CHAPTER 12

Contextual Assessment

OVERVIEW

The chapter describes guidelines for clarifying client concerns and hoped-for outcomes and identifying related factors. A detailed procedural guide is presented in chapter 13, and additional guidelines for assessing families, group, organizations, and communities can be found in chapters 26 and 27. A multilevel contingency analysis informed by practice-related research findings may be required to clarify outcomes and discover related factors. Without it, you may end up with what Pacey (1983) calls one-half technology—attending to just part of a problem, which, in addition to not resolving it, may result in unwanted side effects. Assessment knowledge and skills should contribute to provision of direct services and, if you are a case manager and coordinate services provided by others, should help you to select those most likely to help your clients.

You Will Learn About

- What is involved
- Kinds of questions that arise
- What is at stake
- The difference between diagnosis and assessment
- Thinking critically about psychiatric labels and narratives
- Making assessment of value to clients
- Critically appraising assessment frameworks
- Characteristics of a contextual evidence-informed assessment
- Important distinctions
- Sources of influence that should be reviewed
- Assessing the risk of suicide and abuse
- Ethical issues

WHAT IS INVOLVED

Assessment lays the groundwork for selecting plans. It should indicate how likely it is that hoped-for outcomes can be attained. The likelihood may be slim when needed resources are not available or when problem-related circumstances cannot be arranged. This phase is an ongoing process in which assumptions are altered as needed in response to new information, such as degree of progress. Assessment should indicate what factors influence clients' options. It should suggest "leverage

points" for pursuing valued outcomes. It should suggest: (1) objectives that if attained would resolve problems, (2) what must be done to achieve them, (3) how objectives can be pursued most effectively, and (4) the probability of attaining them, given current resources and options. Interrelated goals of assessment (sometimes referred to as "case formulation") include: (1) identifying problems, (2) clarifying problems, (3) detecting the characteristics of clients and their environments that influence problems, (4) interpreting and integrating the data collected, and (5) selecting outcomes to focus on (Nay, 1979). This lays the groundwork for selecting service plans.

A key part of assessment is making the invisible visible. Consider a child who has extreme temper tantrums. Related behaviors, such as screaming, throwing objects, and hitting, are visible. What is not visible is the environmental history in which such behaviors developed. Reactions of those (for example, teachers and parents) who reinforce hitting, screaming, and throwing objects and fail to provide positive feedback for desired behaviors are not as vivid. Consider also the following examples:

- Mrs. Rivera, a client of the Sumner Mental Health Clinic, seems quite depressed. How can I discover what factors may be related to this?
- Ralph, a 17-year-old foster child, will soon be emancipated from care and needs to find a job. How can I determine the adequacy of his job-seeking skills?
- The Sumner community has acquired money to be spent on improving the quality of their neighborhoods. How can residents determine how to use this money most effectively?

Critically Appraising Assessment Frameworks and Methods

Assessment frameworks differ in what is focused on and in the degree to which they can be and have been critically tested. They differ in how compatible they are with empirical data regarding how behavior develops, changes, and is maintained and how successful they have been in leading to successful interventions. History suggests that some approaches are more successful than others. For example, trying to assess people by examining the bumps on their head was not very fruitful; however, for decades many people believed it was useful (Gamwell & Tomes, 1995; McCoy, 2000). Assessment frameworks are more likely to be useful if they take advantage of knowledge about factors related to problem-related behavior and circumstances and the accuracy of different kinds of data. Frameworks should be instrumental, that is, help clients achieve valued outcomes. It is not very useful to carry out an assessment that offers few, if any, guidelines for resolving problems or for discovering that they cannot be resolved given current resources. If maintaining conditions are not identified, plans may be misdirected. Focusing solely on personal characteristics may result in "psychologizing" rather than helping clients. Focusing solely on environmental characteristics may result in overlooking individual characteristics that influence problems of concern. The complexity of many problems highlights the value of a multilevel contextual analysis.

Key implications of evidence-based practice for assessment include: (1) drawing on available problem-related research, for example, about related factors; (2) selecting empirically grounded assessment frameworks that reflect research findings regarding outcomes of interest; (3) using reliable, valid assessment measures including measures designed to assess risk of certain outcomes, such as suicide or child maltreatment; (4) avoiding common errors in integrating data from multiple sources; and (5) involving clients as informed participants and considering their values and preferences. Evidence-based assessment calls for asking questions such as:

- What assumptions am I making? Can I provide evidence or a sound argument for them (e.g., demonstrate compatibility with research findings regarding behaviors of concern)?
- Are there better-argued alternative views?
- Have I relied on valid sources of information? Are assessment measures valid? Do they measure what they purport to measure? Do they apply to my client?
- Is there evidence that assessment methods relied on do more harm than good (e.g., create anxiety among clients about problems for which there are no effective services)?
- Are assessment measures used reliable? Do they provide consistent data by the same person at different times and over different practitioners?
- Are norms available for assessment measures that involve people like my client?
- Does my assessment have clear intervention guidelines? Does it help my clients and me es-

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timate the probability of attaining hoped-for outcomes and guide planning about how to attain them?
- Have I avoided common errors in integrating data, such as focusing only on data that confirm my preferred views?
- Have I considered the values and preferences of my clients and their significant others (those who interact with and influence clients)?

Concerns about the evidentiary status of assessment frameworks and tools are illustrated by the following examples:

- Genograms are commonly used and claimed to be of value in assessment in spite of a lack of rigorous appraisal of claims.
- The Rorschach Ink Blot Test is used in spite of a lack of evidence for its validity (Hunsley, Lee, & Wood, 2003).
- Clients are categorized into psychiatric categories based on the DSM-IV-R in spite of problematic reliability and lack of validity (e.g., Houts, 2002; Kutchins & Kirk, 1997).
- Counselors may create false memories (e.g., Loftus & Ketcham, 1994).
- Most practitioners rely on self-report of clients and do not use other measures, such as observation in real-life settings to check on the accuracy of such reports.
- Most practitioners do not know how to carry out a descriptive and functional analysis of behaviors of concern and related competing behaviors.

Critical appraisal of assessment frameworks can help us to discover the extent to which different views have been critically tested and found to enhance the likelihood of selecting effective plans. Parsimonious accounts that involve limited inferences are easier to test than those that include many, perhaps conflicting, theories. Thinking critically about our beliefs about behavior and how (or if) it can be changed can help us to identify underlying assumptions related to different views and their possible consequences (e.g., psychiatric and social learning views). It can help us to spot values about what people should do (e.g., take a certain screening test) disguised as scientific guidelines (e.g., McCormick, 1996; Moynihan et al., 2002; Thornton, Edwards, & Baum, 2003).

A broad contextual view of problem-related factors may point to particular areas requiring more detailed review. Assessment should indicate how likely it is that outcomes of interest can be attained. The possibility may be slim when needed resources are not available or when the environment cannot be rearranged. Assessment should indicate what factors influence options, make demands on clients, or create discomfort (see Exhibit 12.1). Consider a client who is said to neglect her child because of her heroin addiction. A contextual analysis requires information about the pattern of heroin use (assuming that the parent does use heroin and that this does interfere with her parenting), including high-risk situations (those in which she is likely to use heroin) and low-risk situations (those in which she is unlikely to use heroin). It also requires a clear description of "neglect" and related factors. Detailed information is needed about the mother's parenting skills and the personal and environmental factors that affect them (e.g., a belief in the value of severe physical punishment, an abusive partner, no money for needed medical services, and her alleged heroin use). What parenting skills does the mother possess? Which ones are absent? What factors interfere with the use of positive parenting skills? What environmental factors are related to heroin use and the quality of parenting, such as poverty and legislation regarding fathers' obligations for contributing financially to the care of their children?

Helpers differ in their skill in avoiding misleading accounts that result in selection of ineffective methods. They differ in the quality of their interpersonal skills for placing clients at ease and involving them in the helping process. Knowledge about the accuracy of different assessment frameworks and measures can help you to select referral sources and evaluate data gathered by others. Judicious selection of assessment methods maximizes opportunities for accurate problem description including discovery of available alternative behaviors that will successfully compete with disturbing behaviors. Let us say a parent tells you that she is a good parent and knows how to use positive methods to discipline her child. How can you find out if this is accurate? Or, let us say that your supervisor asks you to use the Zung Depression Inventory to assess a client's complaint of depression. What information do you need to judge for yourself whether this measure is a good choice (i.e., is it reliable, and does it provide an accurate account of depression for this client)? Observation in real-life settings may be required to clarify problems and identify related circumstances. This may reveal discrepancies between self-report data and what is observed. Here, as well as in other helping

EXHIBIT 12.1
Characteristics That May Be Related to a Problem at Different System Levels

Level 1: Individual

- ___ Health
- ___ Developmental
- ___ Temperament
- ___ Intelligence
- ___ Problem-solving skills
- ___ Social skills
- ___ Vocational skills
- ___ Self-management skills
- ___ Reinforcer profile
- ___ Acculturation level
- ___ Cultural background

Level 2: Family

- ___ Problem-solving skills
- ___ Family composition
- ___ Income
- ___ Cultural norms
- ___ Interaction patterns
- ___ Extended family network
- ___ Living space
- ___ Goals and values
- ___ Cultural conflicts

Level 3: Community

- ___ Recreational opportunities
- ___ Crime rate
- ___ Educational resources
- ___ Physical environment
- ___ Cultural norms
- ___ Accessibility of services (e.g., medical, legal)
- ___ Cultural diversity
- ___ Social support available
- ___ Transportation available

Level 4: Service System

- ___ Services provided
- ___ Problem definitions favored
- ___ Eligibility rules
- ___ Favored intervention methods
- ___ Links with other agencies

Level 5: Societal

- ___ Cultural diversity
- ___ Tolerance for violence
- ___ Programs funded
- ___ Economic inequities
- ___ Options for influencing policy
- ___ Emphasis on consumerism
- ___ Patterns of discrimination
- ___ Expected gender roles
- ___ Media (e.g., diversity of points of view readily available)

phases, specialized knowledge as well as critical thinking skills may be needed to appraise the accuracy of claims and to integrate diverse sources of information including findings from practice- and policy-related research and the unique circumstances and characteristics of a client.

Decisions

Decisions must be made about what data to collect, how to gather it, and how to organize it (see chapter 17). These decisions will be influenced by preferred practice theories, for example, cognitive-behavioral, family-systems, radical behavioral, or psychoanalytic (e.g., see Payne, 2005). Required decisions include the following:

- What data will be most helpful in making well-reasoned decisions about how best to describe and understand problems?
- Where and how can I obtain the data?
- How will I decide when I have enough information?
- What should I do if I obtain contradictory data?
- What criteria should I use to check the accuracy of data?
- How can I avoid inaccurate and incomplete accounts?
- How can I communicate most effectively with clients to obtain needed information?

Let us say that you work in a student counseling center and a young woman is referred to you because she is having trouble studying and is receiving failing grades. What data will be useful in clarifying complaints and related factors? Will you focus on her study habits? Will you explore her "self-esteem"? Will you explore her current life circumstances, including her financial resources and significant others? Will you consider cultural differences that may be related to her concerns? How will you translate "trouble studying" and "receiving failing grades" into specific outcomes that,

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6. Diagnosis

if attained, will resolve the problem? What questions will you pose that may help you to locate valuable research? Where and how will you look for such research? How will you evaluate the quality of research you find? Relevant questions here include:

- For college students receiving failing grades, what are common reasons? (a descriptive question)
- For college students receiving failing grades, is enhancing study habits or insight-oriented counseling more effective in improving grades? (an intervention question)

What knowledge and skills will you use to avoid accounts that result in selection of ineffective methods? Your knowledge about behavior and how it is maintained and can be changed will influence what information you gather. A gated approach includes an initial screening using a valid indicator of the need for further assessment. This screening tool is designed to identify the most severe form of a problem. For example, intake workers in child welfare agencies use risk assessment measures to identify high-risk children. Such a measure may divide children into three categories: low, medium, and high risk (Baird &Wagner, 2000). Depending on the classification, further assessment is carried out and service provided as needed.

KINDS OF QUESTIONS THAT ARISE

Questions that arise in this phase of helping concern description, assessment, and risk (see Exhibits 12.2 and 12.3). All three may arise with one client. Each should be translated into a well-formed answerable question that facilitates a search for external research findings. Assessment is more likely to be useful if we take advantage of research related to information we need—for example, information about factors related to problems and the accuracy of different kinds of data. Many different areas of research are of potential value in assessment as reflected in the kinds of questions that arise in this phase of helping. Consider Mrs. Rivera, who is depressed. Information needed here may include description (for depressed single adults living in poor neighborhoods, what factors have been found to be related to depression?), assessment (for such adults, what is the best measure to assess degree of depression?), and risk (with someone like Mrs. Rivera, is there risk of a suicide attempt over the next 6 months?). Each of these questions calls for a different kind of research methodology to pursue answers. See chapter 11 for an overview of questions to ask when critically appraising research involving description, assessment, and risk questions. Consult other sources for additional detail (e.g., Gibbs, 2003; Geyman, Deyo, & Ramsey, 2000; Greenhalgh, 2001).

Description Questions

Professionals often seek descriptive information, such as common problems confronted by those who are transitioning out of foster care or by caregivers of frail elderly relatives. A general question may be: Among caregivers of frail elderly relatives, what problems arise in offering care? Results of survey data as well as qualitative research may be of value.

