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CLINICAL SOCIAL WORK PRACTICE

An Integrated Approach

MARLENE G. COOPER JOAN GRANUCCI LESSER

SIXTH EDITION

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About the Authors

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Preface

This book grows out of our experiences as practitioners and as clinical faculty at our respective schools of graduate social work. Both of us have taught clinical practice to students over the years and have struggled with ways to build on the foundation level curriculum so that the advanced year could become a meaningful expansion of both knowledge and skill. The mandate of the social work profession is ever growing, as is the two-year Master of Social Work (MSW) curriculum. We have the challenge of teaching—and the students have the challenge of learning—multiple theoretical practice models. It is indeed a challenge to help students understand the constructs of a theory and also help them use that theory to guide assessment, establish goals, and plan interventions. We have tried to incorporate that integration in this book as we introduce a number of theories, and then demonstrate through case examples interwoven with theoretical constructs, their applicability to clinical practice.

We chose the term *clinical social work practice* over the more generic term *social work*. There is tension within the profession whether the mission of practitioners is social change, or individual and family change. We believe in the overall commitment of the profession to advocate for and facilitate social change so that individuals have fewer problems resulting from conditions of poverty and oppression. We also strongly believe that clinical social workers have a professional and ethical responsibility to work therapeutically with those individuals, and families whose lives have been profoundly affected by these larger social issues.

There has been conflict, over the years, as to the language used to describe the clinical social worker and the client. In the Freudian model, the client was referred to as a patient, and the therapist, as a doctor. Some social workers today are referred to as therapists; others are called practitioners, clinicians, consultants, trainers, teachers, providers, and even conductors. In some settings, clients are called members; in others, they are referred to as consumers. The language that describes the participants in the therapeutic relationship is often a reflection of the theoretical perspective being used. Different theories use different language, and there is room for all of these terms. We also recognize that different theories refer to the clinician in different ways. As we incorporate theories from different sources, we address the social worker at times as social worker, practitioner, therapist, clinician, and even as consultant.

We are aware that social work education today is quite broad. However, we are firmly committed to teaching clinical knowledge and skills, for it is these components that enable our students to evolve into true professionals. Our book, therefore, has taken on that charge. We have included an array of theories that are psychodynamic, transtheoretical, motivational, relational, cognitive, behavioral, and postmodern. Despite their differences, the theories included in this book all view the therapeutic process as being created by the therapist and client in an atmosphere of mutuality and collaboration.

The theoretical chapters of *Clinical Social Work Practice* are "student friendly," illustrating technique with dialogue from actual work with clients. Our clients reflect the larger social issues of our times: They are survivors of child abuse and neglect, domestic violence, discrimination, racism, and mental illness. The case discussions show both clients' and social workers' struggles with change and the therapeutic process. We include process recordings that reflect our work with individuals, families, and groups of different cultural, racial, ethnic, and religious backgrounds. Learning objectives and reflection questions assist in processing the case material.

The book is divided into 13 chapters. In Chapter 1, we introduce the student to the concept and evolution of theory within a historical perspective. We discuss theory selection, and offer representative examples of theories for students to follow when attempting to apply theory in practice. A model for integrating theory and practice is illuminated with a case example.

In Chapter 2, we move into the clinical interview and the processes that evolve during the beginning, middle, and end stages of treatment. Discussion and case material focus on several meetings with a teenage boy diagnosed with a conduct disorder. The transtheoretical model, the stages of change, and motivational interviewing frame the clinical interviews. In Chapter 3, the biopsychosocial assessment, we discuss the preparation of this assessment on an advanced level. We present a clinical example of a 7-year-old Black boy who was placed in a residential treatment facility. This material serves as a model for teaching the conceptualization of a theoretical formulation and a diagnostic impression based on ego psychology, the *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition* and the mental status exam.

Chapter 4 discusses multicultural practice. It is our belief that sensitive, skilled clinicians can meet the challenge of working effectively with clients of different cultural backgrounds. We include content on intersectionality—socially constructed categories or social locations of oppression and privilege—and cultural trauma. We include an example of a women's group for Latina women who are struggling with depression, and walk the student through the beginning, middle, and end stages. In a second practice example, we discuss the treatment of a Vietnamese adolescent with substance abuse issues. These cases illustrate practice that is culturally sensitive and culturally competent.

Chapters 5 through 12 present clinical illustrations through the lenses of specific theoretical models. Each of these chapters includes a detailed discussion of a theory, assessment, and treatment. Dialog is used to illustrate how theory guides practice. We have selected theories that offer insight into clinical social work practice with individuals, families, and groups whose lives have been profoundly affected by social, cultural, political, sexist, racist, and emotional forces.

In Chapter 5, we present object relations, a psychodynamic theory, and its relevance to contemporary social work practice with vulnerable client populations. Clinical intervention with a female survivor of severe childhood abuse illustrates this concept. Chapter 6 presents the theory of self-psychology and its application to brief treatment. The theory is illustrated in interviews with an older adult woman seeking counseling to understand why her son has undergone a sex change and how she can relate to him now that he has become her daughter. This case further shows the complexity of doing clinical social work practice against the backdrop of social stigma. Also in this chapter is a discussion of the application of self-psychology to brief group therapy with heterosexual women who have experienced domestic violence. We introduce relational theory in Chapter 7. Attention is given to contemporary psychoanalytic relational theory as well as cultural relational theory, which evolved from the earlier feminist model of "self-in-relation" theory. Group treatment with women who are learning to assert themselves in their work and family relationships demonstrates this model.

In Chapters 8 and 9, we discuss behavioral and cognitive social work practice, respectively. Behavioral theory is explicated in Chapter 8 in the case discussion of the brief treatment of a woman who suffers from obsessive-compulsive disorder. We also provide two examples of behavioral therapy with children and adolescents. We illustrate cognitive theory with the treatment of a client suffering from anxiety and depression in Chapter 9.

Chapters 10 and 11 illustrate two postmodern theories—narrative and solution-focused therapies, respectively. Both chapters also demonstrate family treatment. Treatment of a Puerto Rican family grappling with intergenerational differences as they attempt to acculturate to U.S. society illustrates the narrative model, which is presented in Chapter 10. A group of children diagnosed

with Attention Deficit Hyperactivity Disorder (ADHD) illustrates the use of externalizing conversations in narrative therapy. The application of a solution-focused approach to family treatment with a child who is lying is presented in Chapter 11.

Chapter 12 addresses trauma theory. We provide an overview of trauma and the neurobiology of trauma, discuss several types of trauma, and the effect of trauma on attachment and development. We present a summary of several contemporary trauma theories. A psychodynamic, mentalization-based approach to the treatment of complex trauma in an adult client and short-term trauma focused cognitive behavioral therapy to the treatment of a young child provide examples of these two models of treatment.

In Chapter 13, we address four practice issues that deserve special consideration: ethics, suicide, substance abuse, and telehealth. The coauthors offer lengthy commentary on how these issues have emerged in their clinical practice.

We hope that this book will provide students and mental health professionals with the knowledge and skills that are required to practice on an advanced clinical level and that they will learn as much by reading it as we have by writing it.

NEW TO THIS EDITION

Overview of high level updates:

- A new chapter on the Theoretical Base for Clinical Social Work Practice (Chapter 1).
- A revised chapter on Trauma Theory (Chapter 12).
- A new chapter (Chapter 13) on Special Issues in Clinical Practice.
- New content on neuroscience in Chapters 5 (Object Relation), 6 (Self-Psychology), Chapter 7 (Relational Theory) and Chapter 10 (Narrative Therapy).
- New practice example on Multicultural Practice (Chapter 4).
- Reflection questions have been added to each chapter.
- References have been updated in each chapter.

Chapter Revisions

Chapter 1:
Theoretical Base for Clinical Social Work Practice: We highlight the evolution of different theoretical models, how to select a theoretical model to guide clinical practice, an understanding of evidence-based practice, the significance of the therapeutic relationship across theoretical models, and how to integrate theory and practice. References have been updated.

Chapter 2:
The Clinical Interview: The Process of Assessment (previously Chapter 3): Includes content on the interviewing children and their parents. References have been updated.

Chapter 3:
The Biopsychosocial Assessment (previously Chapter 4; The Psychosocial: The Product of Assessment): This chapter includes new content on the developmental assessment of children and adolescents. References have been updated.

Chapter 4:
Multicultural Practice (previously Chapter 5): New content includes standards for cultural competence, multicultural oppression, and social justice. A new practice example illustrates the application of multicultural theory to a group of Latina immigrant women who discuss isolation, depression, lack of inclusion, access to resources, cultural identity, and transformative social action. References have been updated.

Chapter 5:
Object Relations Theory: A Relational Psychodynamic Model (previously Chapter 6): There is new content on neuroscience in this chapter. References have been updated.

Chapter 6:
Self-Psychology: A Relational Psychodynamic Model (previously Chapter 7): This chapter now includes content on self objects, attachment, and neuroscience. References have been updated.

Chapter 7:
Relational Theory (previously Chapter 8): New content on relational theory and the third space and relational theory and neuroscience has been added to this chapter. There is also an expanded section on Relational Cultural Theory and its application to clinical practice. References have been updated.

Chapter 8:
Behavior Therapy: A Structural Approach (previously Chapter 10): This chapter has new content on Applied Behavioral Analysis (ABA) and expanded content on Acceptance and Commitment Therapy (ACT). References have been updated.

Chapter 9:
Cognitive Theory: A Structural Approach (previously Chapter 9): References have been updated.

Chapter 10:
Narrative Therapy (previously Chapter 11): Contemporary content on neuro-narrative therapy has been added to this chapter. References have been updated.

Chapter 11:
Solution-Focused Therapy (previously Chapter 12): Solution-focused therapy with clients with disabilities has been added to this chapter. References have been updated.

Chapter 12:
Trauma Theory (previously Chapter 13): This is a totally revised chapter with new sections on complex and collective trauma, the neurobiology of trauma and traumatic memory, trauma, attachment, and development, psychopharmacology, trauma, and substance abuse. Additional models have been added to the section on the theoretical models for treatment of trauma and include somatic experiencing, Eye Movement Desensitization and Reprocessing, exposure treatment, Internal Family System theory, Sequential Relationship-Based model, and Metallization based treatment. There is also a new section on trauma resilience. References have been updated.

Chapter 13:
Special Issues in Clinical Practice (new chapter replacing previous Chapter 2 on Key issues in clinical social work practice): This chapter has been revised and includes four sections: working with suicidal clients, ethics and professional boundaries, substance abuse and substance use disorders, and telehealth. The section on working with suicidal clients has an expanded section on working with suicidal clients, "suicidal narrative and suicide crisis syndrome. The section on substance abuse and substance use disorder includes the neurobiology of substance abuse disorders, screening and assessment, screening for co-occurring disorders such as trauma and substance abuse, expansion of treatment models to include brief compassion therapy, and digital support for substance abuse. There is an expanded section on Telehealth, including the impact of Covid-19, and a new commentary section on ethics and professional boundaries, suicide and substance abuse treatment in which the authors share thoughts about their own clinical practice. References have been updated.

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A very special thanks to Rebecca Fox-Gieg and the team at Pearson for their support throughout this 6th edition. Joan gives special thanks to her husband, Martin, for his enduring support and to her family, which has grown over the six editions to include her son Eric, daughter-in-law Alison, granddaughters Rose and Nora, daughter Rebecca, son-in-law Sam, and daughter Julia and boyfriend Patrick, who make all things possible. Joan also gives warm thanks and appreciation to her coauthor Marlene for partnership and friendship over the years.

Marlene dedicates this book in memory of her parents, Thelma and Daniel Cooper, and gives special thanks to her husband Bernie and her son Alex, daughter-in-law Katelyn, and granddaughter Alyssa and to Joan, her wonderful collaborator and dear friend.

In addition, we would like to thank the following reviewers whose comments contributed to the book's development through several editions: Shanna Burke, Florida International University; Heather Burroughs, University of Central Florida; Michael Mancini, Saint Louis University; and Elizabeth Ruegg, Saint Leo University.

INSTRUCTOR RESOURCES

This edition of *Clinical Social Work Practice: An Integrated Approach Practices* provides a comprehensive and integrated collection of supplements to assist students and professors in maximizing learning and instruction. The following resources are available for instructors to download from www.pearsonhighered.com/educator. Enter the author, title of the text, or the ISBN number, then select this text, and click on the "Resources" tab to download the supplement you need. If you require assistance in downloading any resources, contact your Pearson representative.

Instructor's Resource Manual and Test Bank: The Instructor's Resource Manual and Test Bank includes an overview of chapter content and related instructional activities for the college classroom and for practice in the field as well as a robust collection of chapter-by-chapter test items.

