



# The Social Work Process 3

Social workers traditionally use a series of steps or processes to help clients resolve their problems. These steps include collecting information about the client (assessment), making sense out of the information (diagnosis), collaborating with the client to develop a plan to change the problems being experienced (the treatment plan), and determining whether the process has been helpful (evaluation). We use two very powerful approaches to help the client change: (a) the helping relationship we develop with the client and (b) using one of the five or more helping approaches described in the prior chapter. This chapter discusses the social work process and the importance of developing a positive and cooperative helping relationship with clients.

## Collecting Information About the Client: Assessment

Whereas medicine uses labels to describe conditions, social workers try not to use labels because they may fail to accurately describe the client's unique qualities or the historical reasons clients currently are having problems in their lives. Instead, we use a psychosocial assessment that summarizes the relevant information we know about a client into concise statements that allow other professionals to understand the client and the client's problem(s) at the same level that we understand them. Psychosocial assessments try not to use psychiatric labels or words that might create a biased perception of the client. They differ from the terms often used in the most commonly used diagnostic manual in mental health (the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV]) because they provide brief historical information about the possible cause for the problem. Although they are problem-focused, they also provide an evaluation of the best evidence from the literature to support the

assessment. The client's strengths are included in the assessment, as well as the problems that might interfere with the client's treatment. Van Wormer (1999) describes the need to include the positive behaviors of the client when doing an assessment:

The first step in promoting the client's well-being is through assessing the client's strengths. A belief in human potential is tied to the notion that people have untapped resources—physically, emotionally, socially, and spiritually—that they can mobilize in times of need. This is where professional helping comes into play—in tapping into the possibilities, into what can be, not what is. (p. 51)

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## An Outline of a Psychosocial Assessment

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### *SECTION I: BRIEF DESCRIPTION OF THE CLIENT AND THE PROBLEM*

In this section of a psychosocial assessment, we include concrete information about the client such as age, marital status, family composition, what he or she is wearing, level of verbal and nonverbal communication, emotional affect, and anything of interest that may have happened in the interview. We should also include the defined problem(s) as stated by the client. We normally don't make interpretations here but just report the relevant information. Important information might be that the client cried throughout the interview, or he or she just stared off into space and answered questions in a flat monotone. We aren't certain exactly what this behavior means, but it tells us that the client isn't doing very well for reasons we have yet to discover.

### *SECTION II: HISTORICAL ISSUES*

This section includes any past issues of importance in understanding the client's current problems. For example, if a client complains of memory loss, we might want to find out if he's been in an accident that caused minimal organic brain damage, if he has an illness that might be causing the symptoms, if he's using legal or illegal medications that might cause memory loss, or if he's had a traumatic emotional experience that has led to repressed memory loss. Many people who have experienced violence in their lives do not remember the violent situation and may have repressed (forgotten) it so that they don't reexperience the event and then feel anxious or depressed.

### SECTION III: DIAGNOSTIC STATEMENT

The diagnostic statement is a brief overview of what we consider the most relevant problems experienced by the client and their potential causation. In the diagnostic statement, we combine material from the prior two sections and summarize the most relevant information into a brief statement.

A diagnosis often suggests a label defining what the client's problem is. However, words such as *schizophrenic* (mental illness) and *bipolar disorder* (manic-depressive behavior) have powerful negative meaning in our society, and it's important that we not think of a diagnosis as a negative label. Although labeling for diagnostic purposes may be relevant in medicine, diagnostic labels for mental health purposes are sometimes poorly defined and biased. Labels often harm people, and the most vulnerable among us—the poor, minority groups, women, immigrants, and the physically, emotionally, and socially disadvantaged—are those most harmed by labels. This may be particularly true of minority clients, where harm frequently occurs when labeling is used. Franklin (1992) says that African American men want to see themselves as “partners in treatment” and resent labels that suggest pathology because labels send signals to black clients who have had to deal with labels that subtly or overtly suggest racism. Franklin also states that African American men want to be recognized for their many strengths, and that clinicians should take into consideration that they may be doing well in many aspects of their lives. According to Franklin, African American men are particularly sensitive to male bashing and other sexist notions that berate men or negatively stereotype men in general and black men in particular. I think this is true of everyone. No one wants to be defined by a label that fails to include unique human qualities that make one person very different from another.

