSM and clinical diagnosis in general will be discussed shortly.

Clinical Diagnosis May Be Unknown or Irrelevant Often, the caseworker does not have sufficiently extensive contacts with a client to make a clinical diagnosis with any degree of certainty (even though for administrative or reimbursement purposes the worker may be required to do so). In many situations, especially in brief treatment, if there is no indication of psychosis, further delineation of the clinical diagnosis is not needed in order to help the client with the particular problem that has brought him or her to the worker. Problems with family or other social systems often are not the function of clinical disorders. One need not be considered "disordered" to benefit from social work help.

Clinical Diagnosis in Conjunction with Consideration of Other Factors But, as we shall discuss further, when difficulties in the personality itself are the major

focus of treatment, such a diagnosis—*along with the assessment of strengths, the situation, and interacting systems in the client's life*—may be useful in adding clarity to the overall evaluation and treatment.

In some ways, the clinical classification is more complicated than the problem classification. The client usually tells the worker what the problem is, but the clinical classification must be deduced from facts and observations of the social study and assessment. It depends in part upon the recognition of signs or symptoms that are generally known to be characteristic of particular neurotic, psychotic, or personality disorders. Hallucinations, delusions, severe depression or anxiety, obsessions, and phobias, for example, usually lead one to consider a category of mental disorder. The clinical diagnosis is an attempt to define or classify, or put into a category, *one* way in which the personality as a whole functions when substantial dysfunction or distress is indicated. The *functioning* or the *condition* is categorized by psychosocial workers, *not the person.* (One is not a "borderline," although one may have a borderline personality disorder.)

When personality diagnosis is called for, the worker first attempts to arrive at the *broadest discriminations.* Is the person apparently functioning adequately without serious distress or impairment? Or is there evidence of psychosis or some kind of neurosis or personality disorder?

Psychosis The extent to which clinical workers are familiar with psychoses depends on the settings in which they practice. In a psychiatric hospital or outpatient facility, the worker will be familiar with many types of mental disorders. Although psychosis is in many respects a medical condition, all practitioners should learn to recognize the major symptoms of schizophrenia and other psychotic conditions.[25] *Persistent* delusion—of persecution, of grandeur, of having one's thoughts controlled, of controlling thoughts of others, of being spoken to by the dead, of "thought broadcasting," (i.e., the notion that others can hear one's thoughts), of "thought insertion," (i.e., that thoughts of others are being inserted into one's mind), etc.—suggest the possibility of schizophrenia, although it is always necessary to consider any cultural basis for seemingly "bizarre" thoughts. Auditory, visual, or olfactory hallucinations; "thought disorders," including loose associations, constant jumping from one idea to another, and incoherence; flat or "inappropriate" affect (e.g., laughter in the face of sad events or unprovoked outburst of anger); and certain types of disturbed psychomotor activity, including extremely odd mannerisms and catatonia, are all characteristic of some schizophrenic disorders. For most individuals who are severely afflicted, there are confusions around identity, limited capacity to take reasonable care of oneself, and recurrent problems in interpersonal relationships. Often, but certainly not always, these disorders first appear in adolescence or early adulthood.

Sometimes family members or others report extraordinary changes in a teenager or young adult. For example, if a young person who was previously an outstanding student, an athlete, and respected by his peers suddenly starts failing in high school or college; becomes reclusive, elusive, or antisocial; or begins acting or speaking in a bizarre manner, shows extreme obsessiveness or ragefulness not previously manifested; or evidences any *radical* shift in behavior and attitudes, a psychiatrist—preferably an expert in schizophrenia—should be consulted. Adolescence is usually accompanied by turmoil, mood changes, and often rebellious attitudes, but changes that seem to permeate

or transform the personality of the individual *may* be an indication of the early onset of schizophrenia.