PowerPoint Slides®
The PowerPoint® slides highlight key concepts and summarize text content to help instructors structure the content of each chapter to make it meaningful for students.

Brief Contents

Contents

1

Theoretical Base for Clinical Social Work Practice

Learning Outcomes

At the conclusion of this chapter, students will be able to:

- Appreciate the evolution of different theoretical models
- Consider how to select a theoretical model to guide clinical practice
- Demonstrate an understanding of evidence-based practice
- Understand the significance of the therapeutic relationship
- Discuss how to integrate theory and practice
- Appreciate the importance of supervision

WHAT IS A THEORY?

Clinical social work must be guided by theory as well as principles. Sommers-Flanagan and Sommers-Flanagan (2018) suggest that a theory is organized knowledge about a particular subject, for example, human emotions or behavior. Harry Guntrip (1968), a noted object relational theorist, considered all theories of human nature to be influenced by the cultural era, the prevailing intellectual climate, and the dominant ideas of the time. Payne (2015) suggests that the term *theory* covers three different possibilities: models (describe what happens in practice), perspectives (help you think in an organized way), and explanatory theory (theories that tell you what works). All these components are necessary for a theory to be useful. Theory is essential to ethical and responsible social work practice. Theory provides social workers with a way to view their clients and an approach to guide them toward achievement of their goals. Theory informs assessment, diagnosis, and treatment and even offers a way to provide evaluation (Sommers-Flanagan & Sommers-Flanagan, 2018; Gehart, 2016).

There are many different theoretical models of therapy available to help treat a wide range of issues and conditions. Some theoretical models are well known and have been systematically studied in the professional field, while others may be less well known or emerging to meet the needs of specific populations. It's important to decide which theories and therapy practices you wish to incorporate into your practice and gain adequate training to use them effectively. It is rare for a social worker to use a single orienting theory or a single practice framework, and strict adherence to one theoretical orientation may be somewhat limiting. Most social workers utilize an integrative approach, consisting of a wide variety of orienting theories and a set of compatible and complementary perspectives, theories, and models. This requires that social workers be familiar with multiple theoretical orientations and best practices (Gehart, 2016; Gentle-Genitty, Chen, Karikari, & Barnett, 2014; Teater, 2010; Miley, O'Melia, & Dubois, 2011; Gentle-Genitty, 2013).

Meichenbaum (2017a) developed a list of component core tasks of psychotherapy from process research on psychotherapy, the evidence for empirically supported treatments, and his 35 years of practicing, supervising, and teaching psychotherapy. They include (1) developing a therapeutic alliance; (2) educating patients about their problems and possible solutions; (3) nurturing hope; (4) ensuring patients have coping skills; (5) encouraging patients to perform personal experiments to ensure that they take data as evidence to unfreeze their beliefs about self and world; (6) ensuring that patients take credit for change by nurturing a sense of personal agency or sense of mastery; and (7) conducting relapse prevention. For patients with a history of trauma and ongoing victimization, Meichenbaum adds the following tasks: (8) addressing patients' safety and helping them develop symptom regulation; (9) addressing memory work and helping patients retell their story while altering their belief system and implications; (10) helping patients find meaning and transform pain; (11) helping patients reconnect with others who are not "victims" and addressing the impact of trauma and disorder on significant others; (12) addressing issues of possible revictimization (2017a, p. 187).

This chapter introduces the student to the concept and evolution of theory within a historical perspective, discusses theory selection, presents representative examples of theories, provides illustrations with a range of diverse practice examples, and offers a model for students to follow when attempting to apply theory in practice.

THE EVOLUTION OF CLINICAL THEORY

First Wave: Psychodynamic Theory

Psychodynamic theory originated in the work of Sigmund Freud and involves a comprehensive understanding of the interplay between an individual's internal and external worlds. It refers to the human potential for self-alteration and self-correction. It incorporates a developmental perspective and assumes the ubiquity of conflict, limitations on conscious influence, internal representations of relationships, mental defenses, and the complexity of human experience (Fonagy, 2015; Bornstein, 2010, 2018). The psychodynamic perspective has evolved considerably since Freud's time and now includes innovative new approaches such as psychodynamic relational psychotherapy and the integration of psychodynamic and neuropsychological concepts (Bornstein, 2010, 2018). Psychodynamic theory deals with a broad range of issues, including normal and pathological functioning, motivation and emotion, childhood and adulthood, individual and culture, individual and collective trauma, internalized and implicit racism, and attachment and trauma bonds (Bornstein, 2010, 2018; Safran, 2012; Bonilla-Silva, 2015, 2018; Berzoff & Drisko, 2015). The biopsychosocial chapter (Chapter 3) in this book is framed within the theoretical framework of ego psychology with attention to ego functions and defenses in assessing mental status, which in turn leads to diagnosis and development of a treatment plan and is illustrated with a case. We also present three other psychodynamic theories (object relations, self-psychology, and relational) illustrated with case examples.

Object relations theory has increased many social workers' interest in studying psychodynamic ideas and concepts. It represents a natural bridge between the psychodynamic perspective and theories of attachment, developmental, and social psychology, which posit that mental representations of significant people play an important role in shaping our behavior and social cognition. A parallel development to object relations theory was the work conducted by John Bowlby on internal working models and later by Mary Ainsworth, who developed models of

specific attachment patterns. A more contemporary outgrowth of attachment theory is the concept of mentalization, which, unlike attachment theory, provides a guide to clinical treatment (see Chapter 12 on trauma).

Object relations theory has been described as the "bridge" to self-psychology theory (Bacal & Newman, 1990), transforming the authoritarian stance of the therapist with the constructs of self-object, vicarious introspection, and empathy. The concept of the self-object (see Chapter 6 on self-psychology) provides the clinical transition from one-person psychologies to the postmodern, two-person psychologies, relational and intersubjective theories. Self-psychology has also contributed to understanding the kind of world that supports healthy psychological and social development (Rasmussen & Salhani, 2010).

Relational theory further builds on object relations and self-psychology, situating intra-psychic conflict within the relational dyad that is enacted between the therapist and the patient. Feminist relational theorists introduced constructs related to autonomy, individuality, power relations, and systems of domination in the formation of the self and relationships (Goldstein, Miehls, & Ringel, 2009). Intersubjectivity moved the pendulum beyond the therapy room to include the complexity of subjectivity as it relates to power, privilege, and the multiple identities that client and therapist bring to the encounter. Intersubjective work is both psychological and social, highlighting the larger sociocultural context within which the therapy takes place (Safran, 2012).

Relationship is a key vehicle for neurobiological development. These relational theories give attention to the role of neurobiology and appreciate that clinical relationships can help rebuild neural networks that may have been disrupted by earlier relational trauma, contributing to new capacities to retrieve memories, modify intense feelings, and develop new potential for being in relationships (Bornstein, 2010).

As previously stated, theory is rooted in the culture of the time. Payne (2015) points out that psychoanalysis originated in middle-class Jewish Vienna, with the cultural assumption that deviations from the white middle-class norm are abnormal and need to be cured. Psychoanalytic theory is based on a medical model that views problems as pathology that needs to be treated and cured. Payne further states that this theory reinforces stereotypes of women as subordinate to men and does not incorporate culture, ethnicity, or gender in its basic premises or encourage social change. This analysis may be somewhat dated because the more modern psychodynamic theories give significant attention to the social identity constructs of therapist and patient and stress more equality in the patient/therapist relationship (see Chapter 7 on relational theory). Psychodynamic theories continue to be of value as they provide a rich source of understanding of human development and the complexity of our lives and our minds (Payne, 2015).

Second Wave: Cognitive Behavioral Theories

Cognitive theory proposes that dysfunctional thinking is at the root of psychological disturbances. Rather than examine their inner world of fantasies and unconscious processes, patients learn to look at their thoughts in a more rational way, which produces more rational thinking. For a lasting effect, patients go deeper and explore their underlying beliefs about themselves, their world, and other people, which modifies dysfunctional thoughts and helps patients to feel better and function better (Beck, 2011). Behavioral therapy is based on the premise that all behaviors are learned, acquired through conditioning, and can be changed. Cognitive behavioral therapy is based on the premise that thoughts and beliefs influence moods and behaviors. The treatment goal is to change both a person's thinking and her behavior patterns (Angell, 2013). Our chapters on cognitive therapy (Chapter 9) and behavioral therapy (Chapter 8) describe the basic concepts of these theories, which are illustrated with examples from practice.

Third Wave: Existential/Humanistic Theories

This approach is rooted in the European humanistic and existential philosophy of self-inquiry, struggle, and responsibility and the American humanistic tradition of spontaneity, optimism, and practicality (Schneider & Krug, 2017; House, Kalisch, & Maidman, 2018). Existential and humanistic approaches to therapy emphasize the same factors that research suggests make any therapy successful, such as therapeutic alliance, empathy, the provision of meaning and hope, and affective attunement. What makes existential-humanistic psychology different from other theories is that all aspects of therapy are seen through the lens of a concept called presence, which suggests entering a heightened self awareness focused on what truly matters and what stands in the way of change and future opportunities.

Fourth Wave: Feminist and Multicultural Theories

These models often challenge the diagnosis (DSM)-driven medical model because they often ignore social contexts, including the historical oppression of socially marginalized groups (e.g., women, the LGBTQ community, persons of color). Feminist and multicultural theorists suggest that earlier theoretical models are based on white male heterosexual norms that privilege Western values (Corey, 2017). Critical race theory expands on critical legal studies and radical feminism, conventional civil rights thought, and earlier American radical activists and includes different interest groups, such as Asian Americans, Latinos, LGBTQ people, Native American Indians, Muslims, and Arabs, each with their own priorities (p. 3). We offer a relational cultural theory, a feminist multicultural model, in the chapter on relational theory (Chapter 7) and devote a chapter to multicultural theory (Chapter 4).

Fifth Wave: Postmodern: Poststructural and Constructivist Theories

Fifth-wave models emphasize the dialogic process that occurs between the client and the therapist. Postmodernism offers an ideological critique of the authority and certainty of the medical model with an emphasis on diagnosis (DSM) that is often embedded in the perspective of dominant social groups. Poststructuralism offers a method of understanding how meanings and subject matters are constructed in language. We present a postmodern example of psychodynamic theory in the chapter on relational theory (Chapter 7). We also highlight narrative and solution-focused therapy as examples of constructivist, postmodern thinking. Case illustrations are provided to showcase how these different theories guide therapeutic interventions.

Integrative Psychotherapy

Integrative therapy combines different therapeutic tools and approaches to fit the needs of the individual client. An integrative therapeutic approach modifies and/or combines standard treatments (e.g., psychodynamic, behaviorist, cognitive, family therapy, body-psychotherapies) to tailor treatment to the needs of individual clients. By combining elements drawn from different schools of psychological theory and research, integrative therapy becomes a more flexible and inclusive approach to treatment (Zarbo, Tasca, & Cattafi, 2015; Barth, 2014). Integrative therapy also stresses the therapist's commitment to learning about diverse theoretical models and developments in the field of psychotherapy and clinical practice (Ginter & Roysircar, 2018; Erskine, 2015). Further information on integrative psychotherapy can be found at the Institute for Integrative Psychotherapy's website (www.integrativetherapy.com).

HOW TO SELECT A THEORY

Theory selection is a complicated and multifaceted process that depends on assessment, evidence-based research, and practice wisdom. Theories provide the basis for a treatment plan that attends to criteria that will be used to evaluate the effectiveness of the treatment. We refer the reader to the chapter on biopsychosocial assessment (Chapter 3), which provides a format for data gathering, formulating a symptom-based diagnosis, and culling this information together within a theoretical framework.

Regardless of theory, all therapists differ in their execution of the theory based on their own personality and engagement with the theory and the client. Two therapists utilizing the same exact theory may still think and respond differently to the same client with the same issues (Nystul, 2016). Petko, Kendrick, and Young (2016) suggest that theoretical orientation is a developmental process that requires discipline, training, and time. Theory selection should not be based on personal preference but rather on careful consideration of the model "that is most applicable to the client and most authentic to the therapist" (Cook, Schwartz, & Kaslow, 2017, p. 545).

A number of authors describe psychotherapy as being both an art and a science and discuss the importance of the balance between the two. It is important to understand and critically examine the scientific literature about different models of psychotherapy. It is equally important to appreciate the therapeutic relationship and the skill and empathy with which a clinician executes any model of treatment (O'Donohue, Cummings, & Cummings, 2006; Nystul, 2016; Wachtel, 2013; Corey, 2017; Cochran & Cochran, 2015).