The need for multiple levels of analysis to understand complex phenomenon, such as the relationships between work and family life is illus-

EXHIBIT 12.2
Content Knowledge of Potential Value in Assessment

Type of Information	Potential Value
1. Prevalence of a problem	1. Share this information with clients, estimate the likelihood that a client has a concern, estimate the value of screening
2. Factors related to a complaint such as depression	2. Provide guidelines for assessment and intervention
3. Reliability and validity of assessment measure including measures of risk	3. Allows evidence-based selection of measures
4. Acceptability of different assessment frameworks and methods	4. Discover client preferences
5. Evidentiary status of different assessment frameworks and methods	5. Allow evidence-based selection of assessment frameworks
6. Diagnosis	6. Allow informed selection of services

EXHIBIT 12.3
Examples of Questions That Arise During Assessment

Description
• In adolescents with anger management problems, what social skills do they often lack?
• In frail elderly adults, what are common needs?
• In 5-year-olds, what is the prevalence of enuresis?
Assessment
• In students with behavior management problems in the classroom, is classroom observation compared to teacher self-report more accurate?
• In foster care youth transitioning out of care, is a social skill self-report inventory or observation in role plays more accurate in identifying needed skills?
Risk
• In children who are prescribed antidepressants, what is the risk of a suicide attempt?
• In frail elderly people, what is the risk of falls in those who have incorrect vision corrections compared to those whose vision correction is correct?
• In children who have been physically abused by their parents, what is the risk of further abuse?

trated by Hochschild's research (e.g., 2003). For example, she argues that survey data describing attitudes toward work and family life do not "question the construction of the social worlds that shape how people feel about their families, and the researchers don't dig deep into the paradoxes their own data reflect" (p. 202). She suggests that some researchers omit mention of what she views as "the symbiotic—even parasitic—relationship between work and family" (p. 202). She suggests that much of the literature describing the relation of work to family "is based on the unquestioned assumptions about what families and workplaces feel like and mean" (p. 202) and that we can only understand the work-family balance by considering the larger context.

Questions About Assessment Measures

Professionals use a variety of assessment measures (e.g., Corcoran & Fischer, 2000; Jordan & Franklin, 2003). An assessment question is: "In married couples who have communication problems, what is the most accurate measure of related concerns?" Another example is: "For youth transitioning out of foster care who need employment, what is the most accurate way to determine their current employment skills?" (see chapter 17).

Questions About Risk/Prognosis

Over the last decades, there has been great interest (some, such as Skrabanek & McCormick, 1998, would argue excessive) in identifying "alleged" risk factors for certain problems and conditions viewed as unhealthy or troubling. A large portion of public health endeavors is occupied with identification of risks of certain diseases and providing and promoting strategies to minimize them, for example, provide screening programs. Professionals often attempt to estimate risk, for example, of future child maltreatment. An example of a risk question is: "For children who have been physically abused by their parents, which risk assessment measure best predicts the likelihood of further abuse?" Another example is: "In an elderly client diagnosed with depression, what is the risk that they will make a suicide attempt in the next 6 months?

WHAT IS AT STAKE

Although decisions typically must be made on the basis of incomplete data, without a sound assessment, interviews may drift, opportunities to gather useful data may be lost, and assessment may be incomplete, resulting in selecting ineffective or harmful plans (see Exhibit 12.4). Clients may be referred to agencies that offer ineffective or harmful services. Here, as well as in other phases of helping, knowledge may be available regarding problems and related causes that contribute to sound decisions. Not sharing uncertainties may hide the fact that decisions involve a value judgment about how to balance risks and harms. Benefits related to a practice or policy will often require a subjective judgment based on a number of kinds of evidence (see Exhibit 9.10). Many tests used by professionals are pseudo-scientific; that is, there is no evidence that they are accurate and do more good than harm; there is no evidence that they contribute to accurate assessment (see also chapter 17). If this is true, they waste money and time. For example, how much time and money is spent on the use of projective methods that contribute nothing to helping clients or objective tests that are not valid, such as inaccurate risk assessment instruments? Thus, it is important to critically appraise them.

- Does a risk assessment measure accurately predict further likelihood of child abuse?

EXHIBIT 12.4
An Example of Incomplete Assessment

John, a social work student, works in a crisis center. One of the clients to whom he provides ongoing services is a 46-year-old African American woman, Mrs. K., who lives in a "satellite" home for psychiatric patients. Her 12-year-old daughter lives with her in the home. Mrs. K. had what was called an "acute psychotic episode," which led to a short hospitalization and her current residence in the community care home. John decided to focus on decreasing Mrs. K's "sense of shame." No information was provided about the condition that precipitated the "acute psychotic break"; the whereabouts of her relatives (including her three other children); her assets, work, medical, and educational history; or a description of the changes she wanted in her life. The student had never visited the home where she lived (and was not sure his supervisor would approve of his visiting), had never seen Mrs. K. and her daughter together, and had no contact with Mrs. K.'s other children. John also had no information about what was happening in her life at the time of the "acute psychotic episode" or what had been happening over the past 10 years.

Obtaining an overview of Mrs. K.'s problems and desired outcomes as well as relevant historical data and additional information about her current life revealed a fuller picture of this woman and her situation that called into question the focus on shame. Mrs. K., who was originally presented as a debilitated, problem-ridden psychiatric patient with few assets, was discovered to be a woman who had raised four children (three of whom lived close by but with whom she had no contact) and had held a responsible job for 15 years. She was in good health, had many interpersonal skills, and enjoyed being around people. She loved her children and was concerned about creating a good environment for her youngest child, who lived with her. The problems of concern to her were improving her relationship with her youngest daughter, getting along better with the people in the community home, and decreasing negative thoughts about herself. Mrs. K. was a woman with many potential assets, including relatives with whom she could cultivate positive contacts.

This example of incomplete assessment is not unusual; it is common even among second-year master's degree students with whom I have worked. Often, as in this case, premature closure results in selection of a negative outcome (decreasing shame) rather than a positive one (e.g., increasing enjoyable exchanges with significant others).

- Does an anxiety measure accurately identify clients who have a level of anxiety that warrants service provision?
- Does a measure designed to assess the effects of traumatic life experiences accurately identify those who could benefit from counseling?

Here too, as when making decisions regarding selection of intervention methods (see chapter 21), we should inquire about the evidentiary status of the method being considered, in comparison with alternatives. Standardization in how a measure is administered and interpreted is important not just for scientific purposes, but also to increase the accuracy with which a test is used. If we read a claim that a measure is reliable and valid, is this true and what kind of reliability and validity were assessed? (See chapter 17 for discussion of reliability and validity.) Are claims made about its usefulness sound? We must be careful because limitations are often *not* candidly acknowledged. Rarely will you find a statement such as the following: "We only examined inter-item reliability (correlation among items). We do not know if the measure is stable over time. That is, we do not know whether a person who takes the inventory today, will get a different score four weeks from now in the absence of intervention." Unstable measures cannot accurately reflect change that may result from provision of services. Thus, if a measure is unstable, feedback from the test may be misleading. For example, it may be assumed that positive changes have occurred when there has been no change. Have the validity and reliability of a test been independently investigated? Have only the creators of a test investigated its reliability

and validity? And to what extent does a measure provide accurate information about clients in real-life situations? Responsibility for gathering such evidence falls, not to those who raise questions regarding the accuracy and reliability of a measure, but to those who forward claims about it.

Problems and Their Prospects

Problems have different prospects for resolution. These prospects are influenced by the accuracy of problem description. That is, a problem may be defined in a way that encourages or discourages discovery of promising options for attaining related hoped-for outcomes. Problems may have many causes. They vary in their complexity. Questions to ask when exploring complexity include the following:

- Will achieving valued outcomes have negative as well as positive effects?
- Are contexts available that will facilitate change?
- Do significant others and clients have required knowledge and skills?
- Are problems interlinked?
- Are needed resources available?

Research in psychotherapy suggests that characteristics of the client (for example, motivation to change, willingness to carry out agreed-on tasks) as well as characteristics of their environment (social support available) are related to outcome (Asay & Lambert, 1999). Significant others may lack needed skills, have interfering beliefs, or be threatened by proposed changes. A parent may lack verbal statements of praise that her children find reinforcing. A problem may be linked to other areas that must be addressed, such as a lack of vocational skills. A grandparent may visit a family and reinforce a child's annoying behavior. Staff may complain about the "dependency" of residents, not realizing that they themselves encourage and maintain dependent behaviors. They may oppose a plan in which independent behaviors will be reinforced, viewing this as bribery. Attempts to resolve problems may create more problems. Distinguishing between problems and efforts to resolve them will help you and your clients avoid confusing the results of attempted solutions and the effects of the original concern (Watzlawick, Weakland, & Fisch, 1974).

Limited resources (such as day care, vocational training programs, recreational centers, high-quality educational programs, parent training programs) and limited influence over environmental contingencies often pose an obstacle. For example, you may have little influence over teachers who do not know how to plan effective curricula or to encourage valued behaviors by means of positive change methods. Discriminatory policies and practices may stand in the way. Expected role behaviors may limit change. For example, a father may view child-rearing as totally his wife's responsibility. You may have little influence over inadequate housing or access to crack cocaine that contributes to a parent's neglect of a child. Agency policies and practices and the physical characteristics of the environment affect options. The lack of coordination among services may limit access to needed resources. Clients may receive fragmentary, overlapping, or incompatible services.

Common Errors

Evidence-based practice encourages a focus on collecting data that describe uncertainty about how to attain outcomes that clients value (or if they can be attained). An assessment informed by practice-related research is more likely to avoid three interrelated errors: (1) focusing on irrelevant outcomes, (2) offering inaccurate and incomplete causal analyses, and (3) choosing ineffective or harm-inducing (iatrogenic) service plans. An accurate assessment avoids inaccurate and incomplete causal analyses that may result in focusing on irrelevant outcomes or choosing ineffective or harm-inducing (iatrogenic) service plans. Collecting irrelevant data wastes time and money and increases the likelihood that you and your clients will be misled by irrelevant material. Assessment frameworks differ in their vulnerability to certain kinds of errors. Approaches that focus on alleged pathologies of clients may result in overlooking valuable resources, such as caregiving skills. Such approaches can be contrasted with an individualized assessment that includes attention to alternative behaviors that will compete successfully with undesired behaviors and to environmental resources, such as sources of social support. Such an assessment encourages a contextual understanding of problems and their possibilities.

Unexamined speculation may result in acceptance of incomplete or incorrect representations of problems. Examples of incomplete assessment include the following:

- Problem-related behaviors are not clearly described.

- Cultural factors are overlooked.
- The functions of behaviors of interest are unknown (e.g., related environmental consequences, such as reactions by significant others are not identified).
- Related setting events and antecedents are not identified.
- The client's strengths are ignored.
- Positive alternatives to undesired behaviors are not identified.
- Baseline data are not available (e.g., description of the severity of behaviors, thoughts, or feelings prior to intervention).
- Related physical characteristics of the environment are overlooked.
- Higher-level contingencies are overlooked, such as loss of financial aid.

Inaccurate or incomplete accounts may occur because attention is too narrowly focused on one source (e.g., thoughts). Related environmental contingencies may be overlooked. Objectives may be selected prematurely. Sources of error that result in inaccurate or incomplete views of problems and their analysis are:

- Vague descriptions
- Hasty assumptions about causes
- Failure to search for alternative accounts
- Ignoring practice-related research findings
- Speculating when data collection is called for (e.g., observation in real-life settings)
- Confusing the form and function of behavior
- Using uninformative labels
- Confusing motivational and behavior deficits
- Focusing on pathology and overlooking assets
- Collecting irrelevant material
- Relying on inaccurate sources of data
- Being misled by first impressions
- Being misled by the client's superficial resemblance to another client in the past
- Overlooking important cultural differences

Collect data that decrease uncertainty about how to attain outcomes clients value (or if they can be attained). Such practice should help to minimize common errors in this phase. For example, collecting irrelevant data wastes time and money and increases the likelihood that you and your clients will be misled by irrelevant material. Unexamined speculation may result in acceptance of incomplete or incorrect accounts of problems. Hasty, incomplete assessment may result in selecting outcomes that are not of concern to clients or do not address circumstances that must be altered to attain desired outcomes. You may accept an incomplete account because you attribute behaviors of concern to other behaviors. A teacher may attribute poor academic performance to low self-esteem because a student often "puts herself down" (has a high frequency of negative self-statements). This assessment is incomplete. Factors related to both self-esteem and negative thoughts (such as past history of punishment in schools and current punishing consequences provided by the teacher) have not been identified. The *fundamental attribution* error is made when behavior is attributed to characteristics of the individual, overlooking the role of environmental causes.

Assessment may reveal that change efforts should focus on significant others who maintain undesired behaviors by reinforcing them and by failing to reinforce valued behaviors. Understanding their role may call for a restructuring of how a problem is defined. For example, rather than "personal" problems, such as depression and drinking, resulting in marital discord, the association may be the reverse (Jacobson, Holtzworth-Munroe, & Schmaling, 1989). That is, marital discord may result in these problems.

What About Person-Environment Fit?

The concept of person-environment fit has been suggested as a key one in social work. Problems are viewed as mismatches between environmental and personal characteristics. Examples include lack of a ramp allowing persons in wheelchairs to enter buildings and lack of information needed by clients to obtain food stamps. Indeed the environment, rather than the client, may require change. But do mismatches always create problems? Don't people adapt to less than ideal conditions? Clients may not complain about discrimination or oppression they experience. The term "raising one's consciousness" reflects a concern to identify causes of unhappiness that are not apparent. Consider an elderly person living alone who tells the social worker that she is satisfied with the few social contacts she has, which may be true. But it also may be true that she has adapted to (learned to be happy with) few social contacts and would be happier if she had more. Rachlin (1980) suggests that we feel happiness and sadness when we move from one level of reinforcement to another and that when we "get used to" a new level, we may be as happy as we were with a richer one. Our ability to do well in many different environments is suggested by the fact that income level is not neces-

sarily correlated with happiness (see Diener & Seligman, 2004).