There are people who have been diagnosed as having schizophrenia, yet they function quite well most of the time in many areas of life. Some people, probably relatively few, have an acute breakdown that never recurs. For others, episodes of severe psychotic symptomatology are years apart, with periods of remission in between. Often medication can prevent or minimize exacerbation of symptoms. Occasionally, remissions are spontaneous. Tragically, a substantial number of people are chronically disabled by schizophrenia and their functioning deteriorates over a period of years. Unfortunately there are no "cures." Even when severe episodes are alleviated by medication or various kinds of therapy (including family treatment) and other supportive services, many people with schizophrenia still become increasingly disabled over time. The long-term downhill course this disorder frequently follows is often compounded by the cumulative consequences of medications; although drugs assist patients in their ability to function, they often do so at a price. Accurate diagnosis of various forms of schizophrenia requires knowledge of the course the condition has taken; a full history from the patient and/or the family is therefore extremely important.

The bipolar (formally known as manic-depressive) disorders sometimes have and sometimes do not have psychotic features. Bipolar conditions are characterized by episodes of excited, often euphoric, sometimes grandiose thinking and behavior; at other times there may be episodes of depression, from mild to psychotic. These occurrences may alternate with periods of relatively "normal" moods, but clients are often either manic or depressed when they come to our attention. Whether psychosis is involved or not, a bipolar disorder frequently responds well to medication. Therefore, when a worker suspects a person has this condition, psychiatric consultation is definitely in order.

By being alert to any of the symptoms of psychosis and related disorders, it is then possible to determine which of one's clients should be referred for a psychiatric diagnosis and evaluation for possible medication or hospitalization. One need not arrive at a definitive diagnosis, but when there is evidence enough to suspect psychosis, a medical opinion should be sought. Where an organic factor is involved, caseworkers have very little diagnostic competence, but here too they need to have sufficient knowledge of symptomatology to recognize signs that can then be reported to a medical consultant.

Neuroses and Personality Disorders

When psychosis is not indicated, but the cause of the problem seems to lie sufficiently within the client to indicate some type of personality disturbance, the next distinction to be made is most frequently between some type of personality disorder (described in DSM Axis II) and neurosis. The term *neurosis* has been omitted from recent editions of DSM in an effort to maintain its atheoretical position and dissociate itself from Freudian or psychodynamic theories about etiology; nevertheless, some conditions in Axis I—especially the affective disorders—refer to syndromes that could be called "neurotic." We choose to preserve the term *because* of its implications about origin and intrapsychic dynamics.

Neuroses and neurotic symptoms are basically responses to internalized or intrapsychic conflicts, stress betweeen the ego, id, and superego. The stress can be significantly augmented by life events. From the psychoanalytic point of view, in neurosis, the

individual in childhood reached a fairly high level of psychosexual development, although the personality may have regressed from this level as a result of recent serious pressures or trauma. Repression, suppression, isolation, intellectualization, and rationalization (see Chapter 2) are common ego defenses. An extremely demanding or punishing superego, compulsive and perfectionistic tendencies, depression, obsessions, excessive fears, anxieties, and conversion symptoms (i.e., specific physical symptoms that derive solely from inner conflicts or needs) are among the indicators that *may* lead to a diagnosis of neurosis. Obviously, cultural factors and current life circumstances must be weighed before a definitive determination is made. Many people with neurotic features function extremely well even though they may be painfully unhappy.

In *personality disorders,* psychological development has not been as fully reached as in neuroses. The roots of the difficulties lie in large part in the early formation of the ego, the failure to develop a repertoire of ego functions and defenses that operate adequately; ego synthesis is not fully achieved. Anxiety in neurosis results from conflict between differentiated parts of the personality. In severe personality disorders, especially but not exclusively borderline and narcissistic conditions, anxiety may result from the unevenly developed ego's effort to avoid regression to a very early stage—a stage characterized by strong feelings of helplessness—and to stave off ego disorganization. Many of the more "primitive" or "immature" ego defenses described in Chapter 2—including pervasive denial, regression, "splitting," projective identification, primitive idealization, and devaluation—can be found in some people with serious personality disorders. Some degree of impulsivity and failures of judgment and reality testing are not uncommon. People whose intellectual functions are easily overwhelmed by emotion, who consistently have a very fragile sense of their own well-being or the goodwill of others, who are self-centered with little capacity for reciprocity, affectional attachment, or empathy in relationships, may be showing signs of personality disorder. As is true in all psychological conditions, personality disorders fall along a continuum from the relatively mild to the very severe. Most of us have traits that are associated with these disorders, especially under stress. It is therefore important to get an overview of the person's overall patterns of functioning before arriving at a diagnosis.