Evidence-Based Practice: The Science of Psychotherapy

Evidence-based practices in psychotherapy "emphasize the best available research with clinical expertise in the context of the patient's culture, individual characteristics and personal preferences" (Cook, Schwartz, & Kaslow, 2017, p. 577). Evidence-based practice ensures that clinicians are using the best existing evidence as a starting framework while affording flexibility to individualize treatment by assessing the data available and applying it to individual patient circumstances. Some examples of these circumstances are developmental history and life stage, personal problems, degree of social support, personality structure, readiness to engage in therapy, and sociocultural and environmental factors (e.g., unemployment). Evidence can include numerous methodologies as long as the evidence is assessed and applied appropriately in clinical decision making. The best research evidence includes data from meta-analysis of randomized controlled trials, which are challenging for social workers to conduct. However, effectiveness studies, process studies, single case studies, qualitative and ethnographic research, and clinical observation can be informative and are friendly to social work usage (Cook, Schwartz, & Kaslow, 2017, p. 538). It is also important to consider the wide range of evidence-based research regarding the importance of the "common factors across different forms of psychotherapy, such as the working alliance, therapist empathy, and the patients' expectations about treatment effectiveness" (Blease, Lilienfeld, & Kelley, 2016, p. 5). Meichenbaum (2017b) summarizes a number of research studies and suggests that the quality and nature of the therapeutic alliance accounts for a "significantly larger proportion of treatment outcome variance than do therapist effects and the specific treatment interventions or the specific form of acronym therapy that is being implemented" (p. 197).

Another key goal of evidence-based psychotherapy is to maximize patient choice and to ensure that decisions are made collaboratively between the therapist and the patient. Clinicians have a professional responsibility to be familiar with the state of the field, regardless of their own preferences and bias regarding models of practice. For example, clients have the right to know why

the therapist has chosen the theory/model of treatment for their clinical intervention. Blease, Lilienfeld, and Kelley (2016) note: "Patients with obsessive-compulsive disorder (OCD) have a right to know that exposure and response prevention [see Chapter 8 on behavioral theory] is the best-supported intervention for their condition and hence a first line treatment. On the other hand, conditions such as major depression tend to respond to a broad range of psychological treatments, including cognitive and interpersonal" (p. 5).

The majority of theories that are documented as evidence-based practices are cognitive behavioral. In addition, as Shedler (2010) notes: "Considerable research supports the efficacy and effectiveness of psychodynamic therapy" (p. 98). He reviewed the empirical evidence for the efficacy of psychodynamic therapy and found that the "benefits of psychodynamic therapy not only endure but increase with time, perhaps related to the focus on intrapsychic processes such as reflective function and attachment organization" (pp. 101–102). (See Shedler, 2010, for more specific information on these studies.) It is also important to remember that "psychological health is not merely the absence of symptoms, it is the positive presence of inner capacities and resources that allow people to live life with a greater sense of freedom and possibility" (Shedler, 2010, p. 105).

When evaluating evidence, remember that research samples often underrepresent minority populations and patients with comorbid conditions and/or complex social stressors. Also, evidence-based practice focuses on ameliorating symptoms, and many people seek psychotherapy to cope more effectively with life's challenges. Reliance on the scientific research behind evidence-based practice is problematic as there are no agreed-upon criteria for determining if a psychotherapy is evidence based or empirically supported, and what is statistically significant and suggestive of empirical support may not be clinically relevant. Many times randomized controlled trials compare an active intervention with a wait-list control that does not exist in the community. Until efficacy and effectiveness studies include treatment conditions that resemble practice in the real world, it is challenging to draw conclusions that can improve clinical practice from the existing data (Duncan, Miller, Wampod, & Hubble, 2010).

Finally, psychotherapy research is highly contentious and difficult to interpret. There are differences in the way therapists practice. "What takes place in the clinical consulting room reflects the qualities and style of the individual therapist, the individual patient, and the unique patterns of interaction that develop between them" (Shedler, 2010, p. 103). It is also important to recognize that when elements of the treatment are changed, the therapy is no longer the same as the researched practice model. In addition, evidence-based treatment research generally involves intense training of those who are implementing treatment protocols and careful observation of their efficacy in doing so. This may not necessarily be the case in most clinical practices where training and supervision may be less rigorous (Cook, Schwartz, & Kaslow, 2017). Basing therapy solely on evidence-based practice misses the art of psychotherapy, which is to recognize that psychotherapy is unique to each person and to the fit between the person and the therapist.

The Therapeutic Relationship: The Art of Psychotherapy

A key task in therapy is creating and maintaining an optimal therapeutic relationship, which has to involve elements such as empathy, positive regard, and instilling hope while also supporting clients in exploring areas and making changes that are desired but may be challenging and painful (Baldwin & Imel, 2013; Wampold, 2019).

The concept of therapeutic relationship or alliance can be traced back to Freud, whose conception evolved from a purely transferential one, a projection of the client's feelings from early relationships onto the therapist, to the possibility of a working alliance—a real, collaborative

relationship between the patient and the therapist that is focused on achieving therapeutic goals (Rogers, 1951; Horvath & Greenberg, 1989; Hovarth & Luborsky, 1993). As Bordin (1979), in his classic paper on the "generalizability of the psychoanalytic concept of the working alliance," writes: "The optimal therapeutic relationship is achieved when patient and therapist share beliefs with regard to the goals of the treatment and view the methods used to achieve these as efficacious and relevant" (p. 272). Cochran and Cochran (2015) refer to the therapeutic relationship as the "heart of counseling." Ardito and Rabellino (2011) discuss a number of articles that investigated the therapeutic relationship and outcome in psychotherapy. They found that regardless of the psychotherapy approach, the relationship between the client and the therapist is a reliable predictor of positive clinical outcomes. The therapeutic alliance will influence outcome not because it is necessarily healing in its own right but because it is an ingredient that enables the patient to accept, follow, and believe in the treatment. Cook, Schwartz, and Kaslow (2017) write: "The relationship acts in concert with treatment methods, patient characteristics, and practitioner qualities in determining effectiveness. In fact, the therapeutic relationship accounts for why patients improve, or fail to improve, at least as much as the particular treatment method" (p. 542). These authors recommend that for evidence-based practice to be as effective as possible, there needs to be a comprehensive understanding of how the therapeutic relationship acts in concert with other determinants; therapists should be attuned to patients' experiences of psychotherapy and must be caring, understanding, and accepting. Other authors (Stamoulos et al., 2016; Kazantzis, Dattilio, & Dobson, 2017; Lipchik & Rey, 2011; Wachtel, 2013) provide considerable evidence that the therapeutic relationship makes substantial and consistent contributions to psychotherapy outcomes, independent of the type of treatment.

Greater attention may need to be paid to the "evidence-based relationship movement," which seeks to integrate research and practice "in a manner that places greater value on patient-centered care and the relationship between the patient and the healthcare provider" (Cook, Schwartz, & Kaslow, 2017, p. 548).

HOW A STUDENT LEARNS TO INTEGRATE THEORY AND PRACTICE

A Case Illustration

This case illustration provides an example of a male student intern interviewing a client, a 38-year-old Dominican woman. The student intern has selected self-psychology as the theory that best informs his treatment. He chose this theory because self-psychology has been applied to brief treatment with clients like Mrs. Diaz who suffer from depression and low self-esteem due to experiences of loss and disappointment with relationships. The goal of treatment from a self-psychological perspective is to enhance Mrs. Diaz's self-esteem by providing self-object functions that then become internalized. The two functions that the worker attempts to apply are mirroring and twinship (see Chapter 6 on self-psychology). Mirroring is a self-object function that reflects back, like a mirror, an appreciation of the client's capabilities, talents, sense of self-worth, and value (Kohut, 1971, 1977). Self-object needs for twinship include our need to belong, to feel connected to another who is similar. When twinship self-object needs are met, the individual feels a connection to a larger group, a sense of intimacy, and feelings of belonging.

When the developing child does not have these self-object experiences, the internalization of psychic structures cannot occur, and shame and humiliation result. Below is a model for how the student learns to integrate theory and practice.

FIGURE 1.1 Three-Column Model for Process Recording

Dialogue	Student's Self-Reflection	Student's Application of Theory

FIGURE 1.2 Example of Student Process Recording

Dialogue	Student's Self-Reflection	Student's Application of Theory
Intern: Don't worry Mrs. Diaz. The two of us will clear things up later. It is her job to supervise children while parents are in session. Can I comment on something that I have noticed?	She's always feeling responsible for other people. Now she feels responsible for me. (Would Kohut see this as Mrs. Diaz being the self-object for others?)	I am trying to be the *self-object* for Mrs. Diaz.
Mrs. Diaz: Yeah, sure.		
Intern: You had nothing to do with the situation with the aide, and yet you felt really guilty about what had happened.		Offering *reassurance* and *interpretation*, but I think I need to be more empathic—maybe say, "You really feel responsible for many things...."
Mrs. Diaz: I don't know ... I just feel responsible somehow. I feel responsible for my husband's depression, my sister's unhappiness, and my mother's too.	She takes on a lot.	*Listening* and *exploring*
Intern: Wow, you are responsible for a lot of people—your daughter, your husband, mother, sisters, et cetera.	Mrs. Diaz nods with a forced smile. I must have hit on something here. In the past, Mrs. Diaz told me that she was reared to be the caregiver for the younger children in the family and that this role was typical in Latin Caribbean cultures. Her situation was compounded by the sense of abandonment she felt when her mother left for New York without her. She was deprived of the chance of having a mutually empathic relationship with her mother and may have begun to feel unworthy. This client is not able to achieve warm and fulfilling relationships with others because of the lack of foundation set by the mother.	I am trying to use *mirroring*, but I don't think I really understand how to do this.
Intern: When you were trying to separate from Mr. Diaz, who supported you during that time?		I think I move away from theory here. I have to try harder to stay with Mrs. Diaz's experience.
Mrs. Diaz: No one at that time—even my mother came and put a guilt trip on me so I would stay with him.	She's so alone. Her own mother wouldn't take her side.	
Intern: That must have been really hard on you.		I attempt another self-psychology intervention here, providing *empathy*—a *mirroring* response—I think. Am I using mirroring correctly now?
Mrs. Diaz: Yes, it was. No one ever supports me, not even my friends.		
Intern: What are your friendships like?	I wonder why I was questioning this here.	*Exploration*—but maybe I should have continued *mirroring*.

(*Continued*)

Dialogue	Student's Self-Reflection	Student's Application of Theory
Mrs. Diaz: Well, my friends are like my sisters. They all have these problems with their husbands and their children—they all need help too.	She seems sad.	
Intern: It sounds as if you are more overburdened being a mother to everyone. I can understand how you feel; actually I can feel the heaviness when you walk into the office.		I am using *empathy* here.
Mrs. Diaz: I am a mother to everyone.	I made a good comment here. She seems to be reflecting on what I said.	
Intern: No one deserves to feel that way, especially when you have so many positives going for you.	I'm feeling sad for her. I want to raise her self-esteem.	I am trying to continue offering *support*—being *empathic*—offering myself as a *self-object*.
Mrs. Diaz: I don't feel like I have any positives.		
Intern: You said that your mother is always yelling for you to clean your apartment even more than you do—right? Your apartment looks beautiful.	Her apartment is always immaculate. She doesn't see her own worth.	I am helping to *build her self-esteem* by *providing support*.
Mrs. Diaz: Yes, she wants me to be the perfect Dominican housewife, while my husband stares at the wall doing nothing.	She seems angry. He sounds like a real loser.	Perhaps I should ask something about Dominican culture? Is this the norm for all marriages? Or is this another example of how her mother can't put her first?
Intern: So you are expected to do everything for your family while your husband sits and rests all day.	How can she stay with him?	
Mrs. Diaz: Yes, I am not going to have it.	Good. She's sounding stronger.	*Empowering*
Intern: I think we are getting somewhere today.		I use the "we"—a self-psychological concept called *twinship*. I will try to show her that I am allied in the work with her.
Mrs. Diaz: (crying) No one is there for me.	I wish I could take away her sadness.	
Intern: I can see how this must have been very upsetting to you. You love your mother, yet she wasn't always there when you needed her.		*Validating* and *mirroring*
Mrs. Diaz: No, she wasn't at all. She left my sisters and me with our cousin while she went to New York to follow her dreams.		
Intern: So as a mother, would you say she was excellent, very good, good, or poor?		This is an attempt at empathic introspective questioning, but I think I am coming across as though I am interrogating Mrs. Diaz.