THE DIFFERENCE BETWEEN DIAGNOSIS AND ASSESSMENT

The term *diagnosis* was borrowed from medicine, in which a physician makes a diagnosis of a patient's condition and then recommends a treatment based on this diagnosis. Observed behavior is used as a *sign* of more important underlying processes, typically of a pathological nature. A staff member in a mental hospital may say that "Mr. Smith tries to hit staff and spits on them." When asked for an explanation, he may say, "Mr. Smith has a borderline personality disorder." Assessment differs from diagnosis in a number of ways (see Exhibit 12.5). A contextual assessment includes a clear description of complaints and related factors and a description of what a person can do and cannot do, what he or she can learn to do, and what is expected of him or her, as well as environmental factors that influence problem-related behaviors (Hobbs, 1975, p. 105). Practice-related research regarding concerns and possible causes and ways to discover them are drawn on. This kind of assessment often reveals that environmental deficiencies contribute to problems (e.g., a lack of recreational opportunities, a lack of day care, low wages). Assessment encourages the description of *processes* rather than the study of *conditions.* For example, rather than describing a client as anxious, a contextual assessment requires the description of the context in which the anxiety occurs and the patterns of related behaviors, thoughts, and feelings. "A fitting metaphor is the motion picture rather than the still photograph" (Peterson, 1987, p. 30). Observable behaviors are not used as signs of something more significant but as important in their own right, as samples of relevant behaviors. Behavior is considered to be related to environmental or personal characteristics, such as escape from disliked tasks in a classroom.

Assessment requires a clear description of problem-related behaviors and a search for associated setting events, cues, and consequences. Trait labels (e.g., aggressive personality) do not offer information about what people do in specific situations and what specific factors affect their behavior. Attributing the cause of problems to character traits ("She's just lazy") or to thoughts or feelings increases the likelihood of "pseudoexplanations" (circular explanations that are not helpful). You may say "She is lazy," referring to the fact that she does not complete her homework. When asked, "Why doesn't she complete her homework?" you may say, "She is lazy."

Providing a diagnosis does not preclude a contextual assessment. That is, a client may be given a diagnosis (perhaps as a requirement for third-party reimbursement), and a thorough assessment can then be conducted. One danger is being led to believe by giving a diagnosis that your work is over—that there is no need for a contextual assessment.

THINKING CRITICALLY ABOUT PSYCHIATRIC LABELS AND NARRATIVES

Social workers use labels in two main ways. One is as a shorthand term to refer to a cluster of specific behaviors. The term *unmanageable* may refer to the fact that a student often gets out of his seat and talks out of turn in class. A second way labels are used is as diagnostic categories that are assumed to indicate the cause of the problem and suggest remedies. For example, a teacher may conclude that a child has ADHD (attention-deficit/hyperactivity disorder) because he has difficulty concentrating on assigned tasks and sitting in his seat. She may further assume that he should be medicated (e.g., take Ritalin). Notice the circularity here:

Observed Behavior	Inference	Reasons for Inference
Does not work on assigned tasks.	Hyperactive	Does not work on assigned tasks.
Often gets out of his seat		Often gets out of his seat.

This label is based on the two observed behaviors, and no such underlying condition may exist. If this is the case, a descriptive term is used as a pseudo-explanatory term. The use of labels in this manner can be frustrating, since although it may seem that more is known, no additional information is available. Indeed, misleading directions may be offered (see Exhibit 12.5). We should think critically about labels and ask: When are they helpful? When are they irrelevant? When are they misleading or harmful? Do they offer guidelines about how to help clients? What are underlying assumptions? Are they well argued? For example, what is a "disorder"? Is there such an entity as schizophrenia?

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EXHIBIT 12.5
Diagnosis or Assessment?

Guevara and Stein (2001) published an article titled "Evidence based management of attention deficit hyper-activity disorder." This article generated many letters as well as a review and integration of their content by Greenhalgh and Smyth (2001). One indication that this is not an evidence-based piece of work is lack of any critique of the diagnostic category of attention-deficit/hyperactivity disorder (ADHD). There is no mention of the controversy as to whether ADHD is a true entity rather than a classification based on the consensus of alleged experts. Guevara and Stein (2001) state that: "You confirm the diagnosis of attention-deficit/hyperactivity disorder by using the DSM-IV diagnostic criteria and the Conners parent and teachers rating scales. You inform the parents of the potential risk of additional psychiatric disorders and persistence of symptoms into adolescence. You prescribe a stimulant drug and arrange review" (p. 1235). A number of letters written in response to this article note the reliance on the DSM checklist of symptoms and parent and teacher behavior checklists in lieu of conducting an individualized assessment. In one letter entitled "A naive use of evidence," Coghill (2001) wrote: "They justify this approach by quoting the impressive effect sizes, sensitivity and specificity of the Conners rating scales." Coghill notes that this is problematic because the studies were "conducted under ideal conditions; actual performance on the scales in a physicians' offices would be expected to be poorer." He also notes that the authors simply informed the parents of the risk that their child suffered from a comorbid disorder when they should have described any other problematic concerns. In integrating the various concerns regarding this report, Greenhalgh and Smyth (2001) described the following limitations: the case description is extremely brief; we do not have the details that would allow us to carry out an individualized assessment. She also noted the problem of the great variation in the prevalence of ADHD over different studies ranging from 4.2% to 26%; "estimates such as prevalence, effect size and likelihood ratio are only as robust as the definitions that underpin them."

Some argue that ADHD refers to many behaviors normal children engage in. For example, William D. Carey (2003), in testimony to a panel on prescribing Ritalin, noted that only a small percentage of children would meet the criterion of ADHD (6/18/01). "Abundant evidence supports the conclusion that one–two percent of children are so pervasively over-active or inattentive that those qualities *by themselves* severely impair chances for normal living and make these children very hard for any caregivers to manage" (p. 2). The U.S. Center for Disease Control and Prevention (Health, United States, 2004) states that 7% of school-age children in the United States are diagnosed with ADHD, and many of them take psychostimulant medication. Carey (2003) argues that this raises concern not for this 1% to 2%, (that he argues are accurately diagnosed) "but for the rest of the 3 to 5 or up to 10 to 15% of American children who today are being diagnosed with ADHD and usually being treated with stimulants inappropriately." He suggests (as do others, Diller, 2002) that the ADHD diagnosis is seriously flawed. Indeed there is no evidence that 6 out of 9 or any specific number of ADHD behaviors are related to abnormal brain function.

Critics of this diagnosis argue that ADHD diagnostic criteria ignore the role of environmental variables as causes of the behaviors and the likelihood of referral, that the diagnostic criteria and the questionnaires used to assess them are highly subjective and impressionistic, and that other problems with the current ADHD diagnosis include: (1) the fact that the most important factors in children getting the diagnosis are probably either learning problems or low adaptability (which some call poor executive functions); (2) lack of cultural and historical perspective; and (3) the small practical usefulness and possible harm from the label. One of the letters entitled "Real or Imagined" (Lake) said as follows, "As a society we now seek not to tolerate

EXHIBIT 12.5 *(continued)*

deviations form the normal in young children, probably due to the breakdown of both nuclear and extended family support and mothers away at work, together with difficulties over discipline." (See also Timimi 2002; Timimi & Taylor 2004.) For a view of ADHD as a "brain disease," see Barkley et al. (2002). Thus, there is a controversy about the use of this label, so much so that bills have been passed in some states limiting the pressure schools can exert on parents to medicate their children. There is no mention of this controversy in this article, including critiques of the validity of methods such as neuroimaging (e.g., Leo & Cohen, 2003). Thus, one way to recognize material that is not evidence-based (even though it is so labeled) is not mentioning controversial issues regarding key concepts and evidentiary claims.

How do we know? Is there such a thing as "mental illness"? Such terms are useful to clients and professionals only if they do more good than harm, for example, suggest common causes based on research findings and suggest promising intervention options (or their lack).

Keep in mind that labels are classifications and thus can suffer from all the ways in which classifications are wrong (for example, over or under inclusion). The classification system may be faulty in not accurately distinguishing between different "syndromes"; that is, there may be "boundary" problems. Does a given diagnostic category represent a "syndrome" (a cluster of symptoms) that can be distinguished from others? Does a given label differ from others "with respect to basic features that are external to the behaviors that define the hypothesized diagnostic construct. Such correlates might include genetic influences, neuropathology, biological indices, course and response to specific treatments" (Fombonne, 2002, p. 59). How many different classifications can one person fall in? Is there any hierarchical order to these—that is, are some more primary than others? Clients may be given an incorrect label (it does not really describe them), or a label that does accurately describe them may not be used and valuable services may be withheld. (See discussion of false positives and false negatives in chapter 20.) As many authors have noted, labels can obscure heterogeneity-important individual variations among people. It thus can encourage the "patient uniformity myth." Use of labels may overlook important cultural differences and encourage "the psychopathologist's fallacy—that because a child has been brought as a patient there must be something wrong with him or her" (Taylor & Rutter, 2002, p. 4). We may start to think of a person as the label he or she is given. The DSM indeed warns readers against this possibility. We may think our work is over when we give a person a diagnostic label rather than realizing it is just beginning in relation to carrying out a contextual assessment. Having a label may result in seeking out characteristics that complement the label rather than searching widely and more accurately. (See discussion of confirmation biases in chapter 8.) Classifying a client by one label may get in the way of identifying co-occurring concerns. (These are termed comorbid in the literature. I think the term *co-occurring* is far less stigmatizing and use it here.) For example, use of labels could obscure the relationship between different concerns, such as anxiety and depression, which are often co-occurring. Saleebey (2001) suggested a "diagnostic strengths manual" as an alternative to a system focused on pathology.

Controversies Regarding Psychiatric Labels

Psychiatric labels have been applied to an ever-increasing variety of behaviors viewed as mental disorders (see also the discussion of the medicalization of deviance in chapter 6). The latest edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-R)* (2000) of the American Psychiatric Association contains hundreds of diagnostic categories. DSM diagnoses are required for access to care, use of medications, and research funding. People differ in their beliefs about the usefulness of diagnostic labels, such as *borderline personality.* Some argue that diagnostic labels are valuable in communicating among different professionals. Some people believe that there is convincing evidence that a disorder called schizophrenia exists and has a biological cause (Torrey, 1995). Others present cogent arguments against these beliefs (Boyle, 2002). Some scholars argue that the

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concept of mental disorder is culturally relative (e.g., Kirmayer, 1994). Others argue that it is not (Wakefield, 1994). In *The Mismeasure of Woman* (1992), Tavris contends that labels newly included in the *DSM-IV* (1994) continue to misdirect attention away from political, social, and economic conditions related to expected gender roles and toward supposed individual deficiencies (see Exhibit 12.6). The controversies concerning the empirical status of psychiatric diagnoses are so sharp, that if you are interested in pursuing this further, you should read related material for yourself (e.g., see Boyle, 2002; Houts, 2002; Wakefield, 2003).

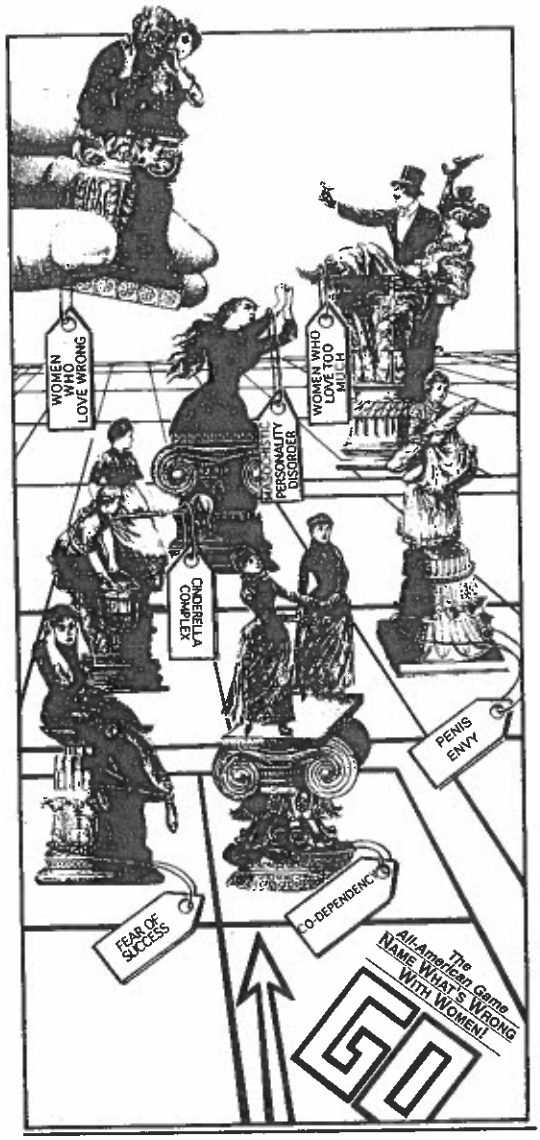
Problems with Psychiatric Labels

The popularity of psychiatric labeling has not gone uncritiqued (e.g., see Thomas Szasz's many books). In *Follies and Fallacies in Medicine* (1998), Skrabanek and McCormick suggest that "because there is no need to confirm diagnosis by strict, objective criteria, psychiatry is at a particular risk of creating diseases" (p. 79). They suggest that the use of "Latin and Greek helps to reify dubious entities" (p. 79) and that a knowledge of Greek "is particularly useful in describing new diseases: silurophobia, fear of cats; kynophobia, common in postmen, fear of dogs; iatrophobia, often understandable, fear of doctors; phobophobia, fear of fear" (p. 84). Skrabanek and McCormick argue that new terms for diseases may serve as a camouflage for a lack of understanding. "By pronouncing Greek or Latin, the doctor pretends to be in charge of the daemon of disease" (p. 85). "As doctors [social workers too?] are generally uncomfortable about exposing their ignorance, there is a temptation to 'diagnose,' to label inappropriately, to create non-diseases. Although attaching dubious labels may be rationalized as response to patient need, too often the label becomes firmly attached" (p. 86). Training in use of the DSM increases use of mental disorder judgments (Pottick, Wakefield, Kirk, & Tian, 2003).