### SECTION IV: THE TREATMENT PLAN

The treatment plan describes the goals of treatment during a specific period of time and comes from the agreement made between the worker and client in the contractual phase of treatment (see below). As an example of a treatment plan, let's assume that a client comes to see a social worker because he or she is experiencing marital problems and is feeling depressed. The treatment plan answers the following questions: How long might it take to resolve the problems in the marriage? How will we know if the problems are resolved? and Which approach will we use to help the client (see chapter 4)? It also implies a cooperative relationship between the social worker and the client and assumes that they will work together to achieve the same goals in ways that involve the client fully and focus on the client's strengths.

## SECTION V: CONTRACT

This is the agreement between the worker and the client. It determines the problems to be worked on in treatment, the number of sessions agreed to, and other relevant rules related to being on time, payment, and the cancellation policies. Many workers have these rules in written form, with the client and the worker signing the contract.

### You Be the Social Worker

This case was first presented in a book I wrote on evidence-based practice (Glicken, 2005, pp. 77–79) and is modified for this book. After reading the following material, try to conclude what exactly is wrong with the client. Some questions are posed after the case to help you decide what problem(s) the client is experiencing.

#### The Case

Jorge Rivera is 19-year-old Mexican National who came to the United States under the sponsorship of his maternal uncle to attend a California university. Jorge had been in the country a year and was doing well until signs of emotional change became apparent to his family. He was becoming increasingly aloof and secretive, had stopped attending school, and seemed to be a very different person from the happy, motivated young man he had been just a year earlier. Suspecting an emotional or physical problem, Jorge's uncle took him to see his family doctor, an American of Hispanic descent. The doctor was immediately struck by Jorge's aloofness, fearfulness, and social isolation. He did multiple tests and, unable to find anything physically wrong, urged the uncle to take Jorge to a Hispanic male social worker with whom the doctor had had prior positive experiences.

Because Spanish is Jorge's more proficient language and the one with which he can express his inner feelings with more accuracy, the first interview was conducted in this language. Jorge told the therapist that he was hearing voices at night when he tried to sleep and that the voices were telling him to do things that Jorge found repulsive and dangerous. These voices were new to Jorge, and he feared that he was going insane. Jorge began to talk about his fears that he was becoming psychotic and how this would place him in great jeopardy with his family. He said that being "muy loco" was what happened to people who were sinful, and that he would be punished by his family and friends with ostracism.

It was clear to the therapist that Jorge was in great distress, but pending additional information, the therapist deferred making a diagnosis. By using the major diagnostic tool of the helping professions, the *DSM-IV*, the therapist saw signs of schizophrenia. He decided to interview the uncle's family to determine the point of onset of Jorge's symptoms. Everyone confirmed that Jorge had been very outgoing, showing none of the signs of the mental illness he was now exhibiting. The onset was sudden, within the prior 3 months, and the symptoms had been rapid and worsening.

Below is a list of warning signs suggesting the onset of schizophrenia that was developed by families who have a relative with this disorder (World Fellowship for Schizophrenia and Allied Disorders, 2002, p. 1). Although some of the behavior would be considered normal, family members felt that there was a subtle yet obvious awareness that the behavior they were witnessing was unusual. Everyone noted social withdrawal as an important early sign that something was wrong. Most respondents believed that their relative had been a “good person, never causing any trouble”; however, seldom had the person been socially “outgoing” during his or her formative years. The warning signs of schizophrenia identified by family members were:

- excessive fatigue and sleepiness or an inability to sleep
- social withdrawal, isolation, and reclusiveness
- deterioration of social relationships
- inability to concentrate or cope with minor problems
- apparent indifference, even in highly important situations
- dropping out of activities (e.g., skipping classes)
- decline in academic and athletic performance
- deterioration of personal hygiene; eccentric dress
- frequent moves or trips, or long walks leading nowhere
- drug or alcohol abuse
- undue preoccupation with spiritual or religious matters
- bizarre behavior
- inappropriate laughter
- strange posturing
- low tolerance to irritation
- excessive writing without apparent meaning
- inability to express emotion
- irrational statements
- peculiar use of words or language structure
- conversation that seems deep but is not logical or coherent
- staring; vagueness
- unusual sensitivity to stimuli (e.g., noise, light)
- forgetfulness

As a way of comparing the subjective reports of family members of clients with a diagnosis of schizophrenia, the National Institute for Mental Health (NIMH) identifies the following diagnostic signs for early-onset schizophrenia:

The first signs of schizophrenia often appear as confusing, or even shocking, changes in behavior. The sudden onset of severe psychotic symptoms is referred to as an “acute” phase of schizophrenia. “Psychosis,” a common condition in schizophrenia, is a state of mental impairment marked by hallucinations, which are disturbances of

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sensory perception, and/or delusions, which are false yet strongly held personal beliefs that result from an inability to separate real from unreal experiences. Less obvious symptoms, such as social isolation or withdrawal, or unusual speech, thinking, or behavior, may precede, be seen along with, or follow the psychotic symptoms. (1999, p. 1)

In the next interview, the social worker asked Jorge to tell him about his life in Mexico and to provide the therapist with the client's theory about what was happening. Jorge had been romantically involved with a young woman who came from a highly affluent and influential family in Mexico. The couple were in love, but the young woman's parents were opposed to the marriage and had hired a *bruja* (literally, a witch) to cast a spell on Jorge so that he would become unattractive to the young woman and she would lose her feelings for him. The bruja was sending Jorge little totems that represented evil, which were frightening him and driving him into social isolation and withdrawal. He was convinced that the voices he heard were her doing and, as a result of the spells she had cast, that he would become insane, lose his beloved, and die a horrible death. He had known others who'd had similar fates in Mexico. Brujas were evil and caused immense harm, he told the therapist.

The therapist had grown up with stories of witches and spells, but wasn't a believer. Nonetheless, he contacted the uncle, told him what had happened, and wondered if he knew of some way to deal with the effects of the bruja. The uncle contacted a well-known *curandero* (remover of spells) he knew of in Mexico, paid his way to come to the United States, and had the curandero remove the spell in a ritual that lasted 24 hours. When the ritual was over, the curandero gave Jorge an amulet to wear around his neck to ward off future evil spells and urged him to break off the relationship with the young woman to cease the bruja's attacks on Jorge's mental health. The uncle again intervened, spoke to the young woman's family in Mexico, promised that Jorge would no longer be in contact with the young woman, and urged them to cease any more witchcraft on Jorge. Her family agreed, and a broken-hearted but functioning Jorge was able to return to school with his family's support and an occasional visit to the therapist.

### Questions

1. Witches and counterwitches are pretty hard to believe. Couldn't Jorge have had a brief bout of mental illness brought on by the stress of school, loneliness, and his new life in the United States?
2. On the other hand, isn't it possible that Jorge was actually responding to his fear of witchcraft and that the fear (and nothing actually done by the bruja) was responsible for his psychotic-like condition?
3. The sudden onset on schizophrenia is a frightening thing for most clients and their families. Is it possible that, much like a disease or illness that comes and

goes, that schizophrenia is an opportunistic disease that often runs its course and, much like a severe virus, goes away in time?

4. You can see that a diagnosis of schizophrenia suggests a serious problem. What do you imagine most people believe are the chances of getting well again if someone is diagnosed with a mental illness?