In most cases in which long-term treatment of interpersonal maladjustment is sought (and can be arranged despite pressure for short-term treatment), it is possible for the experienced clinical worker to make finer distinctions among the neuroses such as: obsessive-compulsive, anxiety, phobic, and depressive (dysthymic) neuroses. Similarly, distinctions among personality disorders are important; avoidant and schizoid disorders have some similar features but very important differences. Borderline, dependent, and histrionic personality disorders have some common but many distinctive features. Although space limitations prohibit us from detailed descriptions of the many neurotic and personality disorders, clinical social workers dealing with intrapsychic and interpersonal problems need to be familiar with the literature that elaborates on the assessment and treatment of these conditions.[26]

In many settings, personality disorders seem to be diagnosed more often than neurotic or affective disorders. Features of neuroses and personality disorders often appear together in the same person, however. There are very few "pure" conditions or disorders. Clinical terms represent a cluster of focal points on several different continua. When individuals show features of more

than one disorder, all possibilities should be kept in mind with indication of where the greater emphasis lies *as it relates to the person's current concerns or treatment objectives.* Once again, emotional or personality difficulties can *never* be evaluated or accurately diagnosed without an understanding of the family and societal context in which people are living.

When intensive work on interpersonal problems is being undertaken with individuals suffering from any type of severe clinical disturbance, there is often value in psychiatric consultation. The more severe the dysfunction appears to be, the more important such consultation may be. Any physical symptoms also call for medical evaluation, even when in the worker's judgment these appear to be of psychological origin. Psychological problems in clients with serious psychosomatic disorders should be treated under medical auspices or in close coordination with medical treatment. If depression is present to any significant degree, psychiatric consultation is often helpful, partly because medication may be indicated and partly because it can be useful to have a medical opinion as to whether the severity of the depression or possibility of suicide makes medical supervision or even hospitalization advisable. Whether or not there is a biologic or genetic predisposition to particular clinical conditions (and opinions often differ about this), increasingly there are medications available that provide clients with relief from anxiety, depression, and obsessive-compulsive conditions; such medications work especially well when used in conjunction with psychotherapy. Problems with drug and alcohol abuse also often benefit from medical consultation that accompanies other treatment approaches.

The helpfulness of psychiatric consultation depends upon the quality of psychiatry available. Communities and settings differ enormously. There is much variation in the training and experience of psychiatrists. Consequently, the usefulness of consultations varies. If a patient interview with a psychiatrist is required, the advantages have to be weighed against the disadvantages of procedures and attitudes that the client will have to face in the medical diagnostic process. In these days when social workers are the primary providers of mental health services and often have far broader therapeutic experience than many psychiatrists, it may be discouraging to worker and client alike if consultation is required when there is no medical reason for it; among other things, the client may be led to believe that the worker is not certain of his or her own competence or judgment.