The American Psychiatric Association claims that its classification system is based on scientific evidence. However, critiques raise doubts about these claims (e.g., see Houts, 2002; Kutchins & Kirk, 1997). The enormous success of the DSM is remarkable, given the questionable reliability and validity of psychiatric diagnoses. In *The Selling of DSM* (1992a), Kirk and Kutchins (both social workers) discuss the role of political and economic considerations in the creation and "selling" of the DSM and document reliability and validity problems with this system. These include the consensual nature of what is included (agreement among individuals is relied on rather than empirical criteria), lack of agreement about what label to assign clients (poor reliability), and lack of association between a diagnosis and indications of what plans will be effective (see Exhibit 12.7).

Research suggests that client ethnicity, race, or

EXHIBIT 12.6
The All-American Game: Name What's Wrong with Women!



Source: C. Tavris (1994), The illusion of science in psychiatry. *Skeptic*, 2, 79. Reprinted with permission.

EXHIBIT 12.7
Problems with Psychiatric Labels

Are typically vague, resulting in low reliability.
Lack validity.
Do not offer information about how to resolve problem.
Are often used for reasons that benefit professionals rather than clients (reimbursement, creation of an aura of expertise).
Pathologize clients.
Are based on shifting consensual grounds.
May discourage search for environmental causes.
Are used for social control purpose.
May encourage behavior in accord with the label (argued by labeling theorists, e.g., Scheff, 1984).
Give an illusion of understanding the causes of problem.

characteristics (such as obesity) influence helpers' views of psychiatric concerns (e.g., Garb, 1997). Some writers argue that psychiatric classification systems trivialize human problems in living and encourage blaming victims for their plights rather than examining the social circumstances that are often responsible. Many scholars argue that labels, such as "mental illness," are used for social control purposes and often result in harming rather than helping people (e.g., Szasz, 1994). Consider labels such as *drapetomania* (an irresistible propensity to run away). This "disease" was alledgely common among slaves in the southern United States in the past. Hobbs (1975) suggests that: "Categories and labels are powerful instruments for social regulation and control, and they are often employed for obscure, covert, or hurtful purposes: to degrade people, to deny them access to opportunity, to exclude 'undesirables' whose presence in some way offends, disturbs familiar custom, or demands extraordinary effort" (p. 11). Status offenders have been labeled as mentally ill and confined, without due process, to inpatient psychiatric and chemical dependency units of private hospitals (Schwartz, 1989). (The term *status offender* refers to youths who fall under juvenile court jurisdiction because of conduct prohibited only because of their juvenile status, e.g., disobedience, curfew violations, running away, and truancy.) Ira Schwartz (1989) argues that reasons include insurance policies favoring inpatient care, widespread advertising describing residential treatment centers, lack of community-based services for status offenders who cannot be confined in juvenile correctional institutions, and too many hospital beds. He refers to this relabeling of typical teenage behavior as mental illness as "the medicalization of defiance." Increasing concern has been raised regarding the relentless medicalization of problems as discussed in chapter 6.

Howitt (1992) contends that labels given to clients often obscure lapses in agency services that create problems (e.g., via false assumptions due to uncritical thinking). Many social workers believe there are serious misuses of the DSM, including assigning an inappropriate diagnosis simply for reimbursement reasons (Kirk & Kutchins, 1988). Thomas Szasz (1961, 1987) has been the most persistent and cogent critic of the very concept of mental illness, arguing that this is a rhetorical device (a metaphor) obscuring the difference between real diseases (e.g., syphilis) and troubling behaviors. Diagnostic labeling implies the need for specialists to help people with their problems. As more and more behaviors are assigned a label, the mental health industry can grow ever greater (Moynihan, Heath, & Henry, 2002). Key conceptual questions (such as "What is mental illness?" "What is a disease?" "What is a disorder?") are often glossed over.

Psychiatric labels are stigmatizing. They say too little about positive attributes, potential for change, and change that does occur and too much about presumed negative characteristics and limits to change. People labeled are often regarded as if they possess only the characteristics of a category (e.g., "schizophrenic").

> Few options for change are generated by an assessment that regards Mary to be an "inadequate personality." . . . [T]his kind of diagnosis doesn't indicate what needs to be changed. The vagueness of the label can prevent us from knowing when that label is no longer deserved or appropriate. It will be difficult for Mary to prove her labelers wrong. If we deal with the specifics of the children being clean, going to the doctor if they have earaches, and receiving proper nutrition, the directions for change become clear. It will also be clear to everyone when the problems are resolved. (Kinney, Haapala, & Booth, 1991, p. 86)

Labels often do not reflect changes that take place. That is, even though changes may be made, the same label (e.g., "developmentally disabled") may be applied to a client. Labels often provide an illusion of understanding. You may think you know more about how to help a client (or discover that you cannot), but in fact know nothing more about the client's concerns, the factors related to them, and how to attain desired outcomes (see earlier discussion of circular accounts). Accepting a label may prematurely close off consideration of prom-

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ising options. Labels that limit exploration do not have to be fancy ones like *hyperactive* or *paranoid;* they can be everyday ones like *old lady.* The tendency to use an either/or classification system (people either have or do not have something, e.g., being an alcoholic or not) obscures varied individual patterns that may be referred to by a term.

Although they may sound sophisticated, too often labels offer few if any guidelines about what to do to resolve problems. Keep in mind that in the introduction to the DSM (2000), it states that diagnostic labels say nothing about etiology nor offer guidelines for selection of services. Psychiatric labels are descriptive, not explanatory (see introduction to the DSM, 2000). Just how descriptive they are in terms of clarity is another question. From a behavioral point of view, most are quite fuzzy. Neither trait nor diagnostic labels offer enough detail about what people do in specific situations and what personal and environmental events influence their behavior to be of value in clarifying problems and related factors. The individual variability of behavior is overlooked, resulting in lost opportunities to discover unique relationships between a client's behavior and his or her environments. Dispositional attributions shift attention away from observing what people do in specific situations to speculating about what they have done. General predictions about a person based on tiny samples of behavior in one context are not likely to be accurate, especially when behaviors of interest occur in quite different situations.

Within labeling theory, the label itself is considered to be partially responsible for deviant acts (Scheff, 1984). For example, applying labels such as *delinquent* or *shy* may encourage behaviors that match this label and hinder change. A client who has trouble making friends may think of himself as shy and may use this label as an excuse not to initiate conversations. An adolescent labeled *delinquent* may begin to think of himself as a "delinquent" and so engage in other acts compatible with this label. Labeling is viewed as a behavior that varies from culture to culture, from person to person, and from time to time. This point of view is very different from a psychiatric one, in which there is a search for a correct diagnostic label for a client.

Evidence-Based Diagnosis?

The term *diagnosis* refers to accurately identifying the cause(s) of symptoms of an individual. Evidence-based diagnosis can be defined as the use of certain symptoms and signs (feeling hot and having a fever as determined by a thermometer) to identity an underlying condition (a bacterial infection). Such a diagnosis is evidence-based in two senses: (1) the signs and symptoms accurately indicate the underlying condition, and (2) accurate identification of the underlying condition points to an effective remedy (e.g., antibiotics). (See also discussion of appraising research regarding diagnostic measures in chapter 11.) Let us say you have a persistent cough. A guess on the part of your physician that you have pneumonia can be checked by obtaining an X-ray. This example illustrates that in medicine, we often have both signs (an X-ray) and symptoms (complaints of a cough). Is this true of psychological concerns such as depression and anxiety? The answer from psychiatry is yes. It is assumed that symptoms (for example, anxiety in social situations) reflect an underlying disorder (or dysfunction). But what signs do they use? A "sign" is defined as "an objective manifestation of a pathological condition. Signs are observed by the examiner rather than reported by the affected individual" (DSM-IV-TR, 2000). Observed behaviors are used as signs. A social worker observes that a person appears nervous—they sweat, they tremble. Consider Judy, who was referred to a counselor because of social anxiety. She reported being nervous around people and having difficulty approaching them and that this got in the way of making friends. A psychiatric narrative here would argue that Judy has a mental illness (social anxiety). This "diagnosis" would be based on her symptoms (self-reported complaints), the clinician's observation that she appeared nervous in social situations, and perhaps responses on a self-report measure (the Social Anxiety Inventory). Now how does this situation differ from seeing a doctor because of a persistent cough? There are things that are called signs, such as scores on a social anxiety inventory, but there are no signs of biochemical or anatomical dysfunction. The term *disease* is used as a metaphor here. This is why Thomas Szasz refers to such uses as rhetorical—a concept (disease-like) is reified into an alleged reality. There has been an intense interest in identifying possible brain differences in people showing a certain pattern of behavior, for example, by using brain imaging. Some claim that genetic and biochemical differences have been found. Critics argue the opposite. The latter note, for example, that correlations do not causations make. (See later discussion of biomedical factors.)

Diagnoses are also used as summary terms to refer to a number of behaviors, thoughts, or feelings thought to be related (and referred to as a particular diagnosis, such as social phobia or conduct disorder). Such terms are useful to clients and professionals only if they do more good than harm, for example, suggest common causes based on research findings and suggest promising intervention options (or their lack). For example, does a given diagnostic category represent a "syndrome" (a cluster of symptoms) that can be distinguished from others? Does a given label differ from others "with respect to basic features that are external to the behaviors that define the hypothesized diagnostic construct. . . . Such correlates might include genetic influences, neuropathology, biological indices, course and response to specific treatments" (Fombonne, 2002, p. 59). Diagnostic labels may also be valuable in communicating among different professionals.

Now where does this leave us regarding our question "Are there evidence-based diagnoses in the interpersonal helping professions?" How does this question apply, for example, to depression and anxiety? Here we have symptoms without signs—that is, there is no independent objective indicator of the alleged underlying pathology. It is here that differences arise between a contextual assessment and a psychiatric diagnosis. These are competing grand narratives as some would say. The answer depends on whether you accept helper-observed signs as indicators of biochemical dysfunctions. The hundreds of alleged "mental disorders" in the DSM are based on consensus—agreement among alleged experts. There is according to the DSM, no implications of etiology or selection or intervention based on a diagnosis (see DSM, 2000). However, in other contexts, the behaviors included therein are assumed to be mental disorders—even enuresis.

Diagnosis and Assessment: Not an Either/Or Matter

From an evidence-informed point of view, diagnosis and assessment are not either/or endeavors. Providing a diagnosis for clients is a requirement for third-party payment. This does not mean that you cannot or should not carry out an evidence-informed contextual assessment describing, for example, personal and environmental factors that create risks and contribute to resilience. Thus, you can satisfy the requirements of your agency for diagnosing a client and still carry out your responsibility for completing an evidence-informed assessment drawing on relevant research findings about what factors may, for example, create risks or contribute to resilience.

The Relationship Between Risk, Protective Factors, Diagnosis, and Prognosis

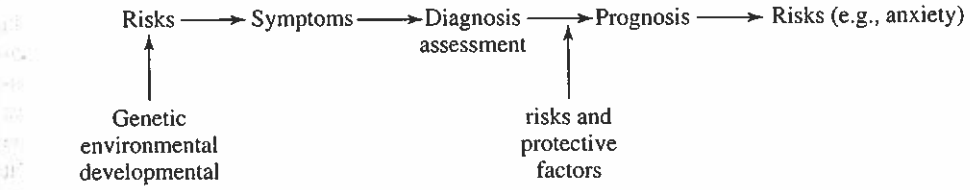
A diagnosis precedes a prognosis. For example, a client may be diagnosed with depression and then, based on the assessment picture associated with this diagnosis, receive a certain prognosis. You may, for example, based on related research findings, predict that a client will have recurrent bouts of depression—that is, you may make a prognosis. Both protective and risk factors enter at many points in this process. They enter prior to a diagnosis; for example, certain people are prone to depression. They also enter following a diagnosis; certain environmental factors such as social support may make a prognosis positive. This is a recursive process. The relationship among these factors is illustrated in Exhibit 12.8. This highlights the importance of knowledge about research findings regarding risk and protective factors and skill in critically appraising related research as well as research related to diagnoses and prognoses and understanding the relationship among these factors.

What About P-I-E?

The National Association of Social Workers helped fund the development of a new classification system. Person-In-Environment (PIE) (Karls & Wandrei. 1994). Although its creators argue that it is useful, others believe that the same concerns that apply to the DSM apply as well to P-I-E, such as a lack of validity (e.g., see Kutchins & Kirk, 1997).

Labels that are instrumental (i.e., they point to effective plans or indicate accurately that there are no effective options) are helpful. Recognizing signs of pathology is important if this increases understanding of what can be accomplished and how. Some elderly clients do have dementia. Labels can normalize clients' concerns. Parents who have been struggling to understand why their child is developmentally slow may view themselves as failures. Recognizing that their child has a specific kind of developmental disability that accounts for this can be a relief. Failing to use labels may prevent clients from receiving appropriate help. Consider the Japanese custom of labeling clients

EXHIBIT 12.8
The Relationship Between Risk, Protective Factors, Diagnosis, and Prognosis



as *neurasthenic* to protect them and their relatives from the social stigma associated with mental illness. Munakata (1989) suggests that the use of such a "disguised diagnosis" given to the pilot was responsible for the 1982 crash of an airliner in Tokyo. The pilot, who had hallucinations and delusions at the time of the crash, had a history of psychiatric problems.

MAKING ASSESSMENT OF VALUE TO CLIENTS

Assessment frameworks should help clients achieve valued outcomes. It is not very useful to carry out an assessment that offers few, if any, guidelines for resolving problems or for discovering that they cannot be resolved given current resources. You can make assessment of value by helping people to clearly describe desired outcomes and related factors. If problems remain vague (a teacher does not identify what she means by a student's "aggressiveness" or a supervisor does not identify what she means by staff's poor caregiving skills), it will be difficult or impossible to identify specific problem-related behaviors and associated causes. If maintaining conditions are not identified, plans may be misdirected. Focus on collecting data that decrease uncertainty about how to attain outcomes that clients value. Collecting irrelevant data wastes time and money and increases the likelihood that you and your clients will be misled by irrelevant material. Assessment should offer clients more helpful views of their problems, a more helpful vocabulary for describing problems and options, and a model of how to break down a problem into manageable parts.