(*Continued*)

FIGURE 1.2 (*Continued*)

Dialogue	Student's Self-Reflection	Student's Application of Theory
Mrs. Diaz: I love my mother; she is not a bad person. She just ... well, she was not very good ... she always sent money and we had food and clothing, but she wasn't there when I needed her.		
Intern: That must make you angry.	Mrs. Diaz has been socially conditioned to show empathy for others in her roles as caregiver, mother, and wife. She often feels guilty when she does something for herself. She's beginning to show anger at others—her husband and mother—who do not show empathy toward her. I view her anger as strength because it shows that she has not been taken over by oppressive forces or social conditioning.	My goal is to provide her with an *empathic relationship*. That is different from what she has experienced. I am again using *mirroring*.
Intern (continuing): This must be a really difficult situation for you. Instead of concentrating solely on getting childcare and job training over the next couple of weeks, could we talk about how your relationship with your parents has affected all your other relationships?	I want to continue exploring the past and how it relates to her present situation. I am trying to be empathic, but this is becoming challenging. I'm afraid of overstepping my boundaries by talking about "we" and "us."	*Empathy*. I use the concept of *twinship* here when I talk about the "we." This is the *partnering self-object*—I show her that we're in this together.

The student writes: "Mrs. Diaz came to the session with her 3-year-old daughter. I asked a case aide if she could watch the child while the mother and I talked. The aide initiated an argument with me in front of Mrs. Diaz. The process picks up after the case aide leaves me in the interview room with Mrs. Diaz and her daughter."

In thinking over this interview, the student poses the following questions, which he will then share with his supervisor. It is helpful if students present their questions in writing, in advance or clinical supervision, so that both they and their supervisors can reflect on the work.

1. I think I felt embarrassed that the case aide and I had an argument in front of Mrs. Diaz. It threw me and I forgot for the moment that I was using the self-psychology model with Mrs. Diaz. How should I have handled it within the framework of self-psychology?
2. I'm worried about how Mrs. Diaz sees me. I am a male intern with white privilege, and she is an immigrant Latina woman living in poverty. She has problems with her husband, whom she claims is abusive. Should I address the gender and cultural issues with her? Would I be able to do that within the self-psychology model? Or am I coming from my own anxieties instead of focusing on being more empathic with Mrs. Diaz?
3. Mrs. Diaz was traumatized by her mother's early migration and what she perceived as abandonment. I, too, have some early abandonment issues. I feel very close to Mrs. Diaz when she talks about this. I'm afraid of overstepping my boundary because I identify closely with her struggle. How do you think I can guard against this?
4. I struggled with the concept of mirroring—I would like to review the places in the process recording where I attempted to use it. I think I used twinship correctly—this was easier for me.

Supervision

A critical aspect of any psychotherapy practice is training, including both initial training in an academic setting and ongoing continuing education and supervision that is part of professional practice (Booth, 2014). The National Association of Social Workers and the Association of Social Work Boards have developed best practice standards in social work supervision to support and strengthen supervision for professional social workers. The standards provide a general framework that promotes uniformity and serves as a resource for issues related to supervision in the social work supervisory community. It is important to the profession to ensure that all social workers are equipped with the necessary skills to deliver competent and ethical social work services. Equally important to the profession is the responsibility to protect clients (retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=GBrLbl4BuwI%3D&portalid=0, October 29, 2018).

In the above example, the student had several self-reflective questions that he would ideally have shared in writing with his supervisor before his supervisory meeting. (The supervisors' questions can also be verbally discussed during supervision.)

Following is an example of a supervisor's possible response to the student's questions that can then be discussed.

1. Self-psychology is an excellent model to use because it demonstrates the use of empathy. Did you select this theory intuitively, or did you find some evidence that this was the model of choice? What do you think of your use of Kohut's constructs of "mirroring" and "twinship"?
2. You are highly empathic during most of the interview. Can you recognize the times during the interview when you move from the empathic response to another intervention? Do you know what you were thinking or feeling during those times? How could you continue to be empathetic and what would you say?
3. You mention that you may have been somewhat interrogating when you asked Mrs. Diaz about her mother. How else might you phrase your question about her mother?
4. In the interview you speak about raising Mrs. Diaz's self-esteem. Can you think about how this would be accomplished within a self-psychological framework?
5. How would raising the gender and cultural issues help your client? What do you think about her marital expectations within the context of her culture?
6. Let's talk more about your concerns re: boundary issues.
7. How might you begin to think about evaluating your practice interventions?

SUMMARY

The profession of social work has evolved over the years and now espouses a breadth of theoretical approaches and treatment modalities. We recognize that applying theory to practice is a challenge. Students have difficulty choosing relevant and applicable theories, learning to be flexible to adjust to the changes in the process of theory application, and avoiding dogmatism and mechanism when using theory in practice. It may take years of study and practice to feel competent working with a wide range of theories. However, forgoing theory may easily result in negligent, harmful, and ineffectual practice. Competent practice in social work mandates that social workers act from the informed knowledge base that theory provides. Graduate social work education is, for many, the first step to becoming a skilled clinician. In this chapter we introduced the

importance of theory, presented an overview of the theories presented in this book, and included a model that students can use to learn how to apply their knowledge of theory in the live interview with clients.

REFLECTION QUESTIONS

1. Discuss the core components of psychotherapy from different theoretical lenses.
2. Reflect on the basis for selecting a theoretical model to guide clinical practice.
3. What do you think the basis was for selecting self-psychology in the student's work with Mrs. Diaz?
4. What other theoretical model might you consider in your work with Mrs. Diaz?
5. Consider a client you are working with currently. What theoretical model are you using, and how did you select that model? Are there other models you might consider that would influence your assessment and treatment?
6. How would you work with Mrs. Diaz from an alternate theoretical model?

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2

The Clinical Interview: The Process of Assessment

Learning Outcomes

At the conclusion of this chapter, students will be able to:

- Discuss the first meeting in a clinical interview
- Elaborate on the first meeting in a clinical interview with a child or adolescent and parent
- Explain confidentiality in clinical practice with children, adolescents, and adults
- Define the concepts of transference and countertransference
- Understand the stages of change model of treatment

In this chapter, we discuss the clinical interview in the beginning, middle, and end phases of treatment. Using the extended case example of Dan, a teenaged boy diagnosed with a conduct disorder, we explore using motivational interviewing and the transtheoretical model of change together with an integrated treatment approach to illustrate the client's and the worker's responses to the various clinical issues that emerge at each stage.

BEGINNING STAGES OF TREATMENT

The First Meeting

Workers conduct initial clinical interviews for the purpose of collecting data. The biopsychosocial assessment is the product of that therapeutic process. Initially, the worker needs to gather the information that forms the basis of the psychosocial assessment. She also begins to establish the working alliance.

When you first see a new client, what do you observe? Sometimes it is how she sits in the waiting room. Is she reading, sleeping, or pacing? Does she seem eager to respond to your greeting or anxious about entering your office? What and who has she brought to the interview? How is she dressed? Seasoned practitioners seem to take in this information through their bones; inexperienced workers, however, will need to be very conscious and use all their powers of observation when meeting a client for the first time. A question that frequently comes up with regard to the first meeting concerns the theoretical framework. This is a tricky issue, and clinicians who work from a particular theoretical lens may conduct their entire diagnostic assessment within a particular framework. This may be based on the clinician's theoretical orientation, but it may also be based on the context of practice. Clinical program administrators may limit options to those that are favored by managed care companies. These tend to be evidence-based models such as cognitive behavioral therapy that have a good degree of merit with certain conditions, such as

mood disorders, fears, and phobias. However, we recommend an initial interview that uses many open-ended questions and allows the client to tell his story as this is the best way to gather information, even when completing a more structured biopsychosocial assessment (see Chapter 3 on biopsychosocial assessment). Beginning interviewers as well as seasoned clinicians must also be self-aware or mindful of what makes for a good therapeutic relationship.

Therapy with Children and Adolescents

Therapy with children and adolescents requires the presence, at least initially, of a parent. It is customary to interview the parent or parents before seeing the child or adolescent. There can be some variation with older adolescents where the initial interview may take place with both the parent and adolescent. Listening to the parents' concerns, answering questions, and providing education about the therapeutic approach fosters the therapeutic partnership. Allow time to take a detailed developmental history and to have the parents sign all necessary releases. Review the mandatory reporting laws and limits of confidentiality (see later section in this chapter) so that the client knows your role as a mandated reporter of child abuse and neglect. If the parents are divorced, establish who has custody of the child and discuss how each parent (including the parent who may not be present during the initial interview) will be involved. If the clinician sees the child on a regular basis, contact with both parents is always preferable.

The initial interview with the parents is also the time to establish what other therapeutic partners might need to be consulted to complete the diagnostic picture. Request permission to talk with the child's pediatrician and obtain results of a recent health examination. Consider getting information from the school adjustment counselor or a teacher. A child psychiatrist, clinical psychologist, or speech-language therapist might be part of the treatment team, especially if the parent or the clinician suspects the presence of a learning disability, attention-deficit hyperactivity disorder, or other problems that are manifested in childhood.

Finally, when dealing with children under age 12, advise the parents on how to explain the therapy to their child. Use developmentally appropriate language. You might, for example, coach a parent of a 4-year-old child attending preschool and not wanting to leave the parent in the morning to say, "I met a very nice woman who plays with children who don't like to say good-bye to their mommies in the morning." Be prepared to talk with the parents about your plan for assessing the child in the child's first interview and how you will be working as you proceed with treatment. This helps the parents feel confident that their child is in the hands of a competent practitioner.

For the first child therapy session, we recommend that the clinician meet with the parents and the child or adolescent together for the first 10 to 15 minutes. During this time, the child or adolescent (who is still a minor) can hear why the parent has brought him to see the therapist. This meeting helps establish rapport so that later in the session, when the child or adolescent meets alone with the therapist, he knows why the parent has brought him for counseling. Then, the therapist might say, "I can see your point, but it sounds like your parents see it differently. What do you think about their point of view?" Keep toys within view when working with younger children. You may want to sit on the floor and engage in some play as you talk with the parents to find out the reason they are bringing the child to "visit" you. In a developmentally sensitive interview, the communication process may rely more on play than words.

Adolescent clients are often silent in initial interviews when parents are present. Use the time to establish the boundaries of the relationship with the adolescent and the parents and refrain from pushing the adolescent to talk. Taffel (2005) suggests beginning the first meeting with adolescents by inquiring about their interests in life as opposed to focusing on problems. He also emphasizes the importance of talking with adolescents about their "second family"—the peer group and pop culture. Be clear and honest with adolescents about the need to inform parents about

high-risk behaviors. The following brief example demonstrates how to engage an adolescent in a discussion of confidentiality: "You're telling me some things right now that I have a lot of concern about. I know you won't like hearing this, but I feel strongly that we need to bring your parents on board for this conversation. Tell me how we can work together to tell them."

Confidentiality

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which became effective on April 24, 2001, set national standards for the protection of health information, as applied to health plans, health care clearinghouses, and health care providers who conduct transactions electronically. Currently, all health and mental health care patients must sign forms signifying that they have agreed to allow their providers to transmit confidential information electronically. The rule does not replace federal, state, or other laws in effect that grant even greater privacy protections, and covered entities are free to adopt even more protective policies or practices. For a general overview of standards for privacy of individually identifiable health information, refer to the government website www.hhs.gov/ocr/hippa/guidelines/overview.pdf.

Reamer (2013) considers the standard of care as the basis for decisions regarding what information should be shared with the parents of a child or adolescent. This standard is defined as "the steps that an ordinary, reasonable, and prudent social worker should take when deciding how to handle complex circumstances involving private, confidential, and privileged information" and includes (1) consulting with colleagues; (2) obtaining proper supervision; (3) reviewing relevant ethical standards; (4) reviewing relevant regulations, laws, and policies; (5) reviewing relevant literature; (6) obtaining legal consultation when necessary; and (7) documenting the decision-making process.

It is also important to let the client know the parameters of the clinical relationship and what material will and will not be kept confidential. Social workers are mandated reporters in a number of situations and have a duty to inform the police and the intended victim when their clients are a threat to themselves or others. In addition, social workers are mandated reporters of suspected child abuse and/or neglect. Therefore, if they suspect any abuse or neglect, they are required to contact the Department of Protective Services in their local area with or without the consent of the child and/or parent/guardian. Determining neglect is especially complicated because it might involve bigger issues, such as poverty, access to resources, and other socioeconomic challenges. Social workers are not mandated reporters of intimate partner violence, unless there is concern about a minor child in the home. Concerns should be discussed openly with parents (unless there is reason to fear for one's safety) and appropriate referrals and follow-up made to ensure the safety and well-being of the child (Matthews & Bross, 2015; Reamer, 2013; United States Department of Health and Human Services, Administration for Children & Families, Administration on Children, Youth and Families, Children's Bureau, 2010).

Understandably, these areas where confidentially cannot be maintained can disrupt the therapeutic relationship and the client's desire to continue treatment and should be handled professionally and sensitively (Loue, 2018).