Value of Clinical Diagnosis

The value of clinical diagnosis is sometimes questioned, in the belief that the dynamic diagnosis is sufficient and subject to fewer risks. But the clinical diagnosis has an additional value of designating a cluster of factors—traits, behaviors, thought and feeling patterns—characteristically found together. For instance, the term *obsessive-compulsive disorder or neurosis,* when correctly applied, immediately conveys certain information about a client. From the psychoanalytic point of view, it signifies that the individual has reached the oedipal stage of development in relationship to parents but has not resolved all the conflicts of this period and has regressed to some degree to an earlier period of development. People with this diagnosis have severe superegos to which they may be overly submissive on the surface but which they are unconsciously fighting. They are often very sensitive to criticism and have strong dependency needs, even though these may be

covered over. They sometimes want to please the worker and other "parent" figures but at other times can either be negative or subtly sabotage suggestions. Often perfectionism and ambivalence are present. Obsessions and/or compulsions can cause much distress, take up a great deal of time, and interfere with functioning. There is usually heavy use of such defenses as intellectualization, rationalization, isolation, and reaction formation. Parents with this condition may be strict in bringing up children, ambivalent in training them, or strict on the surface while unconsciously promoting them to act out. Not all these characteristics will be true of every person with an obsessive-compulsive disorder, but the presence of a few of them in the absence of contrary evidence will alert the worker to the probable diagnosis and to avenues to explore that will either confirm the diagnosis or contradict it.

A clinical diagnosis, then, suggests many qualities the person with a particular disorder *may* have even if they have not yet been observed or described by the client. If an individual is accurately diagnosed as having an avoidant personality disorder, we know there has been a long-term maladaptive pattern of functioning. We can also expect that the client will have extraordinary sensitivity to real or anticipated criticism, frequent and extreme feelings of anguish and humiliation when sensing even the slightest disapproval, painful shyness, deeply felt loneliness, severe self-criticism and self-doubt, and yet a strong desire for social relationships and affection (in contrast to a person with a schizoid personality disorder). Again, although the individual may not have all these characteristics, it is likely that many of them will be manifested to one degree or another.

Using the above example, there are immediate implications for treatment. For instance, we know we must work cautiously, respecting the client's need for gentleness and distance, avoiding strong interpretations or confrontations. Even though the longing for social contact is strong, we would hesitate to make an early referral for any kind of group experience until it seemed likely that the client could tolerate the stress of intense social interaction without taking flight.

Thus, as it takes firm shape, the clinical diagnosis becomes a sort of index to many factors about the individual that have not yet become clear from what has been observed or said. It often enables the worker to anticipate reactions to contemplated treatment steps and to guide them accordingly. Such knowledge can also help greatly in the control of antitherapeutic countertransference reactions. Intellectualism that accompanies the obsessive-compulsive disorder, for example, can arouse feelings of frustration and dislike in the worker. If, however, the worker can recognize this trait as a defense against anxiety created by an oversevere conscience, knowing that the client feels in part like a child afraid of a harsh mother or father, negative feelings may well be displaced by empathy and the desire to help. In the borderline personality disorder, the worker will not be surprised by extreme oscillations of feeling about the self and others, including feelings about the worker. Splitting of others into "good" and "bad" often occurs. The use of projection and denial will be expected and understood as familiar components of the condition, making it easier to accept clients with this disorder and their sometimes provocative attitudes and behaviors.

An accurate diagnosis not only suggests some of the factors and patterns that may be present but also usually tells us something about the durability of the problems associ-

ated with it: A personality disorder points to long-term dysfunctional traits; dysthymia in an adult means that the person has been in a depressed mood for at least two years, and so on. Specific symptoms such as phobias, hysterical or conversion symptoms, obsessions, compulsions, evidences of depression, various defenses such as "splitting," delusional thinking, and so on, quickly alert the worker to *possible* diagnoses. Symptoms alone, however, do not establish a clinical diagnosis. There are always several possible explanations of any symptom. Only when a specific form of behavior can be shown to be part of a larger configuration characteristic of the disorder in question can any certainty be felt about the diagnosis.