5. Wouldn't most Anglo therapists assume that the story about witchcraft was just another indication of Jorge's mental illness? How can we protect against a misdiagnosis happening to people from other cultures?

## Helping Relationships

Most social workers believe that the quality of the client-worker relationship is the key to whether clients will resolve their problems. In recognizing the importance of the helping relationship, Warren (2001) writes, "The relationship between the quality of the patient-therapist relationship and the outcome of treatment has been one of the most consistently cited findings in the empirical search for the basis of psychotherapeutic efficacy" (p. 357). Writing about the power of the therapeutic relationship, Saleebey (2000) says that "if healers are seen as non-judgmental, trustworthy, caring and expert, they have some influential tools at hand, whether they are addressing depression or the disappointments and pains of unemployment" (p. 131).

### *DEFINING THE CLIENT-WORKER RELATIONSHIP*

Keith-Lucas (1972) defines the client-worker relationship as "the medium which is offered to people in trouble and through which they are given an opportunity to make choices, both about taking help and the use they will make of it" (p. 47). Keith-Lucas says that the key elements of the helping relationship are "mutuality, reality, feeling, knowledge, concern for the other person, purpose, the fact that it takes place in the here and now, its ability to offer something new, and its nonjudgmental nature" (p. 48).

In describing the significant elements of the relationship, Bisman (1994) says that therapeutic relationships are a form of "belief bonding" between the worker and the client, and that both parties need to believe that "the worker has something applicable for the client, the worker is competent, and that the client is worthwhile and has the capacities to change" (p. 77). Hamilton (1940) suggests that bonding takes place when the clinician and client work together and that "treatment starts only when mutual confidence is established, only when the client accepts your interest

in him and conversely feels an interest in you” (pp. 189–190). I use the following definition for the relationship:

It is a bond between two strangers and is formed by an essential trust in the helping process and a belief that it will lead to positive change. The worker facilitates communications, enters into a dialogue with the client about its meaning, and works with the client to decide the best way to change a life problem. (Glicken, 2004, p. 50)

### *RESPONDING TO CLIENTS WITH WARMTH, GENUINENESS, AND EMPATHY*

Many social workers believe that client-worker relationships are strongest when workers respond to the client with warmth, genuineness, and empathy. This means that the social worker is a real human being and not acting out a role. It also means that the worker is genuinely concerned about the client and can often sense, at a very significant level, how the client feels emotionally. As workers respond empathically to what clients say, clients are often able to continue discussing their problems at an increasingly introspective and accurate level without any prompting or questions from the worker.

You can determine your own level of empathy by using this simple 5-point scale and statements a client might say. First, I’ll provide an example of how the scale works.

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### **Empathy Scale**

1.0: A response that actually makes the client feel much worse. Think of a response that blames the client for the problem or begins, “You always make the same mistakes and then complain that it’s someone else’s fault.”

2.0: A response that is generally negative or critical. An example might be, “I know you were trying your best, but sometimes that’s just not enough.”

3.0: A neutral response. The client neither feels better nor worse (think of a response where the worker just restates what the client said but doesn’t add to it).

4.0: A response that tells the client you understand and are sensitive to what the client is feeling (this response will bring about the client’s desire to tell you more).

5.0: A response that so accurately captures what the client feels that it puts it into perfect words (this response will bring about a sort of epiphany in the client).

### Example 1:

The client says, "Sometimes I really feel depressed."

The worker responds, "If you worked harder at your problems, you wouldn't feel that way."

Empathy Score: 1.5. The worker has said something hurtful and is blaming the client. This reduces trust and will stop the client from telling the worker anything significant.

### Example 2:

The client says, "Sometimes I really feel depressed."

The worker responds, "It sounds like you feel really depressed sometimes."

Empathy Score: 3.0. The statement was neutral; it neither helped nor hurt the client's ability to progress with what he or she is feeling.