Another way to make assessment of value is to attend to client assets: to help clients to identify what they like about themselves and significant others, what is going well in their lives, and what they can contribute. As Webster-Stratton and Herbert (1994) emphasize: "The essential goal of our collaborative therapy is to 'empower' parents by building on their strengths" (p. 118). They emphasize the importance of exploring and validating parents' ideas and opinions, acknowledging and validating their frustration and anger regarding difficult situations and helping parents focus on the successes in managing their child's behavior. Relationship skills such as empathy, warmth, and genuineness contribute to enhancing positive expectations and encourage hope, a vital aspect of helping (see chapter 15).

Social Workers as Consultants Involved in a Collaborative Process

Social workers often help mediators (e.g., parents, teachers, residential or agency staff) acquire knowledge and skills to address problems with their significant others (e.g., children, students, residents, or other staff). Potential sources of support for mediators include the person with the presenting problem, others they see, and the consultant (you). The term *consultation* highlights the collaborative nature of helping relationships, including the joint decision-making process that is ideally involved in practice. Clients and significant others make decisions about whether to share or collect data, whether to carry out assignments, what plans are suitable, and whether they are satisfied with outcomes of service. You should do your best to encourage helpful actions, but clients and significant others play a key role in what results.

CRITICALLY APPRAISING ASSESSMENT FRAMEWORKS

Assessment frameworks differ in what is focused on and in the degree to which they can be and have been critically tested. They differ in how compatible they are with empirical data describing how behavior develops, changes, and is maintained and

how successful they are in suggesting valuable interventions. History suggests that some approaches are more successful than others (see for example Gamwell & Tomes, 1995). The complexity of many problems highlights the value of a multilevel contextual analysis (see Exhibit 12.9). Assessment frameworks are more likely to be useful if they take advantage of knowledge about factors related to behaviors of concern and the accuracy of different kinds of data. Frameworks should be instrumental, that is, help clients achieve valued outcomes. If maintaining conditions are not identified, plans may be misdirected. Focusing solely on personal characteristics may result in "psychologizing" rather than helping clients. Focusing solely on environmental characteristics may result in overlooking individual characteristics that influence problems of concern.

Critical appraisal of assessment frameworks can help us to discover the extent to which different views enhance the likelihood of selecting effective plans. Thinking critically about our beliefs about behavior and how (or if) it can be changed can help us to identify underlying assumptions related to different views and their possible consequences, for example, psychiatric and social learning views. It can help us to spot values about what people should do (e.g., take a certain screening test) disguised as scientific guidelines (e.g., McCormick 1996; Moynihan, et al., 2002; Thornton, Edwards, & Baum, 2003). Assessment frameworks differ in their vulnerability to certain kinds of errors. Approaches that focus on alleged pathologies of clients may result in overlooking valuable resources, such as caregiving skills. Such approaches can be contrasted with an individualized assessment that includes attention to client assets (such as alternative behaviors that compete successfully with undesired behaviors) and to environmental resources (such as sources of social support) (e.g., see Follette, Naugle, & Linnerooth, 1999; Goldiamond, 1984; Meyer & Evans, 1989). Such an assessment encourages a contextual understanding of problems and their possibilities.

CHARACTERISTICS OF A CONTEXTUAL EVIDENCE-INFORMED ASSESSMENT

The characteristics of a contextual, evidence-based assessment include the following:

1. Individually tailored as needed.
2. Use of assessment frameworks and methods

EXHIBIT 12.9
Contextual Assessment: Honored in Words and Ignored in Practice

Alessi (1988) points out that behavior and learning problems in school may be associated with one or more of five broad areas: (1) the child may be misplaced in the curriculum or the curriculum may contain faulty teaching routines; (2) the teacher may not be using effective teaching and/or behavior management practices; (3) the principal and other school administrators may not be using effective school management practices; (4) the parents may not be providing the home-based support necessary for effective learning; and (5) the child may have physical and/or psychological problems that may be contributing to the learning problems (see Alessi [1988] for supporting references).

To find out whether school psychologists consider these multiple influences, Alessi asked several groups of school psychologists (about 50 in each), in different areas of the country, whether they agreed that each of these five factors played a primary role in a given school learning or behavior problem. They almost always agreed. He then asked for the number of cases each psychologist had examined in the past year to determine the source of learning problems. The answer was about 120. Rounding this to 100 and multiplying by 50 yielded about 5,000 cases studied by the group in the past year. Next, Alessi asked how many of their psychological reports concluded that the referred problem was due primarily to one of these factors. For curriculum factors, inappropriate teaching practices, and school administrative factors, the answer was none. For the parent and home factors, the answer ranged from 500 to 1,000 (10 to 20%). When he asked how many of their reports concluded that child factors were primarily responsible for the referred problem, the answer was 100%.

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3. A preference for testing inferences.
4. A focus on clients' assets rather than their deficiencies.
5. A focus on the present.
6. Attention to contingencies on interrelated system levels.
7. A clear description of problems and desired outcomes.
8. A preference for observation (seeing for yourself).
9. A clear description of assessment methods.
10. A close relationship between assessment and intervention.

A contextual framework decreases the likelihood of errors, such as emphasizing people's deficiencies rather than their strengths, neglecting environmental causes and resources, and choosing outcomes that will not resolve problems. It encourages a broad review that may reveal leverage points otherwise overlooked.

Individually Tailored Assessment

Individualized assessment does not mean you focus on individuals as the locus of problems. It means that whether individuals, families, groups, communities, or organizations are involved, a careful assessment may be required, including an understanding of each person's unique environment including the functions of problem-related behaviors. This includes an assessment of the client's motivation. Why should clients and/or significant others participate? What objections might they have? (see chapter 14). Although we talk about the importance of "starting where the client is" and respecting individual differences (including cultural differences), we may not do so (see Exhibit 12.9). For example, detailed information about behaviors of concern and related circumstances based on observation in real-life settings may not be collected even when this is needed to understand problems and related circumstances and it is feasible and ethical to do so. Individualized assessment avoids the "patient uniformity myth" in which individuals, families, groups, or organizations are mistakenly assumed to be similar (Kiesler, 1966; Wolpe, 1986). Indicators of this myth are:

- Speculating about the causes of problems without checking beliefs against data gathered in real-life settings.
- Using vague labels and description of problems.
- Stereotyping (talking about clients as if they were the same as all other members of a group)

An individualized, contextual assessment decreases the likelihood of errors, such as focusing on people's deficiencies and ignoring their strengths, ignoring important cultural differences, neglecting environmental causes and resources, misinforming clients concerning the evidentiary status of recommended assessment methods, and focusing on outcomes that will not resolve problems. Attending to the unique circumstances and characteristics of a client, including their values and preferences, is a hallmark of evidence-based practice (e.g., see Sackett et al., 1997).

Use of Assessment Frameworks and Methods That Have Been Critically Tested and Found to Be of Value

Assessment is more likely to help you and your clients to make informed decisions if you use assessment methods that provide accurate information and frameworks that have been tested and found to be of value in helping clients attain outcomes they value. This will require familiarity with the evidentiary status of different assessment frameworks and methods as reflected in the scientific literature (see earlier discussion of critically appraising assessment frameworks). You may find a particular assessment model very interesting, even though, compared to others, it has not been found to help clients. Or its value may not have been systematically explored. A focus on helping clients requires asking, "What framework has been found to be of greatest help in achieving hoped-for outcomes?" Sources of information differ in their accuracy. Self-report may not reflect what occurs in real life. Observers may be biased. Validity is a concern in any kind of assessment, however, the nature of the concern differs in sign and sample approaches. In a *sign approach* to assessment, behavior is used as a sign of some entity (such as personality trait) at a different level. The concern is with vertical validity. Is the sign an accurate indicator of the underlying trait? In a *sample approach* different levels (such as behavior and personality dispositions) are not involved. Questions here are: (1) Does self-report provide an accurate account of behavior and related circumstances? (2) Does behavior in role play reflect behavior in real life? (3) Do changes achieved remove complaints? Different kinds of reliability and validity are discussed in chapter 17. Some practice frameworks

have been well tested regarding their value in helping clients, for example, cognitive behavioral methods and applied behavior analysis. Others have not. This does not mean that they are not helpful; it means that their evidentiary status is unknown.

A Preference for Testing Inferences

Unexamined speculation may result in acceptance of incomplete or incorrect accounts of problems. Consider a social worker who saw a family because the mother was concerned about her 10-year-old child's behavior at school. The social worker believed that the child's "misbehavior" in class occurred because the mother's boyfriend had left her and the child was upset about it. The social worker did not observe the child in the classroom or obtain any information about her academic progress. I asked the social worker when the boyfriend had left the mother, and she said he left 8 months before the problems at school started. According to the mother, the child's problems at school started in the last month. The social worker reported that because the child was no longer worried about the boyfriend's leaving (this change was not explained) and because classroom behavior was no longer a problem (no evidence was provided for this claim), she decided not to work on the problem that had brought the mother to the clinic but to offer her supportive counseling for herself.

What are some of the inferences here? One is that the child was indeed misbehaving in class. This inference should have been tested for its accuracy, for example, by observing the child in her classroom. Since the social worker never observed the child in the classroom, we do not know whether or not this was true (or if this child misbehaved any more or less often than did other children in the class). Speculation was relied on when observation was called for. Untested speculation can get in the way of translating problems into outcomes that, if achieved, would resolve problems. For example, if you limit your source of information to a teacher's report about an "unmanageable child," you may mistakenly assume that (1) the child's behavior is unmanageable; (2) it is worse than that of the other children in the classroom; and (3) the causes of behavior can be discovered by relying on the reports of significant others (e.g., teachers). This is a classic example of "working in the dark." Another inference is that the child misbehaved in the classroom because the mother's boyfriend had left. There is little evidence on which to base this and some counterevidence as well (the time lapse between the boyfriend's leaving and the start of the alleged misbehavior). Parsimonious accounts that involve limited inferences (they are closely tied to concrete data) are easier to test than those that include many, perhaps conflicting, theories. A key advantage of evidence-based practice is encouraging you to question your assumptions by consulting related research findings (see Exhibit 12.10). Kinds of inferences questioned in a contextual, evidence-based assessment include the following:

- About the frequency of a problem.
- About related contextual factors.
- About the accuracy of assessment measures.
- About the accuracy of different practice frameworks.

An Emphasis on Clients' Assets Rather Than Their Deficiencies

There is an emphasis on helping clients acquire valuable knowledge and skills. Arthur Schwartz (a social worker) and Israel Goldiamond (a psychologist) combined their efforts to create guidelines for a strength-oriented practice framework (*Social Casework: A Behavioral Approach,* 1975). Behaviors of interest may be related to fulfilling roles (e.g., parent, husband, wife, daughter, or employee). Consider adult children caring for an elderly relative in their home. Valued behaviors include reinforcing independent behaviors on the part of the elderly relative, providing opportunities for recreation and social contacts, arranging timeouts from caregiving responsibilities, planning shared positive events among family members, and constructive problem solving to address concerns that arise. Emphasizing the *construction of repertoires* has many advantages. First, you are less likely to pathologize people. Second, it encourages

EXHIBIT 12.10
Testing Assumptions: Is It True?

- Joan, a school social worker, was taught by her supervisor that observing in the classroom was a waste of time because it was impossible to gather accurate information because of the students' focus on the observer.
- Ralph preferred to use a n-grams to understand the personality of his clients.
- Pat relies on genograms to help her to understand families.
- Robert relies on transactional analysis to understand factors related to presenting problems.

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a search for positive alternatives to unwanted behaviors, especially those that are functional (enhance opportunities for reinforcement in real-life contexts). Increasing alternative positive behaviors is often the most effective way to decrease unwanted behavior. (See discussion of linear and systemic contingency analysis in chapter 13.) Third, attending to clients' assets helps them focus on their strengths and to use them to pursue valued outcomes.

Focus Is on the Present

There is a focus on present concerns and related factors. The biopsychosocial approach favored in social work emphasizes current problems and circumstances. This is also true of ego psychological and behavioral approaches. The circumstances in which a reaction originally developed, such as a fear of crowds, may be different from those that currently maintain this fear. Perhaps the fear is now maintained by attention from significant others and by the avoidance of disliked tasks, such as shopping. Understanding problems often requires an overview of the client's current life, including relationships with significant others, employment, physical health, recreational activities, and community and material resources, such as housing and income. What is a client's typical day like? Does she like her work? Does she have any friends? How is her physical health? Whom does she live with? Are circumstances in any of these areas related to desired outcomes?

What About Past History?

Although all practice perspectives recognize the role of past history in influencing thoughts, feelings, and behavior, they differ in how much attention is given to the past and what is focused on (e.g., feelings, thoughts, or actual experiences). More traditional psychoanalytic practice devotes greater emphasis to helping people understand (gain insight into) their past experiences and the relationship of these experiences to their present behavior. In a behavioral perspective, past history is assumed to be reflected in current behavior, feelings, and thoughts. The influence of the past is suggested by research in many areas. This does not mean that later change is not possible (e.g., see Reid, Patterson, & Snyder, 2002). Information about the past allows you and your clients to view current events in a more comprehensive context (Wolpe, 1990). Major areas include medical history, educational and work history, significant relationships, family history, and developmental history. Helpful coping skills may be discovered by finding out what clients have tried in the past to resolve problems. You may discover valuable information about possible reinforcers or unusual social histories related to problems.

Demographic indicators reflecting past behavior and social competence, such as work history and marital status, are better predictors of future behavior than are personality tests or clinical judgments (Dawes, 1994a). The more that past situations resemble current ones, the more informative data about the past may be in predicting future behavior. Knowledge about past contingencies may be of value when it is difficult to identify current maintaining factors and may be helpful in predicting future problems (keeping in mind that current maintaining conditions may differ from those present when a behavior was established). Although effective intervention does not require discovering a problem's historical causes, understanding how problems began may clarify the origins of behaviors of interest. New ways of viewing past events may be helpful.