One weakness of the *dynamic* diagnosis taken by itself is that it tends to see a little bit of this and a little bit of that in an individual without reaching a definite delineation. It is when one tries to say whether the difficulty is primarily a personality disorder or a neurosis; whether a borderline personality disorder, schizophrenia, or a major depressive episode; and so on, that incompleteness in the psychosocial study or lack of clear-cut evaluation of the facts often becomes apparent. This assumes that when a *clinical* diagnosis is arrived at, it is not a glib designation based on superficial impressions.[27]

Hazards and Misuse of Clinical Diagnosis

Several dangers are involved in the use of diagnostic categories. One is that of stereotyping, assuming that all people with the same condition are exactly alike. As noted earlier, each person has many individual qualities that make him or her unlike anyone else, despite the fact that in the rough outlines of a personality disturbance an individual may have much in common with others suffering from the same disorder. Another danger is careless categorization, assuming a person belongs in a given group because of superficial qualities or overlooking other qualities that point in another direction. Again, it is essential to be clear that we are not diagnosing *people* but *characteristics* of people and their situations that interfere with their coping and contentment.

The clinical diagnosis, by definition, focuses on pathology. Diagnosticians have not yet developed a systematic means for assessing positive qualities and traits that bear upon the way individuals handle themselves and their lives. For example, two individuals may be correctly diagnosed as having a schizoid personality disorder; some of the same etiological and psychodynamic factors may be similar, but the two people may lead very different lives. One may live marginally as a recluse or on the streets; the other may be a high-functioning forest ranger or researcher. Of course, the opportunity structure may play a crucial part in the very different lifestyles.

It also follows from this example that the second individual may have better developed thought processes, more useful defense mechanisms, a greater sense of mastery and competence, more capacity for autonomous functioning, and—as both cause and effect of these—greater self-esteem. The assessment of ego and superego–ego ideal functions may be more useful than the clinical diagnosis. Talents, sense of humor, values, flexibility, curiosity, and capacity for empathy and altruism all can have enormous significance for evaluation and treatment.

Diagnosis is admittedly a subjective process, despite the fact that it is an effort to increase the objectivity with which one views clients and their treatment needs. As a subjective process that often deals with impressionistic data, it is open to influence by suggestion. One prevalent form of suggestion

is the currently popular diagnosis. Just as appendicitis was widely overdiagnosed in a recent period of medical history and before that tonsillectomies were far too widely performed, so in psychiatry schizophrenia has sometimes been too easily assumed to exist, and, especially today, borderline personality disorder may too often seem the appropriate designation. The subjectivity of diagnosis is illustrated by the fact that strong protest by gay rights and other concerned groups apparently was required to persuade the Board of Trustees of the American Psychiatric Association to vote in 1973 that homosexuality should not, after all, be classified as a mental disorder. This was one instance when the biases of those being diagnosed won out over the traditional prejudices of the diagnosticians!

Along the same lines, the "normal" personality in one culture, place, family, or period of history may be considered "disordered" in another. Behavior or traits acceptable in New York City's Greenwich Village might be viewed as bizarre in a small town in the Midwest or in a rural area of Canada. Hairstyles in the 1960s were often used as a measure of normality or disturbance!

Extremely disturbing are indications from research and from practical experience that lower-social-class clients tend to be diagnosed by mental health practitioners, including social work clinicians, more negatively than members of other socioeconomic classes.[28] To the extent that clinical judgments made about lower-class clients are more discouraging than those made about members of other classes, the likelihood is that poor people often will not be offered the best opportunities for treatment.

From the psychosocial perspective, the purely descriptive approach of DSM may be misleading. For example, it may be revealed after a period of treatment that hysterical features are a defense against a narcissistic personality structure; phobic symptoms may cover a borderline condition; compulsive traits may defend against a psychotic process; alcoholic problems may cover dependency, obsessional traits, physical pain, and so on.

Another danger is that of premature diagnosis. When definitive data are not available to make a clinical diagnosis, it is better to admit that we have not been able to establish one than to fix a label superficially. The rate of agreement among clinical diagnosticians is not as high as we would wish, although reliability has improved in recent years. The fact that a high degree of accuracy has not been achieved is not an argument against an effort to improve diagnostic skill. It *is* an argument against snap judgments and against *overreliance* on the clinical diagnosis. The greatest safety lies in building our understanding on many sources of information—the assessment and dynamic diagnosis, the problem classification, health, and the clinical classification—using all the knowledge that each of these can obtain for us.