### Example 3:

The client says, "Sometimes I really feel depressed."

The worker responds, "It must be painful for you on those days when you feel depressed."

Empathy Score: 4.0. The worker has said something that captures what the client feels inside.

The client might then say, "I feel so down on those days, I don't think I can make it."

The worker's brief statement has provided us with important information without a question being asked. We now know more about the depth of the depression.

The worker might then add, "And on those days when you don't feel you can make it, it must be a real struggle for you."

To which the client might say, "I think about how maybe it would be better if I just stopped living."

The worker could then say, "It must be painful to feel so depressed that you don't know you can go on, and yet something very positive and hopeful inside of you prevents that from happening."

And the client might respond by saying, "Yes, I just don't want to do that to my family. I think it would destroy them."

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*Discussion.* In the above example, the worker has been able to find out a great deal about the client just by focusing on the client's feelings and responding empathically. The worker hasn't asked a single question, but has been empathic in responses by focusing entirely on the client's feelings. By doing so, the worker is able to determine that the client is not only depressed but that he or she is also experiencing serious thoughts of suicide, and that the only thing that stops him or her is an unwillingness to embarrass the family. Suicidal thoughts are serious and suggest an at-risk client. We might never have found this information out if we had just asked a number of direct questions.

Time to try it! Provided are five statements a client might give; write a worker response, then score yourself on the 1–5 scale. You must get a 3.0 or higher to allow the client to give you more information about his or her feelings and thoughts.

The client says:

1. "I hate my husband so much I just feel like packing up my bags, taking the kids, and leaving."
2. "School is so boring. I think I'll quit and get a job somewhere and make some money."
3. "Nobody likes me here. I'd be better off staying at home and reading a book."
4. "I can't concentrate on anything. My head just feels all over the place."
5. "I'm sick all the time and depressed. Why is God doing this to me?"

## Evaluation of a Social Worker's Effectiveness

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Determining if a social work client has improved isn't as easy as it might sound. In medicine, we think that if the patient feels better or if his or her blood work has improved that whatever is ailing him or her might have gone away. Of course, this often isn't true, and the same problem might just be hiding only to return and be even worse than it was originally. And though we think treatment may be the reason the patient recovers, we can't always be certain. Many times people heal on their own without medication or even seeing a doctor. In social work, it's even more complicated. How can we possibly prove that it was *our* treatment that led to a client getting better? There are many reasons people improve emotionally, and most are out of our control. A client might have met someone and fallen in love or inherited a great deal of money while seeing us for his or

her depression. Was it the money/love or was it us that helped the client? Who can possibly tell? So to help us decide, researchers have devised the following guidelines to show whether it's our work that causes this change.

*History.* How long did the problems last before the client came for help? The longer a social or emotional condition lasted before the client came to see us for social work help, the less likely it is that the client recovered by chance. It's possible, of course, but less likely.

*Baseline.* When we saw them for the first time, we did a baseline reading of their problems. We found out how much they sleep, how much they weigh, their level of exercise, how much work or school they miss, and how often and how much they drink or take drugs. This is called a *baseline measure*, and it's similar to what doctors do when they see patients in their office. They check vital signs such as blood pressure and weight. If those vital signs improve during the course of our treatment, we usually feel confident that it was because of treatment and not some outside occurrence, although we can't be absolutely certain.

*Outside verification.* We can ask for outside verification to see if the client is doing well outside of our office. This helps give our evaluation a way of factoring out the tendency of clients to tell us that things are better or worse than they really are and makes our evaluation more valid and reliable. It doesn't necessarily tell us that change is because of our work, however.

*Psychological tests.* We can give the client a psychological test for any number of problems, including depression and anxiety. Although tests aren't completely accurate, they do give us a good idea about how well the client is doing and, if the test scores improve as we work together, we can often feel fairly certain that it's because of our work. Sometimes clients work with many professionals, and it might be better to assume that we're all helping.