Information about the past may encourage clients to alter present behaviors and increase understanding of current reactions. A client with low self-esteem may understand how past discrimination based on gender or race resulted in limited opportunities for mastery experiences. Helping clients to understand the effects of the political on the personal is key in feminist counseling. A client may be willing to learn and use positive communication skills if she sees how negative reactions resulted in the loss of valued consequences in the past. Disadvantages of excessive focus on the past include offering clients an excuse for not addressing problems and slowing down progress in removing complaints. Excessive attention to past troubles may create pessimism about the future and encourage rationalizations and excuses that get in the way of solving problems. Furthermore, the clients' descriptions of past events may not be accurate.

Contingencies Are of Interest

A contingency analysis involves describing the context in which problems occur (i.e., the relationships between behavior *in real-life settings* and what happens right before and after), including alternative behaviors that, if increased, would compete successfully with undesired behaviors. For

example, rather than focusing directly on undesired behavior (e.g., eating and binging), Israel Goldiamond (1984) helped a client take advantage of naturally competing activities, such as enriching her social life. This kind of nonlinear analysis often reveals effective ways to resolve problems.

Considerable advances have been made in some areas in identifying problem-related contingencies. For example, assessment protocols have been developed to identify the cues and consequences related to self-injurious behavior of children (Luiselli, Matson, & Singh, 1992). This is truly "starting where the client is." Discovering options for attaining valued outcomes may require a multilevel contingency analysis of agencies and residential settings, including supervisory and administrative practices. This will often reveal competing contingencies that interfere with attainment of valued goals. Some of the myths and misconceptions about contingency analysis are as follows:

- It's easy.
- I can do it sitting in my office.
- Thoughts and feelings are not considered.
- It dehumanizes people.
- The helper–client relationship is not important.

The interest in behavior and related circumstances calls for the translation of problems into observable behaviors and the discovery of options for rearranging the environment.

A *descriptive analysis* involves identification of problem-related behaviors and associated setting events, antecedents, and consequences. Helpful questions to ask when trying to identify influential variables are: What does this behavior communicate? What is its "meaning"? Behaviors have a communication function. They communicate a desire for or a dislike of something. Accurate description of contingencies will help you to select effective methods to change them. For example, the methods required to decrease self-injurious behavior will differ, depending on whether this behavior is maintained by positive reinforcement (e.g., attention from adults) or negative reinforcement (e.g., escape from difficult tasks). An accurate description will help you avoid victim blaming (attributing the cause of problems to the client when the causes lie in the environment). Accounts that do not include a description of problem-related environmental contingencies are incomplete ones that may interfere with the discovery of options. A *functional analysis* requires demonstration that certain antecedents and/or consequences influence behaviors of interest. This involves the systematic variation of selected variables (e.g., certain consequences), noting changes that occur.

The focus on contingencies has a number of implications for assessment. One is observing people in real-life contexts when it is feasible, ethical, and necessary to do so to clarify problems and their causes. A second is an emphasis on collecting information about individuals. Information about group differences does not offer information about what an individual does in specific situations and what cues and consequences influence his or her behavior, although it may offer clues about how an individual may react. Clients are encouraged to recognize and alter the role they play in maintaining problems. For example, teachers and parents often reinforce behaviors they complain about. If you play a role in creating and maintaining problems, you can play a role in resolving them. This is not to say that clients can alter societal conditions related to their problems. Clearly the homeless are in no position to change conditions related to their plight, such as shortages of affordable housing. It is to encourage you to give clients as much influence as possible over the quality of their lives. Achieving community and societal change will require efforts at many levels, including community organizing, coalition building, and seeking changes in legislation.

The Importance of Consequences

The consequences that follow behavior affect its future probability. (See chapter 7.) A contingency analysis often reveals that desired behaviors are ignored and undesired ones are reinforced (see Exhibit 12.11). Studies of residential centers show that contingencies often are counterhabilitative rather than habilitative; they discourage indepen-

EXHIBIT 12.11
Consequences of School Attendance

Parent's point of view		
	[C°	No benefits in having educated children.
B——	[C−	Children treated poorly by teacher.
	[C−	Work at home remains undone.
Child's point of view		
	[C°	Teacher often absent.
	[C°	Inadequate teacher; little is learned.
B——	[C°	No use for what is learned.
	[C−	Required to be a servant.
	[C−	Treated as an inferior.

dence and client engagement (Meinhold & Mulick, 1990). Policies and procedures may contribute to the neglect and abuse of residents (Favell & McGimsey, 1993). Significant others may not realize that they are maintaining the very behaviors they complain about through the consequences they offer (e.g., attention); what they believe are positive reinforcers may have the opposite effect (punish behavior).

Different Kinds of Consequences

Behavior is affected by many kinds of consequences, including reactions from significant others, changes in the physical environment, and physiological changes. Consider test anxiety. The term *anxiety* may refer to physiological changes (increased heart rate), to related thoughts (worries about failure), and/or to behaviors (avoidance of test situations). Taking a test may be followed by negative self-statements (thoughts), increased muscle tension (physical changes), and social consequences (parents calling and saying, "I hope you did as well as your brother did"). An alternative set of consequences might be positive self-statements for a job well done or anticipation of a high grade; a friend suggesting, "Let's go out on the town tonight and celebrate"; and a pleasant tiredness from a job well done.

The sum total of consequences that follow a behavior has been called the *reinforcing event* (Tharp & Wetzel, 1969). This may be mostly positive, mostly negative, or balanced. Behaviors are often followed by more than one change in the environment. For example, drinking alcohol may be followed by increased physical relaxation (a positive consequence) and a decrease in anxiety-provoking thoughts (the removal of a negative event). Discovering the function of a behavior (its effects on the environment) may be difficult when it is followed by both punishment and reinforcement. In these instances, strong behavior may be observed only indirectly because it is displayed in only indirect forms (Ferster, 1972). You may, for example, want to talk to someone you are attracted to but approach the person indirectly because of a fear of rejection. Drawing a diagram of consequences related to behaviors of interest may be useful when exploring contingencies. Consider the example of school attendance described by Kunkel (1970, p. 147). The diagram in Exhibit 12.11 shows that there are no positive consequences for attendance (C+). There are negative consequences (C−) and often a lack of any effects (C°). No wonder school attendance was low in this community!

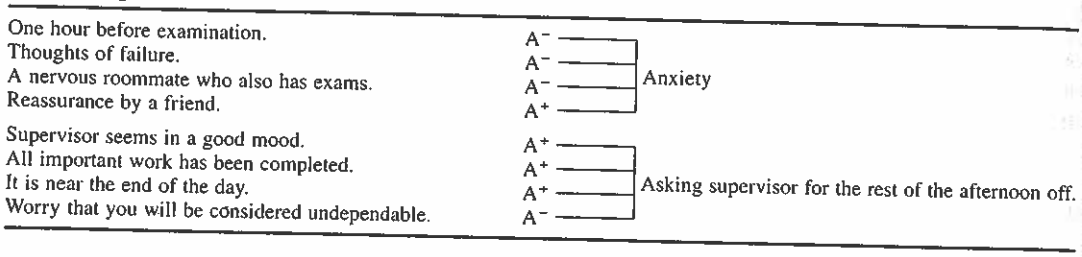
The Importance of Antecedents

Behaviors tend to occur in the situations in which they are reinforced. Cues associated with reinforcement increase the probability of behaviors reinforced in their presence, whereas cues associated with punishing consequences (i.e., behavior is punished in their presence) decrease the probability of behaviors punished in their presence. Brian found that when the dog began to snarl, he might get bitten (see case example in chapter 13). When this happened, he stopped teasing the dog. Snarling was a cue that continued teasing may result in a nasty bite. We usually say hello only when there is someone present. Their presence is the antecedent for saying hello. An elderly resident of a retirement home may snap at the staff when she is asked to carry out a task that is too difficult for her. Disliked reactions may occur because a person is uncomfortable or bored or is asked to do something with little notice in an unpleasant way. In these instances, altering antecedents (sometimes other people's behavior) may correct the problem. One goal of assessment is to identify antecedents that influence behaviors of interest.

Like consequences, antecedents have a variety of sources. If you are relaxed during written examinations, you may think about past successes, share reassurances with a friend, and feel rested after a good night's sleep. If you are anxious, you may anticipate failing (cognitive cue), have had a telephone call from your parents reminding you how important it is to pass the exam (social cue), and be tired from staying up all night (physiological cues) (see Exhibit 12.12). We may make past or future events current by thinking about them, and they in turn influence what we do, feel, and think. The sum total of antecedents related to a behavior can be termed the *antecedent event*. This may increase or decrease the probability of the behavior in the future.

Identify high-risk situations for problematic behaviors. Common antecedents for disruptive behavior of developmentally disabled children and youth can be seen in Exhibit 12.13. Notice that some are demand-based (disruptive behavior occurs when an instruction or demand is given and succeeds in getting rid of unwanted tasks). What are low-risk situations (those in which problematic behavior rarely occurs)?

EXHIBIT 12.12
Reviewing Antecedents



Rearranging antecedents (stimulus control) is one way to change behavior (see chapter 25). *Setting events* are a kind of antecedent that is closely associated with a behavior but is not in the immediate situation in which behaviors of interest occur. For example, because of an unpleasant exchange with his teacher before coming home, a child may respond angrily to a request by his parents. The setting event alters the likelihood of certain reactions in later situations.

Clear Description of Problems and Outcomes

Only if complaints and related setting events, antecedents, and consequences are clearly described can they be translated into specific changes that result in their removal. A focus on vague problems may prevent the discovery of related factors. If hoped-for outcomes are clearly described, it will be difficult to determine the actual frequency of behaviors of interest or to assess progress. The specific referents to which clients refer when using vague terms (such as *uncooperative, immature,* or *aggressive*) may differ. One person may define aggressive behavior as hitting, shoving, or slapping. Another person may include verbal responses such as yelling, shouting, and name-calling. Adults who are thought by many people to have been abused as children (e.g., they were beaten with straps and locked in closets for long periods) may not define this as abuse. They may say, "I was bad" or "I deserved it." Exhibit 12.14 gives examples of clearly described outcomes, and Exhibit 12.15 shows examples of presenting problems, their referents, and related outcomes. Focus on outcomes that succeed in removing complaints. Some can be identified early on, such as need for a different kind of housing, creation of a neighborhood mediation center, or day care for children. Additional information will often be required to identify specific outcomes related to problems.

A Preference for Observation

An interest in clearly describing problem-related behaviors and the circumstances in which they occur, as well as a preference for limited testable inferences, highlight the value of observing behaviors in problem-related contexts. Discovering the unique functions of behaviors of interest so that you and your clients can make informed selection of service plans may require observation in real-life settings. Self-report often offers incomplete or inaccurate account of behaviors and related circumstances. To understand problems you may have to complement armchair speculation with real-life exploration (seeing for yourself). Always ask: "Will my untested speculations help me to help my clients?"

Clear Description of Assessment Methods

Clear description of assessment methods fulfills one of the conditions for informed consent. If you clearly describe your methods, including the benefits and costs (e.g., false positives), your colleagues will be able to duplicate those that are successful, and your supervisors will be able to offer you better feedback. Clear description makes it possible to accumulate information about what works.

A Close Relationship Between Assessment and Intervention

Assessment should offer guidelines for selecting plans. It should help you and your clients discover "leverage points" for attaining valued outcomes. It should indicate (1) objectives that must be reached to resolve problems, (2) what must be done to

EXHIBIT 12.13
Examples of Antecedents of Disruptive Behavior

People	Places	Social Interactions
Specific staff	Novel places	Refusal of a request
New staff	On the bus	Given an instruction
Staff changes	School rooms	Requests to transition
Parent(s)	At work	Provocation by peers
Doctors	In the community	Peers' disruptive behavior
Specific peers	Bathrooms	Difficulty communicating
Female staff		Peers receiving attention
		Presentation of a task

Medical	Self-Created	Ecology/Atmosphere
Pre- and postseizure	After self-stimulation	Crowds
During illness	Moodiness	Noise
Drug side effects	Withdrawal	Absence of schedule
Prior to menses	Agitated behavior	Personal space violation

Source: C. Schrader & M. Levine (1994). *PTR: Prevent, teach and reinforce* (ch. 2, p. 3). San Rafael, CA: Behavioral Counseling and Research Center. Reprinted with permission.

achieve them, (3) how objectives can be pursued most effectively, and (4) the probability of attaining them given current resources and options.

IMPORTANT DISTINCTIONS

Three important distinctions are discussed in this section: (1) form and function, (2) motivational and behavior deficits, and (3) response inhibition and behavior deficits. Overlooking these may result in selection of ineffective plans.

Form and Function

The form of a behavior (its topography) does not indicate its function (why the behavior occurs). Identical forms of behavior may be maintained by different contingencies. Someone might run down the street because he is being chased by someone (whom you cannot see because he has not yet rounded the corner), because he enjoys running, or because he is hungry and lunch is waiting for him at home. Thus, running may be maintained by either positive or negative reinforcement or both. A client may drink alcohol to avoid worrying about unpaid bills, because he enjoys the resulting relaxed feeling, because it upsets his mother and he enjoys her discomfort, or for all these reasons. A child saying the word *toast* might be reading a word, or she may be hungry and this prompts her to say *toast* because this produced food on previous occasions. Or she might be telling her parents that there is no toast (Ferster, Culbertson, & Boren, 1975). Just as the same behavior may have different functions, different behaviors may have identical functions. Saying the word *toast,* banging on the table, or throwing cereal all may be maintained by attention from parents; that is, all three behaviors may belong to the same response class or operant. A behavioral analysis includes a description of behaviors of concern as well as evidence that specific antecedents and consequences affect them; thus it requires both a functional and a descriptive analysis.