Many generally well-functioning people seek social work help under stress. If a worker feels pressured to arrive at a clinical diagnosis, it may be a distorted one, describing the client's reactions only in the crisis state and not at other times. It is also imperative that we emphasize again that even severe clinical conditions are *significantly* affected, positively or negatively, by external circumstances and by the range of options available, including opportunities for decent work, housing, and fulfillment of interpersonal relationships.

Some diagnoses, such as schizophrenia or borderline personality, can seem so discouraging that there is danger that they may relegate the person to very superficial treatment or even to no treatment. This should not happen. A clinical diagnosis is

never a pejorative. The diagnosis tells the worker something about what may help and what probably will not help, but it certainly should not be used as an excuse for not *trying* to help. Realization of the great variation among individuals given the same diagnosis precludes such stereotyping in treatment. The fact is that *the degree to which a person is dissatisfied with his or her condition may be more important than the diagnosed disorder.* The capacity for optimism can be a critical factor. Motivation for change relies heavily on discomfort with the status quo and hope that things can be better.

The person–situation gestalt concept puts the clinical diagnosis in perspective as only one of several aspects of the total diagnostic assessment. The reader will recall the work described in Chapter 3 with Mrs. Zimmer, who was diagnosed as having a borderline personality disorder. Over time this client made very significant changes in fundamental aspects of her personality. In Chapter 20, work with Mrs. Barry, who was suffering from paranoid schizophrenia, will be presented. Paranoid schizophrenia is often considered an especially discouraging diagnosis. Yet, Mrs. Barry was able to gain a good deal of understanding about herself and her relationship with her husband and was also able to recognize the importance of overcoming her reluctance to take medication. Subsequently, she was well enough to live fairly comfortably in the community, avoiding rehospitalization. In such cases, knowledge of the clinical diagnosis makes substantial difference in treatment, but the assessment of the client's individuality and strengths is of equal importance.[29]

THE TIME FACTOR

The degree to which one can arrive at an understanding of the person-in-situation varies with the fullness of the social study on which it depends. Even in a short contact of one to four interviews, one must understand enough of the interplay of inner and outer dynamics to enhance the client's ability to cope with the main problem (often the presenting one) in a way that either resolves it or diminishes its severity. Pressures that can be modified and opportunities or resources that can be located within the limits of time available are assessed. Even in brief contacts, one can get an impression of certain features of a client's ego: perceptive ability, coping powers, ways of handling anxiety, and so on. One sometimes also observes major defenses such as projection, turning against the self, reaction formation, rationalization, and intellectualization. Aspects of the superego may show themselves if it is unusually severe, lax, or inconsistent. Impulsiveness or rigidity is often immediately apparent. Usually, however, it will be difficult to assess the *degree* to which any of these characteristics exist.

Turning to the dynamic diagnosis, one certainly has to understand something of the dynamics of both inner and outer forces and of the interplay between them in all clinical social work whether the contact is brief or extensive. Without this, very little help can be given. In crisis treatment (to be discussed in Chapter 18), where former conflicts and problems may have been brought to the surface because of the present trauma, quick recognition of dynamic elements is required.

A clinical diagnosis, on the other hand, can rarely be arrived at in the first interview and usually only when there is a very serious disorder: psychosis, severe neurotic symptomatology, or personality dysfunction. Usually the clinical diagnosis will be established only very tentatively if at all in the entire brief contact. So little time is available in which help can be given that treatment occupies center stage very quickly. Because the

factual basis is inevitably restricted, it is not only difficult but also sometimes risky to try to determine a clinical diagnosis; often it is not clear whether any such diagnosis is even appropriate.

In general, diagnostic understanding in very brief treatment will be limited to components of the person–situation gestalt that are close to the matters to be dealt with and close to the immediate treatment process.