*Statistical tests.* We can do some very simple statistical tests to tell us whether it was our work that led to change or some other chance occurrence.

*Ask the client.* We can ask the client directly whether it was our work or something else that caused his or her improvement. We can also give a satisfaction instrument that helps us know how happy the client is with our work. We hope being happy with our work translates into the client doing better. This isn't always the case, of course, but we think it's an important variable.

*Ask other professionals.* We can ask other professionals to evaluate the client before, during, and after treatment ends, and let them decide whether the client has improved and if it was due to our help.

*Ask people in our client's life.* We can ask important people in the client's life to provide feedback about the reasons he or she has improved, and if there were some reasons we don't know about. Sometimes people get better because they mature out of their problems. This is particularly true of adolescents, children, and adults going through a mid-life crisis. It is also true of people who have an undiagnosed illness that improves on its own.

*Life changes.* There are life changes that may have a profound effect on people's emotional health. Joining a church, becoming more spiritual, being a volunteer, and finding the right career are all quite separate from our work and may be more important variables in client change than the help we provide.

In the end, the client makes the judgment about whether he or she has improved. Our job throughout the helping process is to get feedback from the client that tells us honestly if what we're doing is helping and why or why not. Let's see if we can tell whether the following client has done better because of our work.

## Evaluating a Client's Level of Improvement

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Gerald Blake is a 21-year-old junior in college. He has sought social work help from the student counseling center because he's been depressed for longer than a year and has begun having suicidal thoughts. When Gerald came to see the social worker, he was sleeping 14 hours a day, missing half of his classes, and was close to failing school. After 12 one-hour sessions of cognitive therapy, he is sleeping 8 hours a day, is doing B-level work in school, and has stopped having suicidal thoughts. Gerald told the social worker throughout treatment that he didn't think he was being helped, and he was often sullen and angry with the social worker for not doing a better job; yet he improved. Gerald thinks he got better on his own because he started taking responsibility for his problems and doing something about them. The social worker believes that Gerald got better because of the help he was given.

Although we know that Gerald has improved, we don't know why. A check with his roommates and parents provides no other reasons for his improvement. A discussion with Gerald confirmed that although he had questions about the social worker, he admitted that she helped motivate him to seek solutions for his depression. He also thought the structure of

having to come for help every week gave him an outlet to discuss his feelings and to solidify ideas concerning what to do about them. Was he satisfied with the help he received? No. Did he think he'd changed? Yes. Was it because of the work he did with the social worker? Probably. So, didn't the social worker help? Maybe she did, and maybe she didn't. The social worker didn't seem very concerned, but she did give Gerald some good advice. So didn't she help? Yes, maybe she did, but she could have been a lot better. And so it went. What do you think? Have you ever gone to a doctor who didn't seem very warm or concerned about you but was still a good doctor? Do you think it's important to be warm, sensitive, and empathic as a social worker? A lot of people think so.

Brent (1998), for example, finds a strong relationship between social workers who are warm and empathic (the ability to accurately sense how the client is feeling) and good treatment outcomes: "From the patients' points of view, provision of support, understanding, and advice have been reported as most critical to good outcomes" (p. 2). In further comments about empathy, Brent (1998) reports that empathy is a strong factor in successful treatment, even stronger than the therapy approach a worker might use. In successful therapy,

The therapist is described as "helping and protecting, affirming and understanding," whereas the patient is seen as "disclosing and expressing." Not surprisingly, therapists tend to attribute success to technique, whereas patients attribute a good outcome to the therapist's support and understanding. (Brent, 1998, p. 2)