Motivation Versus Behavior Deficits

When someone does not know how to perform a given behavior, he has a *behavior deficit.* When someone knows how to perform a behavior but is not reinforced on an effective schedule or is punished, she has a *motivation deficit.* If a desired behavior does not occur, its absence may point to either a behavior or a motivation deficit. Motivation and behavior deficits can be distinguished by arranging the conditions for the performance of a behavior. A client could be asked to role-play behaviors of interest and also asked whether she uses similar behaviors in other situations. If she does engage in desired behaviors in other situations, then she has a motivational deficit. If a client can perform a behavior if he is paid $500 to do so, motivation is the problem.

The distinction between motivational and behavioral deficits is important because different intervention methods are usually called for. Altering a motivational deficit requires rearranging con-

EXHIBIT 12.14
Examples of Outcomes at Different Levels of Intervention

Level	Examples
Individual	Increase parenting skills (e.g., giving clear instructions and offering positive feedback for accomplishments). Increase daily number of planned activities from zero to five.
Family	Increase weekly time spent in shared activities from 0 to 2 hours a week. Hold a 1-hour problem-solving session each week.
Group	Increase number of positive comments exchanged among group members from 0 to 2 for each group member. Increase percentage of group members who complete assignments. Increase leadership skills (e.g., suggest agenda items, refocus discussion on topics of interest).
Organization	Increase weekly positive comments given by supervisors to staff for valued behaviors from 0 to 2. Increase number of people who offer valuable suggestions at case conferences.
Community	Increase the percentage of residents involved in local planning from 5 to 20. Establish a neighborhood mediation board by December 30. Increase percentage of parents who attend parent–teacher meetings at school. Increase percentage of youth who help elderly residents with chores.
Service system	Increase percentage of agreed-on reports received on time. Increase positive feedback to staff for specific behaviors that contribute to service delivery. Increase percentage of successful referrals (those that result in receipt of requested service).

tingencies, but there is no need to establish a behavior, although prompts such as verbal instructions may be needed. If a behavior deficit is the problem, then new behaviors must be established, perhaps by model presentation or shaping (see chapter 24).

Motivation deficits are often mistaken for behavior deficits. A teacher may say that a student does not know how to do addition problems, or a husband may say that his wife does not know how to talk to him about his work. The student and the wife may not use these behaviors because they are not reinforced.

Response Inhibitions Versus Behavior Deficits

Emotional reactions may interfere with desired behavior. For example, a client may not initiate conversations, not because he does not know how to, but because of social anxiety. Role playing can be used to find out whether required skills are available (see chapter 18). If they are, then interfering factors can be sought (e.g., anxiety, lack of knowledge about when to use skills, lack of reinforcement, and/or punishment). A disruption of behavior may suggest that the behaviors were easily disruptable to begin with. Anxiety, for example, "is not so much a thing of itself as it is a general condition of a larger repertoire" (Ferster, 1972, p. 6). If the behaviors were better maintained through positive consequences, a punishing consequence could not disrupt them so easily.

SOURCES OF INFLUENCE THAT SHOULD BE REVIEWED

A contextual assessment requires a review of both personal and environmental factors that may influence problems and options. Possible influences include other peoples' actions, the physical environment, tasks and materials, physiological changes, thoughts, genetic differences, and developmental factors. Material and community resources and related political, economic, and social conditions also affect options.

Social and Public Policies and the Values They Reflect

A contextual assessment calls for attention to the relationship between personal problems and public issues. The values and norms in a society and conflicts about them are reflected in the social and public policies and related social institutions that influence what resources are available. For example the lack of low-cost housing is partly responsible for the increase in homeless families. Court challenges to child welfare practices illustrate the role of poverty and the band-aid nature of short-

EXHIBIT 12.15
Examples of Presenting Problems, Specific Referents, and Desired Outcomes

Presenting Problem	Specific Referents	Desired Outcomes
My 14-year-old daughter is uncontrollable.	She stays out beyond curfew time. She calls me names.	Return home by agreed on time. Discuss issues without name-calling.
Loneliness (80-year-old male).	No one ever visits me at home. I never speak to anyone on the phone. I never go to the senior center.	Have one person visit each week. Have three telephone conversations per week. Visit the senior center for 1 hour once a week.
Lack of participation at community-board meetings.	I don't say anything.	Offer three elaborated opinion statements at each board meeting.
Children have no proper care.	Children are left by themselves for 3 hours when they return from school.	Arrange care for children between return from school and the time parent finishes work.

term services that do nothing to alter structural factors (such as lack of subsidized child care and housing) in removing children from parents (Eamon & Kopels, 2004). Keeping these higher-level contingencies in mind should help you avoid incorrect accounts of problems. Hasenfeld (2000) argues that human service organizations interested in changing behavior are inevitably involved in making judgments about moral worth. He suggests that organizations differ in their views of the social worth of clients, which influences how clients are treated.

Other People

Helping clients may require a cultural change because problem-related behaviors are influenced by people at many different system levels. Consider Exhibit 7.3, which describes contingencies related to wearing seat belts. We can see that behavior is affected by many system levels. You may be able to influence only some related levels. Understanding the big picture may avoid inaccurate estimates of what can be accomplished. How do significant others such as family members view a problem, and what will they gain or lose if particular outcomes are achieved? Attention from others may become an important maintaining factor for behavior, even though it was not involved in encouraging an initial reaction. For example, a woman may become anxious when she is away from home. Her family members may respond with sympathy and support, which may increase her reports of fear, especially if she receives little attention at other times.

Family members may not recognize their role in maintaining disliked behaviors. Brian's parents were unaware of how their reactions helped maintain Brian's behaviors that they found annoying. That is, they attended to (reinforced) him when he teased the dog and ignored him when he played nicely with the dog. Brian, in turn, influenced his parents' behavior. Staff in residential settings are often unaware that they reinforce behaviors they complain about. They may ignore "sane" behaviors that are not troublesome and reinforce "crazy" behaviors with attention (Paul & Lentz, 1977). Supervisors who complain about line staff behavior may not realize that they ignore desired behaviors. Current life circumstances influence whether significant others participate effectively. Mrs. Lakeland's full-time job, coupled with running a household in which the children shouldered few chores, left her tired and, in her words, "more likely to fly off the handle." Her husband worked full-time on one job and three nights a week on another to help his older son pay for college.

The Physical Environment

The influence of the physical environment is often overlooked. Brian did not have a room of his own and had no place where he could work on his hobbies without being interrupted. Physical arrangements in residential and day care settings influence behavior. Unwanted behaviors may be encouraged by available materials. For example, toys may distract children from educational tasks. Temperature changes, crowding, and noise level affect behavior. Increasing physical space can reduce aggressive behavior of severely handicapped persons (Rago, Parker, & Cleland, 1978). Violent acts may be discouraged by decreasing physical spaces that are not open to scrutiny by others (e.g., see Astor, Meyer, & Pitner, 1999). The characteristics of the community in which clients live influence problems and options. Neighborhood variables that influence residents include tolerance of

risk behavior, subcultures, degree of cynicism, disorder, poverty, immigrant concentration, stability, networks/exchanges, and collective efficacy (e.g., see Browning & Cagney, 2003).

Children who live in poor-quality environments (e.g., little play space, industrial neighborhoods, littered streets) are less satisfied with their lives, experience more negative emotions, and have more restricted and less positive friendships compared with children who live in higher-quality settings (Homel & Burns, 1989). The frequency of nonaccidental injuries to children is related to their home's physical condition, which in turn is related to socioeconomic status (Pelton, 1989). Hazards in the rundown housing in which many poor families live include lead poisoning and unprotected windows. Poor people have fewer options for dealing with potential hazards. They may not be able to afford baby sitters or bars on windows. They may fear that, if they complain about dangerous conditions, they will be evicted. Board-and-care operators may crowd residents into small rooms, provide few if any social opportunities, and fail to make needed repairs. Shelters for the homeless may be more dangerous than the streets for those they claim to shelter.

Tasks and Activities

The kind of task we confront influences behavior. In such cases, focus may be on altering the task environment. Behaviors of concern may occur because of boredom or excessive demands. For example, there is a relationship between tasks children confront and injurious behavior (Luiselli, Matson, & Singh, 1992). Assessing the quality of the curriculum as this may influence behaviors is important in classrooms.

Biomedical Factors

Overlooking physical causes may result in incorrect inferences about the causes of problems. For instance, certain kinds of illness are associated with psychological changes. Examples are hyperthyroidism in a young refugee woman referred by an internist because of anxiety; an orange-sized (and curable) meningioma in a middle-aged refugee woman referred by a family physician with a diagnosis of depression; and pellagra in a refugee teacher who suddenly became socially withdrawn, confused, and silly (Westermeyer, 1987). One of my students had her field placement in a school. An 8-year-old girl was referred to her for behavior problems both at home and at school. There were certain indications that some medical cause may be responsible (she felt dizzy at times) and she was referred to a physician for a check-up. He said that she was fine. The student noticed that the little girl appeared to falter sometimes when walking and pressed for a referral to a specialist. This referral was made and an MRI revealed a brain tumor, which was thought to be responsible for the problem behaviors. The sources of information drawn on here included signs (results of an MRI) as well as symptoms. Environmental pollutants and nutritional deficiencies may affect health and behavior, and a lack of sleep may lower our ability to solve problems. Hormonal changes associated with menopause may result in mood changes that may be mistakenly attributed to psychological causes. On the other hand, psychological changes may be mistakenly attributed to hormonal changes. For example, a coworker may incorrectly attribute disliked behavior to premenstrual tension. Enormous attention has been given over the past years to trying to identify biochemical correlates of behaviors labeled as mental disorders, to date with little success (see, for example, Leo & Cohen, 2003; U.S. Department of Health and Human Services, 1999). (See also critiques of biomedical narratives, e.g., Clarke, Shim, Mamo, Fosket & Fishman, 2003.)

Chronic health problems increase with age. Health problems are a major concern for clients with AIDS. A physical examination should be required whenever physiological factors may be related to a problem (e.g., seizures, depression, fatigue, or headaches). Explore the adequacy of nutrition and coffee, alcohol, or drug intake. Drugs, prescribed or not, may influence how clients appear and behave. Fetal alcohol syndrome and drug-affected infants have received increasing attention.

Genetic Influences

Rutter and Taylor (2002) argue that "[r]esearch over recent decades has made it abundantly clear that genetic factors play an important part in the origins and persistence of all forms of behavior, including all forms of psychopathology" (p. 26). (See also McGuffin & Rutter, 2003.) Genetic differences influence vulnerabilities to certain risk factors. There is considerable controversy regarding the contribution of genetic influences in rela-

tion to adequacy of related research (e.g., see Boyle, 2002).

Thoughts: What We Say to Ourselves

Thoughts may function as cues in chains of behavior and may contribute to problems such as anxiety, anger, and depression (for more detail, see chapter 7). A depressed client may have a high frequency of negative self-statements and a low frequency of positive self-statements. The thoughts and feelings we have in a situation are related to past and current experiences in that situation and those that are similar or associated in some way. A causal role may be mistakenly attributed to thoughts because the histories related to their development as well as current related contingencies are ignored. It is not that an explanation that attributes the cause of problems to thoughts is wrong; it is that such accounts are incomplete. A change in thoughts and feelings often occurs as a result of behavior changes. You can examine the role of thoughts (such as self-instructions) by varying certain ones and determining the effects on behaviors of interest.

What About Emotions and Feelings?

Feelings and mood states (such as depression, anxiety, and anger) may be presented as a problem or be related to other problems. For example, a parent's depression may encourage neglect of her child. The absence of certain feelings may be a problem, such as not liking one's children or not having empathy for harm caused to others. Feelings, thoughts, and behavior are interrelated. Our feelings and thoughts may influence our behavior and, in turn, our behavior may influence our thoughts and feelings (see, for example, Ekman, 2003; Forgas, 2001; Lewis & Haviland, 2004). Theories of behavior differ in whether causal status is given to feelings and in the variables believed to account for feelings (e.g., early childhood experiences, past and current contingencies).

Changing feelings will not make up for a lack of skills required to attain a valued outcome or rearrange related environmental contingencies. Here, too, as with thoughts, it is not that attributing the cause of problems to feelings is wrong, it is that the account is incomplete. The relative importance of behaviors, thoughts, affect, and physiological responses may have implications for selection of plans. For example, if social anxiety is mainly related to muscle tension, relaxation training may be called for. If it is mainly cued by negative self-statements such as "I bet I'll be a flop again," cognitive restructuring combined with exposure to feared situations may be the best option. If it is related to a lack of effective social skills, social skills training may be required (see chapter 24). Discovery of situations that contribute to feelings of concern and that lessen them will suggest changes in thoughts, behaviors, and/or environmental circumstances that may alter feelings in desired ways.

People differ in the range of emotions they experience, their intensity, and the situations in which they occur. Cultural norms influence what is viewed as appropriate in specific circumstances. Different people express their feelings in different ways. Just because someone does not cry when a relative dies does not mean she does not care. Arousal patterns and cues may differ in the reactions that they evoke across different cultures. These emotions may be defined in varied ways in different cultures. Patterns of correlations among different aspects of emotions, physiological changes, and reported emotions differ among cultures. Mesquita (2001) notes that "The research generally supports the hypothesis that equivalent emotions in different cultures are characterized by similar appraisal patterns" (p. 229). For example, "Across culture, the situations that produce fear were conceived of as unpleasant, obstructing goals and hard to cope with. Anger was provoked in situations that were seen as unexpected, unpleasant, obstructing goals, unfair, and caused by other people" (p. 229).