Self-Awareness

Self-awareness is an umbrella term. Within the context of the clinical interview, we relate self-awareness to an understanding of the multiple dimensions of the worker's identity and how that interacts with the multiple dimensions of the client's identity. This includes attention to race, gender, sexual orientation, spirituality, and social class. In order to initiate the process of self-awareness, Sommers-Flanagan and Sommers-Flanagan (2017) propose that people sit in pairs

and ask each other the same question a number of times; the same answer cannot be used twice. The questions they ask each other (changing roles) are "Who are you?" and "Who do you see?" Of course, for beginning interviewers, this process of reflection on self and others may have to take place retrospectively. With time and experience, it will begin to happen within the interview.

Introductions

When you introduce yourself to a new client, use your full name. Then ask the client how he would like to be addressed. You may call a client by a first name if so directed; otherwise, using a title and surname is more respectful. This may be particularly significant when meeting older clients and clients from minority cultural groups. Obviously, there may be individuals and settings where this general rule can be relaxed, such as when meeting young children or adolescents for the first time.

Be on time for your first meeting with a client (and all subsequent meetings). If a client is late for the meeting, it is important to ask about this in a nonthreatening manner. Talk to your client about this openly, and collaboratively establish the guidelines for subsequent meetings. This should include a discussion of what to do if an appointment needs to be canceled. Remember, this first meeting often sets the stage for what is to follow.

It is important to pay attention to the seating in your office. You should avoid sitting behind a desk when you are interviewing a client because this may introduce a power imbalance in the relationship. Take your cues from the client's behavior. Remember, the client is assessing you while you are assessing her. Keep pictures of your partner, children, and pets at home; displaying personal items is inappropriate. If your client is struggling with finding a mate, she doesn't need to see you as part of a happy family. It may stir up envy and add to the client's burden.

Why Is the Client Here?

The best way to begin the initial interview is by learning why the client has come to see you. Questions such as "What brings you here today?" or "What is on your mind today?" are helpful in getting started. In the beginning, clients are often too overwhelmed to give much information. It's important to have a tissue box close to the seating arrangement—many clients cry as soon as they hear the comforting voice of a person whom they believe will be able to help them find a way out of their pain.

It is helpful initially to provide structure and to educate your client about what is going to take place in the interview, including what kinds of questions you will be asking and why. Try to present yourself as an interested, empathic, helpful person and not an investigator or interrogator. Make sure that you have acquainted yourself with the questions on the intake form ahead of time so that you can move smoothly into new subject areas as you collect information. Open-ended questions are best to use at this time to give the client an opportunity to tell his story. If you are unclear about something, a gentle interruption such as "What you are saying seems very important—I'd like to ask you a little more about that" may be used. Ask questions about specific symptoms, which may be diagnostically helpful as well as determine your theoretical frame of reference. It is also important to obtain information about the client's resources and coping capacities. Be mindful that the client needs some protection in the beginning—too quick a revelation of all her struggles and defeats may leave her feeling vulnerable and fearful of returning. Try to keep the interview moving. Long silences can create anxiety. When taking notes, let the client know that you need to have some specific information that may be difficult to remember, such as demographic data or dates of certain events, and that you may have to write these things down. Explain what you are writing and get the client's permission before moving ahead. It is not helpful to have a completed intake form only to lose your client because he perceived you as insensitive or preoccupied with note taking.

Answering Personal Questions

Clients may sometimes ask you personal questions in an initial interview. Different theoretical models understand and address this important issue in varying ways. In general, it is important to understand the meaning that such questions have to the client and, whenever you are unsure of the meaning, to feel comfortable asking. This is not to be confused with feeling threatened by a client's asking a personal question and reacting with a response such as "Why do you ask?" which can feel disrespectful or embarrassing to the client.

In most cases, clients ask personal questions because they want to know what kind of life experiences the clinician has had and whether he will be able to understand what the client is talking about. This issue has particular significance in cross-cultural work, especially when the therapist is from the dominant culture and the client is from a minority background. As greater numbers of minorities enter the helping professions, they may also find themselves working with clients from the dominant culture who may be questioning whether the minority therapist can understand their difficulties. Many years ago, a young Black female student was taken aback when a young white female client asked her how she felt about white people, because they were often mean to Black people. White therapists have been asked many times when working with Black clients how they feel about Black people. These are difficult and complex issues for which there is no simple answer.

The key is to understand the significance to the client and to always put her best interests first. The clinician may be uncomfortable sharing personal information even when it might be helpful to the client; in these instances, the clinician needs to acknowledge his understanding of what the client is looking for and honestly share feelings of discomfort. For example, one might say, "I'm sorry. I'm not comfortable talking about my personal life with you. I can understand this may be disappointing to you, but I hope we will be able to work together in spite of my decision" or "I'm not comfortable talking about my personal life with you, but I'd like to understand what asking that question means to you or whether you feel I can help you without answering personal questions."

It is important to differentiate between the client's questions about your personal life and those about how your training, credentials, or personal values that could compromise your ability to be of assistance. You have an ethical responsibility to answer questions that will enable the client to make an informed decision about whether to engage in treatment with you. For example, you might be asked by a client if you are a "Christian therapist," and, upon hearing that you are not, the client might ask if you feel you could work with her and help with her problems even though you have different religious beliefs. You must also tell the client if you are a student or a clinical trainee, regardless of whether the client asks about your credentials. After stating your name, simply state, "I am a student (or an intern) training to be a social worker. I will be working at this agency until May. My work with you will be supervised by a licensed social worker. If you have any questions about this, I would be happy to discuss them." By inviting the client to talk about any concerns she may have, you convey a willingness to be of help, which the client will appreciate.

THE THERAPEUTIC RELATIONSHIP

The concept of the therapeutic relationship has its origins in the psychoanalytic literature. Freud (1912) was the first to speak of the patient as an active collaborator in the treatment process. He introduced several theoretical concepts—transference, countertransference, the real relationship, the working alliance, and resistance—that have survived and, with revision, have continued to influence the theoretical relationship in clinical social work practice. Recent literature on the therapeutic alliance uses the concept of "rupture" as a strong predictor of therapeutic outcome.

A rupture in the therapeutic alliance causes tension in the collaborative relationship between the patient and the therapist. A rupture can range from a minor breakdown to a large breakdown in communication and working together. Ruptures need to be repaired to avoid interpersonal conflict and clients dropping out of treatment prematurely (Christopher & Eubanks-Carter, 2011).

Using Bordin's (1979) classic conceptualization of alliance, ruptures include disagreements about therapeutic tasks, disagreement about treatment goals, or tensions in the bond between therapist and client. In an effort to resolve such ruptures, it is important for therapists to be aware of how ruptures occur and to rebuild the therapeutic alliance, altering tasks or goals in response to disagreements about them and clarifying any misunderstandings that are related to the rupture. Social workers need to be aware of subtle hints that ruptures have occurred. They can then, in an empathic and accepting manner, help the client express any negative feelings she may have.

Transference and Countertransference

Transference, as originally introduced by Freud, is the "experiencing of feelings, drives, attitudes, fantasies and defenses toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions, originating with significant persons of early childhood." Transference is based on a relationship in the past (Greenson, 1967, p. 33). Relational psychoanalytic theories place the concept of transference into the therapeutic dyad and consider that a client's transferential responses may be evoked by the therapist.

Countertransference is a controversial subject in contemporary times. It was originally defined as "a transference reaction of an analyst to a patient ... when the analyst reacts to his patient as though the patient were a significant person in the analyst's early history" (Greenson, 1967, p. 348). Initially confined to the therapist's personal feelings, countertransference, like transference, has become more relational in scope. Countertransference is now considered to be both the result of the therapist's own unconscious processes and an appropriate reaction by the therapist to the patient—an important indicator of the patient's relational style. This reciprocal influence of the conscious and unconscious subjectivities of two people in the therapeutic relationship is called *intersubjectivity*. This concept expands the earlier definitions of transference and countertransference by suggesting that the therapist and the patient not only bring their own separate lives to the therapeutic encounter but also understand and change each other during this process (Benjamin, 2018; Kirshner, 2017).

Cultural Countertransference

Perez-Foster (1998, p. 42) describes cultural countertransference as a "complex and interacting set of culturally-derived personal life values; academically based theoretical/practice beliefs; emotionally driven biases about ethnic groups; and feelings about their own ethnic self-identity." Clinicians have an ethical obligation to be mindful of cultural countertransference, especially in cross-cultural therapeutic relationships. Clinicians should also attend to self-awareness and identity development, multicultural competence, and a respectful "not knowing stance" (Basham, 2004, p. 299) during the interview. Lesser and Pope (2010) remind us that clinicians from a background similar to their clients' must also be aware of cultural countertransference because their assessment could be biased by subjectivity. Clinicians must address their cultural countertransference, and doing so within the context of self-compassion may contribute to honest self-reflection (Germer & Siegel, 2012; Gilbert & Choden, 2014; Neff & Germer, 2018).

The Real Relationship And The Working Alliance

The real relationship is the "realistic and genuine relationship between analyst and patient in the here and now" (Greenson, 1967, p. 217). The concept of the real relationship is embedded not only in psychoanalytic theories but also in the cognitive, behavioral, cross-cultural, and postmodern models

presented in this chapter. In many ways, the real relationship between the therapist and the patient is the precursor to the concept of the working alliance—the rapport that develops between the therapist and the patient that makes it possible to work purposefully in therapy. The effectiveness of therapy depends to a great extent on the strength of the working alliance. Research shows that psychotherapy works best when there is a good working alliance between patient and therapist (Ardito & Rabellino, 2011). This is supported by modern technological developments in neuroscience that highlight the importance of developing and maintaining a therapeutic relationship through activation of areas of the brain related to the attachment system (Siegel, 2012). (See Chapter 5 on object relations.)

Resistance

Greenson (1967, p. 60) presents the original psychoanalytic definition of resistance as "a counterforce in the patient, operating against the progress of the analysis, the analyst, and the analytic procedures and processes." He quotes Freud (1912, p. 103), who states, "The resistance accompanies the treatment step by step. Every single association, every act of the person under treatment must reckon with the resistance and represents a compromise between the forces that are striving towards recovery and the opposing ones." The concept of resistance has also undergone revision in psychoanalytic thinking. Originally considered an obstacle to the therapeutic work, resistances came to be understood as the source of important information regarding the patient's ego functions. Wachtel (2008), writing from a contemporary relational psychodynamic perspective, (see Chapter 7 on relational theory) equates resistance with patient conflicts about changing. Beginning therapists often view resistance as something that has to be overcome. Wachtel suggests that therapists instead view resistance as the way in which the patient is trying to communicate to the therapist at a particular point in the therapy. Behaviors that are considered resistant by the therapist may serve as adaptive functions for the patient and may protect the patient from experiencing pain, anger, shame, anxiety, or many other uncomfortable feelings. This is much more in line with postmodern theories that do not adhere to the concept of resistance as well as the cognitive and behavioral theories that view resistance as obstacles to the change process.

Using These Concepts in Practice

As you listen to the client's story, pay attention to the feelings that are stirred up in you. Often the best aid to forming a diagnosis comes from your own felt responses to the client and to the information that the client presents. A cautionary word is important here: you should be mindful of not confusing feelings that the client's story may arouse in you with acting on those feelings in an inappropriate manner. You have a responsibility to differentiate between countertransference feelings that may be aroused as a result of your own history and countertransference feelings that may be elicited by the client. Regardless of the source of the countertransference, you must always act in a professional manner and in the best interests of the client. Although this may seem obvious, when feelings in the therapist are stirred, it is easy to forget that this is a therapeutic relationship, not a personal one (Wachtel, 2008).

Motivational Interviewing and the Transtheoretical Model of Change

Motivational interviewing (MI) is a counseling approach focused on helping clients explore and resolve ambivalence about making changes (Arkowitz, Miller, & Rollnick, 2015; Rollnick & Miller, 1995). Motivational interviewing was originally developed as a method to understand people with substance use disorder and enhance their motivation to change their behavior.

As an outgrowth of the transtheoretical model (developed by James Prochaska and colleagues in 1977), MI has become an overall form of interviewing and even counseling that is now applied

to many psychological conditions and challenges, including gambling, eating disorders, increasing healthy behaviors, parenting practices, and emotional well-being. In each of these areas, MI shows promise; however, few empirical studies have investigated outcomes, which limits confidence in stating its efficacy in these areas (Lundahl & Burke, 2009).

Within the transtheoretical model of change (Prochaska & Norcross, 2013), ambivalence is a normal process on the road to change. Helping people to work through ambivalence and prepare for change is an important therapeutic skill, enabling one to work with a broader range of clients and not just those who are motivated.