But Dr. Glicken, I suspect you might argue, the client told us that the social worker wasn't very empathic and he didn't respect the social worker's skills, yet he still admits that he got better. Why is empathy so important if the client improved and the social worker wasn't very empathic? Because, although the client may not experience the social worker as empathic, there may be issues that arise in treatment that confuse the picture. Such as? Well, what if the social worker reminds Gerald of his mother, with whom he had a love-hate relationship? What if the social worker is very empathic but Gerald is looking for a more personal relationship, perhaps a friendship or even a love relationship? It happens, and when it does and the social worker doesn't become the client's friend or lover (Freud called it *transference*), clients often become angry because certain basic needs aren't being met. Of course, the social worker is not ethically allowed to become a patient's lover because it would be a misuse of authority due to information the worker knows about the client. Being his friend would make it difficult to be his helping professional. And another thought: What if the client needs to feel that he resolved the depression on his own to save face? These are all good reasons, of course, but maybe the client is right and, in this instance, the client *did* get better in spite of the worker.

## Why Clients Get Better

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There are many reasons why clients improve. The following answers most of the reasons:

1. Clients improve because they are motivated to and, even when the worker isn't competent, they do most of the work on their own.
2. Most problems resolve themselves. If you give them enough time, people can improve.
3. Sometimes the combination of the right worker, the right client, the right approach, and the right timing produce incredibly positive results.
4. Sometimes people don't improve while seeing a social worker, but if you give them time, many of the issues worked on in treatment begin to have an effect and clients improve as a result of treatment.
5. Sometimes people get better because of a combination of factors, including the help they receive, their support systems, their own self-work, and the biological changes that take place as they get well. This suggests that as the client is better able to cope with his or her emotional problems, subtle changes take place in the brain that lessen the biochemical reasons for emotional problems.
6. Sometimes medication taken for an emotional problem has a very positive effect, or the combination of help and medication together create change.
7. Sometimes people recover for reasons we can't explain, or situations in their lives that might be causing them emotional pain resolve themselves.
8. People get better because they have self-righting capabilities (resilience) and are able to cope with traumas and stressors in ways that are often quite unique and amazing.

## Summary

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This chapter discusses the social work processes used in helping people experiencing social and emotional problems. It includes the importance of the helping relationship and the ability to be empathic with clients. The chapter includes a discussion of evaluating change in clients and notes the difficulty in assuming that change is caused by social work intervention. A case example of a problem in diagnosis is provided.

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## Questions to Determine Your Frame of Reference

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1. Doesn't using labels in medicine help doctors find appropriate treatments? How could we treat cancer if we never used the word to describe the patient's condition? Isn't there a danger in social workers not using labels because, although it may be politically incorrect, it's scientifically necessary?

2. People do awful things in their lives, such as physically and sexually abuse children. Why should we be sensitive to how they feel? Shouldn't we just tell it like it is and let them know how we feel about the awful things they've done?

3. If you're working with depressed clients, shouldn't you just come right out and ask them if they're suicidal? Why all this beating around the bush with being empathic?

4. I'm unclear about transference. Why would clients expect their social worker to love them? I don't feel that way about my doctor; why would clients feel that way about their social worker?

5. Isn't there a danger that if you're too nice and empathic to clients that they will misunderstand the relationship? If that's the case, what can social workers do to keep this from happening?

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## Internet Sources

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First, Singer explains his model for practice, which was written while he was an MSW student. Next, Brodley's paper on relationships does an exceptionally good job of explaining why the helping relationship is so important in producing effective professional work. Finally, Tucker-Ladd states how clients effectively use help for social and emotional problems.

1. Singer, J. (1996). *Constructing a model for personal practice*. Retrieved November 27, 2004, from [http://home.flash.net/~cooljazz/mssw/my\\_model.htm](http://home.flash.net/~cooljazz/mssw/my_model.htm)
2. Brodley, B. T. (1987). *Relationships: A client-centered psychotherapy practice*. Retrieved November 17, 2004, from <http://lists.portents.com/~matt/cct.practice.html>
3. Tucker-Ladd, C. E. (2000). *Methods of developing skill from psychological self-help*. Retrieved February 14, 2005, from <http://www.mentalhelp.net/psychhelp/chap13/>