Suh and his colleagues (1998) explored life satisfaction in 40 different countries, including both individualistic cultures and collectivist cultures. They found that the individualistic cultures tended to base their life satisfaction judgments primarily on their emotional experiences, whereas participants from interdependent or "collectivist" cultures tended to base their life satisfactions judgments more broadly, using both emotions and cultural norms. Some views emphasize that emotions can be plotted in a two-dimensional space, the dimensions being arousal level, high to low, and affect, negative to positive. Others argue for the view that there are discreet, basic universal emotions. For example, Ekman (1992) suggests that each emotion has unique behavioral display patterns, motivational value, physiological arousal

patterns, and so on. We can draw on the extensive literature concerning emotions to understand how emotions develop and change.

Religion and Spirituality

Greater attention has been given to client's spirituality and religion and how they may influence concerns and options over the past few years. Religion is often limited to formal institutional structures (for example, is a client Catholic or Muslim?) Spirituality refers to transcendence and experiential processes of personal meanings (e.g., see Hill, Pargament, Hood, McCullough, Swyers, Larson, & Zinnbauer, 2000). Some authors recommend that an understanding of a client's religious values and spiritual experiences and meanings and goals should be a part of assessment (e.g., Richards & Bergin, 1997). You should be sensitive to the role religion and different kinds of spirituality play in the life of a client, especially as this relates to outcomes the clients hope to achieve. And, as always, you should skeptically review research on which claims are based (e.g., see chapter 11).

Cultural Differences

Cultural differences in values and norms may influence the problems clients confront, preferred communication styles, and service options (Dana, 2000; Sue & Sue, 2003). Research concerning cultural differences has expanded greatly over the past years (e.g., see Pederson, Draguns, Lonner, & Trimble, 2002). Norms for behavior differ in different groups. These differences involve far more than race and ethnicity. They include differences related to gender, physical abilities, sexual orientation, geographical region, religion, and age. Cultural differences may be reflected in preferred problem-solving styles and beliefs about the causes of problems. Lack of knowledge about differences may result in incorrect assumptions about the cause of problems and differences of opinion about whether a behavior is a problem.

A client's degree of acculturation is important to assess (Roysircar-Sodowsky & Maestas, 2000). Differences in degree of acculturation among family members may create strains. De Anda (1984) suggests that the interaction of ethnic minority clients with mainstream culture is influenced by the following:

- Degree of overlap between cultures regarding norms, values, beliefs, perceptions, and related contingencies.
- Availability of "cultural translators, mediators, and models."
- Nature of contingencies.
- Overlap between the conceptual style and problem-solving approach of the minority individual and the prevalent styles of the majority culture.
- Degree of bilingualism.
- Similarity in physical appearance to that of the majority culture (e.g., skin color, facial features).

Sue and Sue (1990) suggest that level of acculturation influences dropout rate, level of stress, attitude toward helpers, and the process and goals that are appropriate. Standardized assessment instruments have been developed to assess acculturation (see also Sue & Sue, 2003). Knowledge of problems faced and preferred communication styles of different generations will be valuable.

Developmental Considerations

Knowledge about required tasks and related behaviors at different ages and life transitions can be helpful in making decisions. Data concerning typical behaviors at different times (developmental norms) offer information about the prevalence of a behavior. This knowledge can be used to "normalize" behavior (help clients realize that reactions they believed to be unusual or abnormal are typical). For example, an adolescent may think that there is something wrong with him because he masturbates. The prevalence of masturbation among youth of his age calls for normalization of this concern. A parent may believe that his child is doomed to a career of crime because he was caught stealing. The parent may not know that many children steal some object at some time. This is not to say that nothing should be done to discourage stealing. Information about common changes in different life-cycle phases (e.g., parenthood, retirement) can help in preventive planning, for example, offering support groups for people nearing retirement, or for couples about to have their first child. Being informed about the hierarchical nature of some developmental tasks (i.e., some behaviors may have to be learned before others) may facilitate case planning. Being misinformed about these may impede provision of effective services—that is, you may not provide ser-

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Considerable attention has been devoted to identifying risk and protective factors that if altered contribute to positive outcomes, such as resilience in the face of adversity (e.g., see Fraser, 2004; Rapp-Paglicci, Dulmus, & Wodarski, 2004). This public health approach is reflected in life-stage development models. The risk factors that initiate a problem may differ from those that maintain or exacerbate a concern. For example, we differ in our vulnerability to ongoing anxiety due to an adverse event. Thus, there are proximal and distal risk factors. Research concerning life events provides some valuable guidelines about these two kinds of risk factors as they intersect with psychological and social circumstances and characteristics. Some risks contribute to the development of problems; others to their maintenance. Experiences during childhood (such as degree and kind of parental nurturing) may affect behavior at later ages. Parents offer different kinds of attachment opportunities to their children, for example, secure or insecure (see Cassidy & Shaver, 1999). Such attachment experiences may influence skills in tolerating momentary unpleasant emotional reactions. Knowledge concerning developmental psychopathology may be of value in understanding different patterns of behavior at different ages (e.g., see Rutter & Stroufe, 2000). For example, a history of depression may be related to development of anxiety in later life stages. Examples of recommendations suggested by Holmbeck, Greenley, and Franks (2003) for considering developmental principles in clinical and research work include the following:

- Stay current with developmental literature.
- Consider developmental tasks and milestones.
- Think about the total context.
- Help parents and other relevant adults, such as teachers, become developmentally sensitive; familiarity with norms will help people to understand transitional changes that might occur, for example, in adolescents.
- Anticipate future developmental tasks and milestones and plan for them, for example, arrange a divorce support group for children whose parents are getting divorced.
- Consider the concept of equifinality; different developmental pathways may lead to the same outcomes. This is a major reason people object to being guided simply by diagnostic category.

ASSESSING THE RISK OF SUICIDE AND ABUSE

Social workers are legally required to report suspected elder and child abuse. This includes physical abuse, sexual molestation, and inattention to physical needs, such as inadequate supervision and financial abuse. Child welfare workers must estimate risk of further abuse. Risk assessment involves the identification of predictors of risk. Methods of assessment in relation to risk may include structured, focused interviews, observation in related environments, various forms of psychometric testing, assessment protocols, perhaps even physiological assessment, for example, in relation to patterns of sexual arousal (e.g., Milner and his colleagues, 1998). Actuarial methods based on empirical relationships between predictors and outcome are often used to make such estimates (e.g., see Baird & Wagner, 2000). Such methods are also used in predicting future criminal behavior (Quinsey, Harris, Rice, & Cormier, 1998). As important as it is to detect abuse when it is present, it also is important not to falsely accuse people of abuse. False allegations create havoc in families. Consider, for example, results of false charges of sexual and ritual abuse (Ofshe & Watters, 1994).

A critical question in risk assessment is: What are the reliability and validity of the data (measures) relied on in arriving at an overall assessment of risk? For example, safety and risk inventories regarding children require child welfare staff to indicate whether a number of items, such as history of abuse, apply to a case. Is there a history of alcohol abuse? But what does "a history of alcohol abuse" mean? Does it mean that alcohol abuse was noted in a record somewhere at some time? What intensity of alcohol abuse should be noted? Over how long of a time period? Do lifetime prevalence rates for mental disorders provide a useful estimate of risk? Social workers often depend on secondary sources of information and should have the knowledge and skills needed to evaluate the accuracy of data in sources such as court reports. Many biases may interfere with accurate assessment of risk at any stage of risk assessment including: (1) initial estimate of risk using a screening measure or system, (2) subsequent assessment, (3) selection of services, and (4) evaluation of outcome. (For a detailed discussion of reliability and validity, see chapter 17.) (See also discussion of critically appraising research regarding risk in chapter 11.) The complexity of estimating risk is highlighted by the

recommendation by Azar, Lauretti, and Loding (1998) that we should exercise "extreme caution in conducting such evaluations due to limitations of our current technology and the potential for biases to enter reports" (p. 78). For example, they note that "what exactly is minimally adequate parenting is unknown; tests and measures to assess questions relevant to issues of parenting abilities in child maltreatment are limited. There is little study of the relationship between parental competence and children's needs" (p. 132). (For an effort to identify minimal parenting competencies, see Budd & Holdsworth, 1996; Budd, 2005.) Forensic risk evaluations involve some kind of legal question. For example, estimates of risk could result in removal of children on legal grounds from the care of their parents.

You should be familiar with the risk factors related to suicide (e.g., depression, a preformed plan, prior attempts). This is not to say that you can prevent suicide. Hospitalizing suicidal adolescents to prevent their committing suicide may increase the risk. The identification of risk factors is based on correlational research that does not allow you to predict what a particular person will do (Dawes, 1994a). You can however, take steps to decrease risk, for example, offer support, discuss concerns, and offer hope. Scholars disagree about hospitalizing "suicidal" people against their will to prevent suicide. Some argue that not only is this unethical—it cannot be done (i.e., be used to prevent suicide) (e.g., Gomory, 1997; Szasz, 1994). Others argue that suicidal individuals may, because of a temporary distorted view of their future, not themselves have the autonomy necessary to make an informed decision (Halpern, 2001).

ETHICAL ISSUES

Assessment frameworks and methods can be harmful as well as helpful. For example, they may provide misleading estimates of problem severity and misleading directions for accurate understanding of a problem. Informed consent obligations may be violated by not sharing uncertainties regarding possible harms and benefits associated with use of given assessment frameworks and methods (e.g., a screening test for depression). Discovering whether hoped-for outcomes can be achieved may be possible only via a sound assessment. Given that helping clients may require flexibility and a number of other characteristics, including expert knowledge, professionals have an obligation to consider the ways in which their beliefs may influence the prospects of attaining hoped-for outcomes without creating new unwanted problems, such as irreversible tardive dyskensia as a result of neuroleptic medication. Although decisions must typically be made on the basis of incomplete data, without a sound assessment framework, opportunities to gather useful data may be lost, and assessment may be incomplete, resulting in selection of ineffective or harmful plans. This highlights the importance of thinking critically about assessment frameworks and measures: for example, are they compatible with empirical information about behaviors, thoughts, and feelings?

SUMMARY

Evidence-based assessment encourages use of assessment frameworks and methods that have survived critical appraisal in relation to their accuracy. Helpers and clients have preferred views about behavior and how it develops and is maintained and can be altered. These views differ in the extent to which they have been critically appraised regarding their accuracy and usefulness in providing guidelines about how to attain valued outcomes or if they can be attained. The assessment perspective preferred will affect choice of data to collect and how to collect data. Honoring ethical obligations to clients requires selection of assessment frameworks that are compatible with empirical data regarding behavior and use of measures that are valid; they provide information that contributes to making well-reasoned decisions.

Assessment should indicate the likelihood of attaining valued outcomes. This may be slim because needed resources are not available or because related environmental or personal characteristics cannot be altered. Taking advantage of the steps involved in evidence-based practice, for example, consulting practice-related research regarding questions that arise, should contribute to making well-informed decisions. Assessment should be of value to clients and significant

others by offering some immediate benefits, such as hope and concrete help. It is an ongoing process in which decisions are altered as necessary in response to new information. A contextual analysis should indicate the levels of intervention required to attain valued outcomes (individual, family, group, community, agency, service system, policy). Characteristics of a contextual assessment include use of assessment frameworks and methods that are most likely to offer accurate data, including observation of relevant interactions, when needed, and clear descriptions. Concerns are translated into outcomes that, if attained, will remove them. This may involve behaviors of service providers as well as those of clients and significant others. There is an interest in understanding the function of behaviors of concern: What do problem-related behaviors communicate?

Assessment should be individually tailored as needed for each client and include a search for both personal and environmental resources, and cultural differences should be considered as they relate to desired outcomes and possible resolutions. This framework avoids blaming clients for their problems, relying on misleading stigmatizing labels, and offering incomplete accounts that ignore practice-related research findings. A procedural guide for carrying out a contextual assessment is described in the next chapter.

REVIEWING YOUR COMPETENCIES

Reviewing Content Knowledge

1. Describe the basic characteristics of a contextual assessment framework.
2. Describe the differences between sign (diagnostic) and sample (assessment) approaches.
3. Describe kinds of questions that arise during assessment related to information needed to make decisions.
4. Describe criteria of value in reviewing different practice frameworks.
5. Describe assessment errors that result in incomplete or incorrect problem analyses.
6. Describe the difference between a descriptive and a functional analysis.
7. Give an example of a pseudoexplanation.
8. Describe four ways assessment can be of value to clients.
9. Explain why significant others are important to include in assessment and give examples.
10. Give examples of the difference between motivation and behavior deficits.
11. Give examples of the difference between topographic and functional descriptions of behavior.
12. Describe what is meant by "the client uniformity myth."
13. Describe the differences between a constructional and a deficiency approach to helping.
14. Discuss the role of past history in a contextual assessment.
15. Describe the disadvantages of focusing on the past.
16. Describe the limitations of psychiatric labels and give examples.
17. Describe the difference between setting events and antecedents.
18. Accurately describe different kinds of contingencies and their effects on behavior.
19. Give examples of the influence of the physical environment on behavior.
20. Discuss the roles of thoughts and feelings in different practice perspectives.
21. Discuss the relationship between behavior deficits and behavior surfeits (behaviors that occur too often).
22. Give examples of inadequate and inappropriate stimulus control.
23. Give examples of inadequate or inappropriate reinforcing functions.

Reviewing What You Do

1. You can review a case example and accurately critique it from an evidence-informed, contextual, strengths-oriented assessment perspective.

2. You can review a case example and accurately describe the kinds of information you would need.
3. You pose well-structured answerable questions regarding assessment needs that allow an efficient, effective search for related research findings.
4. You clearly describe client concerns and related hoped-for outcomes.
5. You identify environmental factors related to problems including setting events, antecedents, and consequences.
6. You involve significant others in assessment.
7. You identify personal assets and environmental resources.
8. Your inferences about the causes of problems are informed by related research findings.
9. You avoid noninstrumental labels.
10. You focus on appropriate systems levels (e.g., individual, family, group, agency, community, societal).

Reviewing Results

1. Clients form more helpful views of their problems.
2. Clients report that assessment was helpful.
3. Clients increase their problem-solving skills.
4. Plans selected help clients to attain outcomes they value.