MI relies on identifying and mobilizing the client's desire to change behavior based on collaboration—which builds trust and rapport—as opposed to confrontation. The operational assumption in motivational interviewing is that ambivalence or lack of resolve is the principal obstacle to be overcome in order to effect change. Ambivalence takes the form of a conflict between two courses of action (e.g., indulgence versus restraint), each of which has perceived benefits and costs associated with it. Many clients have never had the opportunity to express the often confusing, contradictory, and uniquely personal elements of this conflict. The therapist's task is to facilitate expression of both sides of the ambivalence impasse and guide the client toward an acceptable resolution that triggers change while at the same time respecting the client's autonomy and freedom of choice (and consequences) regarding her own behavior (Arkowitz et al., 2015).

TRANSTHEORETICAL MODEL: THE STAGES OF CHANGE

The stages of change model uses interventions from several theoretical models and is therefore called *transtheoretical*. (For a complete description of this model, see, for example, Prochaska, Redding, and Evers. 2015, pp. 125–148.) We believe the model can be used to guide the clinical interview, as it enables the worker to conceptualize the movement of a case from beginning to end. Though the stages of change model has undergone several changes over the years, the core stages of this model are as follows:

1. *Precontemplation.* In this stage, the client is not considering change. Denial and rationalization are prominent defenses. In this stage the therapist validates the client's lack of readiness but encourages re-evaluation, consciousness raising, and self-exploration. These techniques are borrowed from psychoanalytic theory.
2. *Contemplation.* In this stage, the client is considering change but may be ambivalent. Clarification, reflection, empathy, and warmth are the techniques borrowed from humanistic/existential theory and are important to use during this stage.
3. *Preparation.* In this stage, the client is trying to change, perhaps planning action within a month. Problem-solving techniques, borrowed from cognitive behavioral theory, help identify obstacles to progress. Creating an action plan (behavioral) with small initial steps is encouraged.
4. *Action.* In this stage, the client overtly modifies behaviors. This stage is behavioral, although the client can also change levels of awareness, emotions, self-image, and thinking. The therapist promotes the client's self-efficacy and focuses on social support.
5. *Maintenance.* In this stage, there is a continued commitment to new behaviors, and rewards are supported and reinforced. Coping with relapse is discussed. Humanistic/existential techniques such as empathy and warmth and behavioral techniques such as positive reinforcement are used.
6. *Termination.* In this stage, self-efficacy has been achieved.

Some stages call for a combination of techniques from different theoretical approaches, and these approaches can be found in several of the chapters of this text.

The Case of Dan: The Beginning

The Referral

Dan, a 16-year-old boy, was referred for treatment by the assistant principal at his school. She mandated that he attend therapy after he received 21 suspensions—all for being disrespectful to his teachers. Dan was described as a charismatic leader who was very angry. A board of education psychiatrist who saw the boy for an emergency consultation diagnosed him as having a "severe conduct disorder." The family agreed to treatment as an alternative to placement in a special school for children with disciplinary problems.

Reading and hearing this referral material would have placed the therapist on guard but she had worked with boys diagnosed with "conduct disorder" in the public school system. Many of those children so diagnosed had turned out to be deprived of nurture and eager to seek approval from delinquent peer groups. And frequently the school system had been too quick to pin a label on a nonconforming child.

Dan Tells His Story

Dan came to the first interview accompanied by his father. Dan was dressed in the baggy shorts and loose T-shirt typical of teenage boys today. What was notable was the baseball cap pulled down over his forehead, the scowl on his face, and his clenched hands. This boy was obviously tense and angry. His father, who was sitting in the waiting room with him, reading, looked perfectly pleasant, with a nice smile on his face and an anxious but warm greeting. Dan entered the office and took the far chair, displaying his desire to maintain distance by sitting far away from the therapist. With encouragement, he spoke readily but with anger about why he was there. According to him, he'd been in continual trouble in school because the teachers were all "idiots," and he backed this up with some examples. He spoke of how he had challenged their intellects as well as their authority. He had earned a reputation as a troublemaker. He said that regardless of who was misbehaving in class, he was always singled out as the one to blame and given harsher and more frequent punishments than his peers. He said that this had been a problem since elementary school. Dan also shared that he had lived with his mother between the ages of 6 and 13, after his parents divorced, that he "hated" his mother for physically and emotionally abusing him. He said that his father had tried to gain custody of him and his sister over the years but had not succeeded in court, and that, finally, his mother "disappeared" after some criminal activity and was last heard from 2 years ago on his birthday. He described her in profane terms and also said she was known to be "mentally ill." This was a lot of information to get from a teenager in an initial interview. The therapist commented to Dan that he was a good provider of information. He answered that he'd seen "shrinks" before, told his story before, and that it hadn't helped. The therapist was interested in why and whether Dan had any hopes that this therapy might be helpful. He said that all the therapists did was listen, and nothing ever changed in his life. He was just doing this so that he could get back into school.

The Therapist'S Response

During Dan's re-telling of why he had been mandated to come to counseling, the therapist remained empathic, supportive, and inquisitive, letting Dan know that she was glad he was here, whatever the reasons, by simply telling him so. She could see that Dan was in the

(*continued*)

The Case of Dan *(Continued)*

precontemplation stage of change. He was not ready to accept ownership of any of the difficulties he was encountering. The therapist explained that she didn't yet know what the reality was, but she accepted his story as his experience of what had happened to him. The therapist was interested to see if Dan had empathy for anyone, because without that quality, the prognosis would indeed be grim. He did say, when asked, that he had a lot of friends—a good sign—and that he cared about his dad. He seemed quite intelligent, and it was apparent that his cognitive abilities had not been impaired by the abuse he had suffered.

Although Dan was angry and challenging, the therapist felt for him, thinking how hard it must be to be raised without a mother's love. His father, when learning that the referral had been made to a woman, commented, "I hope she is smart." Would Dan test the therapist? Would his father? Would Dan be more comfortable seeing a man? The gender of the therapist can sometimes be of significance to certain clients, and Dan had been abused and traumatized by a woman. It was critical that the therapist be as kind and caring as possible so as to provide a different relational experience for this very wounded child.

The therapist told Dan that she agreed that since therapy seemed inevitable, she would like to try to help him out of the trouble he was in so that he could be successful in school. Despite Dan's protests and responses about "not caring," the therapist sensed that he did care very deeply about what people thought of him and that he had a wish to do well, and she told him so. She spoke to Dan about confidentiality and explained that she would only reveal what he shared if she thought he was at risk of hurting himself or others. He had heard this before from his previous therapists and was annoyed at hearing it again. The therapist acknowledged that it can be hard to hear things repeated since he had been in therapy before but that she felt it was important for her to understand how he was feeling this time around. She told Dan that she could understand that he might not be ready for change and that was not uncommon when someone was mandated for treatment and not there on their own volition.

When the therapist asked Dan if there were any times when he was feeling bad enough to want to hurt himself in any way, he responded, "No, not now, I just feel angry now ... there were times in the past when I wished I could disappear, though." The therapist said that it sounded like he may have been very discouraged at those times. "Did you ever think about ways that you might make yourself disappear?" Dan avoided eye contact at this point and said that there were times that he thought he might take some pills, but he didn't want to hurt his father. The therapist replied by saying, "Thanks for telling me about that, Dan. It isn't always easy to talk about these things."

After they had finished talking, the therapist spoke with Dan and his father for 10 minutes together. An adolescent boy in treatment needs to feel separate from his family as he deals with adolescent issues of autonomy and independence. However, it is also important for the therapist to establish an alliance with Dan's father, although he had seemed nervous and not really interested in being part of the therapy. Often, parents feel discouraged and hopeless when they have a child in constant difficulty. The father seemed more than willing to have the professional handle things and wanted to be left alone. Nonetheless, it was important for Dan to hear his father's reasons for bringing him to therapy and equally important for Dan's father to hear Dan's view of the situation. Seeing father and son together would also establish a framework for future joint sessions if they were deemed appropriate.

The Therapist'S Conceptualization

Dan showed many of the characteristics of precontemplation. He was rationalizing his problems, perceiving them as rooted in the lack of expertise of his teachers and their scapegoating

of him. He denied his own part in these troublesome interactions, projecting blame onto others who he saw as ineffectual and unhelpful. It was clear that Dan would need a great deal of understanding and encouragement to motivate him to move toward contemplating change.

It was important for the therapist not to challenge Dan's perceptions, as confrontation in this precontemplation stage would not have helped him to engage. Dan needed to establish trust so that he could begin to think about what he might do to change. To engage Dan, the therapist had made a conscious decision to be as nurturing as possible and began in a very concrete way—providing, in subsequent sessions, donuts and a drink. Dan ate and drank easily and was appreciative and polite. He had good manners—a sign that he could be respectful. As an eclectic practitioner, the therapist conceptualized her assessment in psychodynamic, object relational terms, thinking about some cognitive and behavioral interventions as well, all of which are elaborated on in other sections of this text. The cognitive and behavioral approaches were important because the client and practitioner had to make quick progress—the school needed results, and Dan needed to feel a sense of mastery. She had a tentative working hypothesis: As Dan's story unfolded, she saw a boy who was so vulnerable to criticism after his long history of abuse that he misperceived any adult slight as a dismissal and invalidation of his very being. When wounded, he felt wounded to the core and was very quick to retaliate the only way he knew how—by using his intelligence to plan and strategize a way to at them, usually by humiliating the perceived perpetrator. The therapist would need to be very careful not to hurt him by invalidating his experience in any way. She'd also have to help him learn better coping strategies because eventually she or someone else would give an invalidating response, and Dan would have to learn to better manage his anger so as to have a more trouble-free existence in the real world.

Follow-Up to the Initial Interview

After the initial interview, the therapist requested an earlier school psychological report. This earlier report would provide important information and is always a valuable part of the record when working with a child who has had previous evaluations. If there were no prior school reports, the therapist might have talked with Dan and his father about having an evaluation done by the school-based support team or an outside evaluator. This would help her rule out any learning or attentional issues as well as give a basic understanding of Dan's intellectual capabilities. She was pleased to see that the evaluator's impressions matched her own. The psychological report spoke of a boy with "superior intelligence, who was intense, easily upset, moody, and highly defensive. He appears to misinterpret the intentions of others and sees them as being hostile and threatening. He then responds with anger and hostility that he feels is reasonable and justified. He has particular difficulty with direction/criticism/correction when given by a female teacher."

During these first visits, the practitioner was also in contact with the assistant principal at Dan's school. She had made the referral and seemed to view him negatively. It was important to make an ally of this woman, and so, with Dan's (and his father's) permission, the therapist shared some of her initial impressions. This school-based intervention was an important one in which the therapist tried to clarify the relationship between Dan's emotional state and his behavior in the classroom. The assistant principal softened when she learned of the abuse Dan had described and began to want to work with him. She became a great resource for Dan and, ultimately, his advocate at the school.

The therapist now had an initial picture of Dan from listening to his story and reading his evaluations. Equally important was her response. Sensing a vulnerable child under his aggressive demeanor, she wanted to reach him and wanted him to trust her to do so. She shared the information in the psychological report with him. This was strategic—Dan wanted to know if

(*continued*)

The Case of Dan *(Continued)*

he was "mentally ill" like his mother, and the report reassured him that he wasn't. It was important for Dan to know what the evaluator saw as his issues and not to paint a rosy picture. The practitioner shared her diagnostic formulation and told Dan that she saw it that way, too. She told him that she had some goals for him and that one was to help him learn what his triggers were so that he could manage his anger. She told Dan that she would give him strategies for this—because he had a good strategic mind. The therapist would appeal to Dan's logic, which was his strength, by using a direct, truthful, and reality-oriented approach. This wasn't a child to talk with about feelings—not yet, at least. The practitioner would appeal to his strong mind and motivation to do well (yes, he did want to go to college, if only to be able to choose his own teachers and subjects so he could avoid the "idiots" he was so accustomed to).

Intervention Planning

The most important piece of history that informed the therapist's assessment and treatment planning was the knowledge that Dan had been mistreated. This fact influenced the therapist's choice of an object relations perspective to use within the stages of change model of conceptualization to understand Dan, particularly as it related to childhood abuse. Mistreated children often have an unconscious need to replicate the original trauma. They are hyperalert to signals of possible abuse, often misperceiving and thinking that abuse is there when it may not be, and that can provoke abuse out of an unconscious desire for mastery (James, 1994). This framework helped shape the practitioner's working hypothesis—that Dan was trying to master the abuse he had experienced at his mother's hand by provoking those in authority who appeared dismissive or critical of him in the hopes that he would hurt them and therefore be empowered and triumphant.