In summary, diagnostic assessment involves a many-faceted but orderly understanding of the client–situation configuration. The caseworker tries to understand the nature of the interaction of the multiple factors contributing to the client's difficulties—internal and external factors, past sources of present aspects of the difficulties, and internal dynamics within the personality or among the environmental forces. In preparing for the treatment planning, all that is known, strengths as well as weaknesses, is reviewed and evaluated for the purpose of learning how best to help.

As the contact progresses, the fund of knowledge grows and the worker repeatedly refers to it in making the decisions that either modify or implement plans made at the outset of treatment. The more orderly the ongoing diagnostic process in which assessment is made and dynamic understanding grows, the more wisely will the worker decide what treatment to offer the client.

NOTES

1. Richmond (1917), p. 357.
2. Turner (1994), pp. 168–69; he makes distinctions between assessment and diagnosis that will interest the reader. Many of those concerned about diagnosis, labeling, and classifications are rightfully worried about misuse and abuses of these activities when they attribute blame and deficiency to individuals or do not individualize clients. The wide use by social workers of the classification of mental disorders by the American Psychiatric Association (1994), critics fear, is in sharp contrast to social work's traditional person-in-situation diagnosis of social functioning that considers the context in which clients' difficulties are experienced. See Kirk, et al. (1989), Gingerich, et al. (1982), and Kutchens and Kirk (1988). Later in this chapter we will discuss some hazards of clinical diagnoses, although we, like Turner, do not object to their use if they are not narrowly applied out of context, take into account client strengths, and are not used pejoratively.
3. See the classic, still important, work of Ripple, et al. (1964) on the interacting influences of client motivation, capacity, and opportunity.
4. Highly recommended readings on this subject include Framo (1982), Chapter 2 on symptoms; and Loewenstein (1979).
5. See Klerman, et al. (1994), especially pp. 760–62. See also Elkin (1989). Wetzel (1984) strongly recommends that depressed clients not be treated with medication alone, but with concurrent psychotherapy.
6. Hartmann (1958), p. 23.
7. We recommend Zayas and Bryant (1984), a respectful paper on culturally sensitive treatment of adolescent girls and their families that includes case examples.
8. See Woods (1999) on personality disorders in which this point is made.
9. Collis (1973), p. 81.
10. See early research on these variations by Margaret Mead (1935 and 1949). See also Skolnick and Skolnick (1977).

    As discussed in Chapter 2 and elsewhere, the sources of knowledge concerning these variations are myriad. Many useful references have been included in notes to several other chapters; see especially Chapter 2, notes 37 and 38.
11. See the volume edited by McGoldrick, et al. (1996) on ethnicity and also her edited volume (1998) with several chapters that address these issues.
12. The reader interested in the history of "evidence" gathered in social diagnosis will want to read Richmond (1917), Chapters 2, 3, and 4.

13. The text of Chapter 9 emphasizes the importance of worker self-awareness. See also Chapter 9, notes 10, 11, and 12. Lammert's (1986) article on self-awareness is recommended. Further discussion and references will be found in the family and couple chapters.
14. The concept of complementarity in marriage has been recognized in casework for many years; see Hollis (1949), p. 90. The early family therapists also utilized the same notion when assessing interactional marital patterns; see Ackerman (1954).
15. For an especially wonderful illustration of this point, see Pittman and Flomenhaft (1970).
16. There are many references on the important subject of communication. See Chapter 2, note 44 and Chapter 9, notes 13 and 14. Additional discussions and references will be found in the family and couple chapters. We especially urge the reader to become familiar with Nelsen (1980) and Satir (1983).
17. See Turner (1995), Part 2, for chapters related to physical and medical disorders. See also Chapter 10, note 11.
18. Douglas (1991), p. 525; this helpful article describes a "violence continuum" and suggests prognostic signs to assist in the assessment of specific cases; of course, all batterers are not alike. For references on battering and family violence, see Chapter 10, note 9.
19. See Turner (1995) for many chapters on an array of psychological, personal, and interpersonal presenting problems.
20. The American Psychiatric Association (1994). Since 1980, the DSMs have been used far more widely by mental health professionals, including social workers, than any of the earlier diagnostic manuals were. See Williams (1981), a social worker who has participated in the development of the manuals since 1980; she presents her viewpoint on the importance of social workers becoming familiar with the classification of mental disorders.
21. Kirk, et al. (1989), p. 295.
22 Ibid., p. 304. Of relevance here is the study by Rosen and Livne (1992) that indicated social workers tended to perceive problems as personal rather than interpersonal or environmental, a perspective that greatly influenced the workers' treatment approaches.
23. See, for example, Kutchens and Kirk (1988) in addition to other references cited in notes 2 and 28 in this chapter.
24. See an excellent, informative, and important paper by Newhill (1990) on the role of culture in the diagnosis or misdiagnosis of paranoid symptomatology.