THE MIDDLE STAGE OF TREATMENT—MOVING TO CONTEMPLATION, PREPARATION, AND ACTION

Once the initial impressions have been formulated and the treatment plan selected, the therapist has the task of moving the therapeutic process ahead to meet certain goals and objectives. The middle stage of treatment is where that process takes place. It is often referred to as the *working-through stage*. In the stages of change model, it is where contemplation begins, and preparation and action follow. Before the advent of brief treatment modalities—and more recently, managed care—the worker had seemingly endless time to engage in this phase of the therapeutic process. Clients spent years in therapy gaining insight and greater understanding, and some made major personality changes. But whether treatment is long term or short term, there are some predictable occurrences that must be addressed in the middle phase of treatment.

There are many reasons why therapy can get "stuck" in the middle phase. It is important to remember that it is normal for clients to be fearful of the unknown. Contemplation can be threatening, as the client faces painful emotions connected to events past and present. Change often threatens the stability of the client's situation, even when that stability is unpleasant. Couples may fight and appear to be unhappy in their marriages, but if change implies that the partnership will end, they may find ways to stay where they are. Resistance, or obstacles to progress as referred to in cognitive and behavioral models, takes many forms. Sometimes a missed session might indicate that the client is struggling with the therapeutic work. Arriving late or arriving early to a session might signal anxiety. Talking about the trivial, rather than the important events in a client's

life, can indicate some fears about making changes. It is important that the worker appreciate that there are very real factors that can also present obstacles in the treatment relationship. Many clients lead chaotic or disorganized lives. A single mother may have to take a child to a clinic appointment and wait in line for many hours, missing her therapy session. Clients are often called unexpectedly to their children's schools or to job interviews. Be mindful of the stresses in your client's life before labeling some behaviors as fears or anxiety about change.

When there appears to be an obstacle to progress in the middle stage of treatment, such as a missed session, a worker can address this by simply saying, "I missed seeing you last week. Did anything happen?" If the client answers vaguely, or indicates that she didn't feel like coming, gently ask if anything happened in the previous session that upset her. What has she been thinking about the therapy? What has she been thinking about your working together? That last question will bring you to issues of transference, which are important to air in the middle stage of treatment. Examine for yourself if you have said or done anything that might have offended or hurt your client. Were you too quick to make an interpretation, too confronting, too un-empathic? If you cannot come up with the answer yourself, ask the client or your supervisor. Workers aren't perfect: They make mistakes. But transference reactions occur in spite of what practitioners do. Perhaps you begin to remind your client of a significant person from the past who was critical or judgmental. You can get at this information by asking, "Did I say or do something to remind you of someone in your past—someone in your family or a friend? What was that person like?" It is very important to distinguish transference reactions from reality. Exploring transference will often help the client make significant progress in current relationships. This is most obvious in couples therapy, when both partners begin to recognize that their strong reactions to spousal behaviors are often based on past anger or annoyances with parents.

Exploring the reality—the real relationship—will help the worker adjust to client needs. A client may be justifiably angry with a worker for numerous reasons. Perhaps he was inattentive, unempathetic, or preoccupied. Something as seemingly slight as answering the phone during a client's session may feel like a lack of empathy and produce a strong reaction from the client. You may not hear the reaction right away, but subsequent sessions will provide clues. The skilled worker pays sharp attention during the middle phase to the client's verbal and nonverbal behaviors. It is completely appropriate to mention, for example, that the client seems less talkative, or more edgy, or that something seems different. This is not to be confused with confrontation. Direct confrontation can be offensive and angering to a client, with the exception of those who have or are participating in recovery programs where confrontation is the norm. It is much better to gently comment that it seems hard for the client to talk about something, or to respond to your words, than to rush headlong with an interpretation such as "You are angry that I'm talking about your past." Interpretations often feel like wounds, especially if they are made too early in the work. And they can often be incorrect. It is more appropriate to explore and let the client come up with the meaning for herself. It is important to remember that what is crucial during this stage of therapy is that the client experience safety within the therapeutic relationship so as to be able to overcome the anxiety associated with change and take the necessary steps toward mastery.

The Case of Dan: Middle Phase—Moving to Contemplation, Preparation, and Action

The practitioner's initial sense was that Dan needed a new relational experience—insight into how his past was affecting his current life and the tools to facilitate change. He complained of insomnia. Relaxation training seemed a good method to help him relieve stress. In their fifth session, the therapist taught Dan a relaxation technique and put this on an audio tape that he played before bed. Also included on the audio tape were suggestions

(*continued*)

The Case of Dan *(Continued)*

about how he could manage stress. Dan played the audio tape religiously—it put him to sleep at night. The therapist shared with him her knowledge of what his trigger was, his vulnerability, his Achilles' heel. She did this within the context of her ever-present and conscious decision to make sure that Dan felt safe, respected, and nurtured in their relationship. She used those techniques critical to the contemplation stage of change—warmth, empathy, and clarification. Once trust was established, she could repeatedly but gently remind Dan that he overreacts when he feels criticized, humiliated, or dismissed by someone in authority. These interpretations enabled Dan to begin to consider that he had a part in his difficulties and that he could change his behavior. The therapist conveyed empathy and understanding by letting Dan know that his unsafe feelings originated very early with his mother and that was why his reaction was so powerful. In the beginning middle phase of treatment, the therapist made these interpretations rather than use exploration to help Dan gain this understanding for himself because his extreme behaviors were getting him in trouble in his school. Dan began to listen and to consider what was being said.

The therapist also allowed Dan to ventilate, a technique that enables the expression of feelings and reactions, and he did this quite frequently. Mostly, Dan ventilated his anger. Using a behavioral intervention, the therapist taught Dan some self-statements that he could use when he felt criticized or dismissed. Instead of Dan telling himself things that fueled his anger (e.g., this idiot is out to humiliate me), he was taught to use statements such as "This isn't personal. The teacher doesn't know me; he's not trying to hurt me. I'm reacting because of my past. I need to stay focused on my goals. I want to succeed. If I get through this I can go to college and be on my own. I need to keep myself cool; reacting with anger only gets me in trouble." Dan memorized these positive self-statements and added a few of his own. Dan's acceptance of this behavioral technique demonstrated to the therapist that he was moving into the state of preparation. Dan was preparing to change his behavior, and the therapist was helping to give him the small steps required to do so.

Another technique employed was advocacy. The practitioner intervened in the environment, a concept basic to social work practice that is often critically important in working with adolescents whose behavioral problems can be misunderstood by people in authority who then react punitively, unwittingly replicating past traumatic experiences. She wanted to minimize the opportunity for Dan to become stressed in school. Talks with the assistant principal about Dan's needs resulted in her handpicking Dan's teachers for his fall semester, selecting teachers with experience who had good classroom management skills and nurturing styles. The therapist told Dan that this wouldn't happen throughout his lifetime, and he ultimately had the responsibility of managing his emotions, but that, for now, he needed a chance to be successful and have a positive school experience. His job was to stay cool, get good grades, and prove that he was not a troublemaker. Dan was now looking to the therapist as a source of support. Interestingly, he had started to decline the snacks that she brought for him. Psychologically, he didn't need the practitioner's concrete demonstrations of feeding anymore. He was being fed in other ways.

In continuing middle phase sessions, the therapist reinforced Dan's impulse control by appealing to his intellectual strengths. Recognizing and acknowledging his strengths helped shore up his adaptive capacities. Using the positive relationship, conversations began to focus on his mother more frequently. Dan began to talk about his memories of his mother's abuse, and the practitioner shared her assessment of the origin of some of his difficulties with anger—how his traumatic past has affected his relationships with authority in the present. "You know, Dan, I think some of the anger you have now may have started when you

were a younger boy and you felt confused and upset over how your mother was treating you... . What do you think?"

About 5 months into the treatment, Dan's mother called after a 3-year hiatus. Dan's initial reaction was rage—he wanted to meet her in person and ventilate his stored-up anger—to abuse her as she had abused him. Dan and the therapist discussed what he would need from her to let her back into his life. He was clear. He wanted an apology and some understanding as to why she had behaved so cruelly to him. And he wanted evidence that he could trust her—that she would be available to him on a consistent basis. The therapist supported him in this, noting how logical and correct he was. Dan and his mother began to correspond by e-mail, and she kept up her part of the bargain by writing every day. Dan had clearly moved into the action stage—he was changing, and his new behavior was having an impact on significant people in his life. The therapist continued to promote Dan's appropriate self-assertion and continued to use empathy and encouragement to help him negotiate this new relationship.

Simultaneously, Dan began to reduce his sessions to bi-monthly. The practitioner speculated that Dan was getting closer to his mother and hence more fearful—something he did not want to think or talk about. Knowing his impulsivity, the therapist felt worried. She stayed in contact with his school and learned that he was becoming explosive again, picking fights with students and teachers. Clearly, he was under stress. In exploring the reduced sessions with Dan, the therapist learned that his father was feeling financially burdened and that his insurance company was limiting his benefits. This was a reality that could not be ignored. The fact that Dan needed the help, and needed it on a consistent basis, could also not be ignored. (Biweekly sessions are useful for problem-solving therapies, but this client and therapist were now doing more in-depth work, and they were losing continuity.) The practitioner decided to use e-mail to communicate with Dan between sessions and be available to him via video conferencing from her home to his. She also provided concrete help by asking Dan's father's insurance company to consider reinstating his benefits. She also spoke with Dan's mother by phone, because Dan was hopeful that, with the therapist's assistance, his mother would shed some light on the past abuse experience. It was the therapist's intention to help Dan's mother convince Dan that he was not to blame. The therapist also referred Dan to a group for children of divorced families that was forming at his high school so that he could have the social support so necessary in the action stage of change.

Dan and the therapist did not talk about transference issues in the middle stage of treatment. The therapist was working with the positive relationship—quite deliberately—and wanted to keep it that way. Negative transferential reactions (i.e., Dan's anger at the therapist) might have caused a rift in their relationship, and that would not have been helpful. Dan needed to see the therapist as his ally and supporter—and she could only provide that within a framework of trust and security.

THE ENDING PHASE OF TREATMENT

In long-term treatment, termination is not necessarily agreed on beforehand but is an outgrowth of the therapeutic process that has reached an end. Often, sessions end before all goals are met. In those cases, the worker might try to make a community referral for continued care or help the client take credit for the progress that has been made and extend advice as to how she might continue to work on her own.

Sometimes the client's goals have not been met because of limited internal and/or external resources, and treatment has not been successful. If the client has not been able to change the exterior of his life because of inadequate resources, it is important to empathize with the client's sadness and to validate his reality. If progress has not been made because of some inner problems, the worker needs to gently point out that perhaps the client wasn't ready to make the necessary changes and to share what internal roadblocks have made change difficult.

Termination can be planned or unplanned. Some clients leave unexpectedly before the completion of the work. Often this can be due to the disorganization and chaos of clients' lives. Other times, it may be because of some dissatisfaction with the treatment that went unaddressed. If an unplanned termination occurs, it is helpful to reach out to the client and let her know that the door is always open. If the client cannot be reached by phone, the worker should write a note to that effect and also express well wishes. Clients need to feel that they will not be punished for premature endings and that their actions will be understood within the context of their lives. Even the best-planned termination can be fraught with difficulties. The end of a relationship with the worker is a loss and often brings with it feelings of abandonment for clients, particularly if they have suffered other significant losses in their lives. Clients may react with anger or sadness, or they may not react at all. As a worker, it is important to be able to listen, explore, and empathize but not to personalize. At times, it will appear that there is a resurgence of problems when one is trying to end treatment. Or a new crisis may occur. This may present an opportunity for the client to continue the work through referral to someone else—but this is not a reason to hang on.

Workers need to let go when there are clear parameters to the treatment. If a referral needs to be made, it is important for the client to meet the new worker before you leave. When possible, try to facilitate the introduction. If the client comes back to you and reports that she doesn't like the new worker, that she's not as nice as you, be sympathetic but help the client see that there might be a period of adjustment. You need to appear confident in the new worker's abilities to help the client with the transition. In the ending phase, clients might ask for your home phone number or if they can continue to contact you. This is against ethical practice, and it makes it harder for the client to let go. The best way to be of help is to review with the client the progress that has been made, crediting her with her capacity to be effective, and to remain hopeful about the future. Point out next steps—whether they be the continued psychosocial intervention or concrete service needs. Final goodbyes can be ritualized by sharing a review of progress with the adult client, making a memory book with a child, or giving small gifts that are appropriate to the work accomplished (e.g., a small book of poems). And although therapists are cautioned not to accept gifts from clients, it is important to understand that clients may want to express gratitude, and rejecting the gift can be hurtful and embarrassing.

The Case of Dan: Ending Phase of Treatment

Dan and the practitioner did not have an ideal ending. Dan's father pulled him out of treatment prematurely, claiming that insurance benefits had ended. This became one more abrupt termination for Dan in his lifetime. The court had taken him away from his mother after he made numerous complaints of child abuse. While he was ostensibly happy to be removed from that traumatic situation, the traumatized child can be ambivalent toward perpetrators. And although Dan claims to have been angry at his mother all these years, he readily accepted her efforts to come back into his life. The therapist was concerned that Dan would experience the termination of therapy as abandonment regardless of how carefully it was planned. She also knew that Dan might leave therapy in anger or deny the therapist's importance so as to keep his powerful feelings of loss at bay. They were left with only one session to terminate. During that brief time, the practitioner pointed out the positive steps Dan had taken: the management of his anger and his ability to use his intellect to see his

situation clearly when not clouded by issues of loss, abandonment, and humiliation. She acknowledged that he might need to feel angry with her, because letting go in anger was easier than ending when you are really feeling good about someone. Dan said little. He kept reiterating that he didn't care, that he only came to therapy because the school forced him to. The therapist used the transference and interpreted that it would be difficult for him to recognize her as an important person and to leave at the same time. Using the real relationship, she again stated that she was his ally, that she did care about him, and that she would be there for him if he needed her. The therapist felt sad losing Dan as a client, and she worried about him. But sometimes the most one can do is to leave the door open and hope that the strength of the relationship will carry the client back to you in the future.

SUMMARY

As illustrated in the case of Dan, clients do not always move smoothly through the stages of treatment. Each phase presents a significant challenge. Beginnings are critical because they provide a model for what will follow, whereas middle-stage issues present a different type of challenge because it is during that time that the treatment may appear to be stagnated, without goals or focus. The worker and client may seem to be covering the same ground again and again, and the same difficulties may be occurring. Eventually, perhaps when least expected, progress will occur, some goals will be achieved, and others will be abandoned in light of new and changing realities. Termination can be unpredictable and, more often than not, are difficult for student interns, who can experience the loss as sharply as does the client and can have difficulty letting go. On a final note, clinical competence requires continued learning, self-examination, and a willingness to take risks. One becomes a skilled practitioner with increased experience. By remaining open to learning from your clients, your mentors, and your mistakes, you will achieve this in time.

REFLECTION QUESTIONS

1. What strategies did the social worker use to engage Dan? Can you think of additional strategies to use with adolescents to engage them in treatment?
2. Do you agree with the diagnosis of conduct disorder for Dan? If you had to make a formal diagnosis according to DSM-5, what might it be, and why?
3. What coping strategies would you teach Dan in order to help him deal with high-conflict situations?
4. What are the transference/countertransference issues between the worker and Dan? Would you address these in treatment?

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3

The Biopsychosocial Assessment

Learning Outcomes

At the conclusion of this chapter, students will be able to:

- Appreciate the human rights, social justice, and multicultural context when conducting a biopsychosocial assessment and how issues of power and privilege might affect the therapeutic relationship
- Know the format for conducting and writing a biopsychosocial assessment
- Appreciate the significance of conducting the biopsychosocial assessment within an appropriate developmental context when interviewing children and adolescents
- Conduct a mental status examination
- Understand how to make a diagnosis based on DSM-5 and other relevant data collected
- Understand the importance of theory when conducting a biopsychosocial assessment

PREPARING THE BIOPSYCHOSOCIAL ASSESSMENT

In this chapter, we will discuss the biopsychosocial assessment. This assessment consists of the following: (1) the data that have been gathered from the client and other relevant people and sources; (2) an assessment of the client's mental status and current level of functioning, including ego and environmental strengths; (3) the establishment of diagnostic criteria (DSM-5); (4) a theoretical framework that helps practitioners understand the collected data; (5) treatment goals; and (6) a method to evaluate the effectiveness of practice. Each of these components will be further explained in the following model. A sample biopsychosocial assessment of a child in a residential treatment center will illustrate this assessment method.

A Human Rights and Social Justice Framework

In 1948, the United Nations (UN) established the Human Rights Commission and the Universal Declaration of Human Rights, which were meant to protect vulnerable and oppressed populations and posited the idea that all humans have worth, are equal in dignity and rights, and are entitled to all fundamental freedoms without distinctions, accorded without regard to race, ethnicity, color, culture, country, religion, geography, economic environment, gender, language, opinion, origin, property, birth, demographic characteristic, or any other aspect of human diversity or social status (Donnelly, 2013; UN, 1948, in Poindexter, 2008).

The concept of universal human rights contains three intertwined vital principles: Rights are (1) inherent, (2) universal, and (3) indivisible. First, human rights are by definition present at birth and transcend the biases or discriminations of cultures, religions, governments, and professions. Second, universality of rights means that all humans are equally and unconditionally entitled to all these rights and there should be equal access to equal rights. Third, all human rights are equal to each other, indivisible from each other, and unable to be placed in a hierarchy. In sum, all human rights exist for every human unconditionally and are equally applicable to all humans (Donnelly, 2013; UN, 1948, in Poindexter, 2008).

The National Association of Social Workers' code of ethics sets forth the values, principles, and standards to guide the conduct of social workers. The code is relevant to all social workers regardless of their professional functions, the settings in which they work, or the populations they serve (NASW, 2017, p. 2). The code lists "social justice" as a core value and "the challenge of social justice" as an ethical principle (NASW, 2017, p. 5). The National Association of Social Workers, the Council on Social Work Education, and the International Federation of Social Work all highlight social justice as a primary value and function of social work (Morgaine, 2014, p. 1). In keeping with these principles, assessments of individuals and families from a human rights perspective should include information on clients' access to resources such as housing, food, employment, legal assistance, and medical care; cultural and political realities; and experiences with oppression.

A BIOPSYCHOSOCIAL MODEL OUTLINE

Identifying Information

The leading paragraph in this section of the biopsychosocial assessment provides a general statement about who the client is. This requires a great deal of sensitivity in handling information about the client's age, gender, race, ethnicity, religion, marital status, employment, resources (family, friends, finances, household members), immigration status, and developmental and physical disabilities. For example, many gay, lesbian, bisexual, and transgender individuals may not disclose these identity issues initially. They may not see them as being relevant to their presenting problems. It is important to use descriptive language that does not indicate the assumption of heterosexuality or gender. Describe the client's appearance, noting dress and grooming and able-bodiedness, and the quality of the client's speech (hesitant, spontaneous, disconnected, pressured). The client's attitude toward the interviewer is also important—does she appear anxious, relaxed, angry, impatient, negativistic, cooperative, unfocused, or comfortable? Consider that this aspect of the assessment is linked to the interviewer's emotional subjectivity, including personal bias (Sommers-Flanagan & Sommers-Flanagan, 2017). Who is the referring source? What does the referring source say about the client's problem? Is the client seeking treatment voluntarily or involuntarily? Does the client understand the reason for the referral?

Presenting Problem

This critical paragraph requires a statement of the present problems that have led to the referral—the reason the client has come to see you. You may want to include a statement incorporating the client's exact words in presenting his problem. This may be especially significant when the client's presenting problem differs from the referral source's interpretation of the client's presenting problem.

History of the Problem

This section should tell the reader how the problem developed. Did the situation have a rapid onset or is it chronic in nature? Describe the precipitating events, the course of the symptoms, and any previous attempts to solve the problem. If the client has had previous treatment for the problem, what was the length and frequency of that treatment, and what was its outcome? What was the client's response to the treatment? How did she feel about the therapeutic relationship? What are the circumstances under which the problem is currently manifested (home, school, employment)?

Human Rights and Social Justice

Ask about individual, community, and societal well-being. Is the client aware of her rights, and are they being met? Elicit information about the protection of children, elders, women, and families. Inquire about oppression, stigma, and other abuses or violations of human rights. These areas are included here; however, a human rights, social justice, and well-being perspective should frame the entire assessment.

Previous Counseling Experience

Discuss any previous counseling attempts and their outcomes. It is helpful for the interviewer to have a complete record of the client's experiences with counselors as well as the client's perception of whether the counseling was helpful. Was the client an active participant in the counseling? Was he treated with dignity and respect?

Family Background

Both the facts about the socioeconomic, educational, and occupational background of the family and some conceptualization of how the family members interact should be included here. How does the client view her family, and how do they view her? The genogram (McGoldrick, 2011, 2016; McGoldrick, Gerson, & Petry, 2008), a diagram of all members of the nuclear and extended family, can be a useful assessment tool in gathering this data. Genograms can be used in a variety of ways—for example, to illustrate a family structure, record relevant family information, or delineate significant family relationships (Işık, Akbaş, Kırdök, Avcı, & Çakır, 2012). Akinyela (2002) acknowledges the usefulness of the genogram in clinical practice but suggests a broader use by New Afrikan therapists. She suggests locating the family members' lives in the broader social and political context. For example, she writes "in telling the story of a Black family in the south, in tracing the generations, it becomes critical to talk about the social, political and economic conditions that those ancestors were living in, and to be curious about how they survived those conditions of life" (p. 45). Other authors (Sommers-Flanagan & Sommers-Flanagan, 2017) remind us that the concept of family may be broader within different cultural contexts and not defined strictly along biological lines, such as families that include gay, lesbian, bisexual, or transgendered parents; families formed through surrogate mothers, sperm donor fathers, and open adoptions that include the biological mother (or father) of adopted children; and families of adopted children whose ancestry may be unknown. Pells and Treisman (2012) suggest creating a "cultural genogram" that includes multigenerational legacies related to cultural rituals and spirituality (p. 403). Another useful assessment tool is the ecomap (Hartman, 1978), which offers a visual representation of the family's connections to their environment. (Models for a genogram and an ecomap are presented in Chapter 10 on narrative therapy.)

Personal History

This section may include a developmental history (with a child client) and information about prenatal care, birth, achievement of milestones (such as feeding, toileting, language, and motor development), and whether these milestones were achieved within normal time frames. Were there any

complications? If assessing a child, include information about school and peer functioning, levels of achievement, and learning differences. (For a thorough developmental history outline in assessing a child, see Webb & Drisko, 2011). The client's previous attempts to cope with problems should also be discussed. A vocational history should be noted, including adaptation to jobs, bosses, and coworkers, as well as recreational activities and special interests. Is there current and/or past use of substances such as alcohol and drugs, including prescription medication? It is also important to have the client's sexual history (where appropriate) as well as information about any past physical, sexual, or emotional trauma.

Medical History

A medical history helps to rule out the possibility of medical problems and/or organic factors that may be contributing to psychosocial difficulties and also focuses the client's attention on medical needs that may have been overlooked. It is essential that the client has had a recent medical examination. Were the client's rights to access to care upheld?

Educational/Learning History

It is very important to get as detailed information as possible on a client's educational and learning history (whatever the age) to consider whether there may be an undiagnosed learning disorder that needs to be addressed. These may include various learning differences involving executive function, such as dyslexia, and attention deficit disorders (e.g., ADHD). Although emotional problems may affect the ability to learn, it is important to remember that learning difficulties can also cause emotional problems. Obtain any recent evaluations and make appropriate referrals for neuropsychological and other testing when working with children and, at times, adults. Waber (2010) offers a developmental model of learning disabilities that changes the focus from one of disability to one of adaptation. Assessment addresses the child's interaction with his environment rather than his skill deficits. Immigrants and refugees or persons with limited fluency in English may appear to lack intelligence or communication abilities. Assumptions should not be made until a fuller assessment, in their native language if possible, can be made.

Social Class

Consider the socioeconomic history and current situation. For example, if a family comes from a lower socioeconomic class and now lives a middle-class lifestyle, this may cause a clash in values between parents and children. Couples who come from different class backgrounds may also experience stress. Social class may also affect the therapeutic relationship if the client comes from a lower—or a higher—socioeconomic class than the therapist. Have issues of social class resulted in stigma and oppression?

Cultural History

It is important to understand the presenting problem within the context of a relevant cultural framework. This would include issues of bicultural identity, generational differences in cultural identification, and degree of acculturation to U.S. society. Is the client able to enjoy her cultural rights? The culturagram (Congress, 1994) is a useful tool that addresses the family's reasons for immigration; their length of time in the community; their immigration status (legal or undocumented); the ages of family members at the time of immigration; language(s) spoken; contact with cultural institutions; health beliefs; holidays and special events; family, education, and work values; and traumatic stressors and crisis events. (A model culturagram appears in Chapter 4 on multicultural practice.)

Spirituality/Religion

Include in this section some discussion of the client's current or past religious affiliations or spiritual beliefs. It is important to differentiate between religion and spirituality. Spirituality is a personal sense of meaning or belief about one's life and the world. Religion is the way in which those beliefs are