    See also Wachtel (1993), pp. 24–30, for an interesting discussion of what he terms "accomplices" in interactional patterns; other people in the client's life behave in ways that result in shaping or supporting the actions or difficulties of the individual. This concept is closely allied to notions about complementarity and circular interactions already discussed; in the family and couple chapters we deal in detail with these concepts and with the interpersonal influences of projection and projective identification, concepts also related to Wachtel's point.

    A recommended article by Noonan (1998) on the "difficult" client points out that client characteristics and behavior sometimes "may be problematic but the degree of difficulty is also related to therapist expectations, affective responses and needs, and capacity for tolerance" (p. 129). A case illustration is used to explain the importance of a "dual person" perspective.
25. See Kaplan and Sadock (1985) for excellent chapters on a range of psychiatric disorders and conditions. For selected references that address issues relevant to the diagnosis and treatment of psychoses and chronic mental illness, see Arieti (1974), Bellak (1973), Klein and Cnaan (1995), Libassi (1988), Nelsen (February 1975, reprinted in Turner's 1995 edited volume; and March 1975), Walsh (1995 and 1999), and Zentner (1980). Drake, et al. (1996) discuss treatment of individuals with a dual diagnosis of substance disorder and severe mental illness. The March 1975 article by Nelsen was reprinted in the volume edited by Turner (1995), Chapter 48; see also Chapters 46 and 47 in the Turner book for more readings on schizophrenia.

26. On personality disorders, written by authors with various theoretical orientations, see Beck and Freeman (1990), Clark (1996), Freed (1984), Eda Goldstein (1995), Johnson (1999), Hartocollis (1998), Heller and Northcut (1996), Millon (1996), and Woods (1999). See also Elson (1986); and for further references, see Chapter 3, note 9.

    For readings on neurotic or affective disorders, see Fann, et al. (1979), Guidano and Liotti (1983), Palumbo (1976), Rauch, et al. (1991), Wetzel (1984), and Zentner and Zentner (1985). See also Turner (1999) for chapters on a range of disorders.

27. For additional selected references relevant to assessment and diagnosis and to personality development, see Fox (1993), especially Chapter 6; Gilgun (1996); Hellenbrand (1961); Litz (1968); Mischne (1986); Polansky, et al. (1995); and Pray (1991).

28. See Chapter 2, note 36 and Chapter 8, no

    The danger of misuse of clinical diag is conveyed by Kutchins and Kirk (1987 other references in note 2 of this chapte Levy (1981) on the issue of labeling. At (1982) discusses worker bias against the chotic client; suggestions are offered to teract this and to minimize diagn stereotyping.

29. See Cowger (1994), Howard Golds (1990b), Hwang and Cowger (1998), and Quaide and Ehrenreich (1997) on asses for strengths. See also Chapter 1, not and Chapter 10, note 6. See an articl Kopp (1989) who recommends that client encouraged to play a significant role in sessment through self-observation.

    For articles from the narrative pers tive relevant to assessment: Nye (1994) Strickland (1994).