Orientation to and Validation of Relational Diversity Practice

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Relational Diversity Practice

Social work's emphasis on person-in-environment and person-in-situation (Saari 1986, 2002; Goldstein 1995, 2001; Turner 1996; Berzoff 2011) turned our attention to the client in social context. Less a focus of these important contributions was the centrality of the clinical relationship itself. It remained for the incorporation of psychoanalytic perspectives to emphasize the here and now of the clinical encounter as a primary subject of discovery and impact in clinical social work.

Relational theory evolved in response to clinicians' direct observations of what created therapeutic motivation and efficacy. While many writers have proposed variations in metapsychological theory about the internal landscape that informs manifest client functioning (Fairbairn, Winnicott, Klein, Aron, Bromberg, and many others), those that come under the relational theory umbrella share a common belief in the clinical encounter as the place where internal dynamics are accessible to change. Greenberg and Mitchell (1983) coined the term "relational theory" and in doing so joined it to the social work tradition of the helping relationship itself as the medium of effective social work (Tosone 2004; Hepworth et al. 2006). What elements of therapeutic contact help clients engage in a clinical process? What actions are most significant in helping clients make changes that reduce their subjective distress and manifest dysfunction? Why are these motivations and actions the most powerful? And, how do these factors translate into clinical social work practice with diverse client populations? The answers to these questions propelled the movement that became relational theory, a model that contradicted classical drive theory's emphasis on instinctual gratification, asserting that the central

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"drive" was for meaningful connection with others (Greenson 1967; Strachey 1966; Freud 1957). This paradigm of relatedness as the most essential human factor in development and health shifted the definition of distress and functional problems to interpersonal misalignments (Bacal and Newman 1990; Bennet and Nelson 2010). It further shifted the framework of clinical practice to a psychosocial model – a clear connection to the roots of social work – in which the relational practitioner uses "empathic attunement, interpersonal interaction, and experiential learning in efforts to facilitate change and growth" (Borden 2009).

The forms of misalignment, such as failures of empathic relating, interpersonal neglect and disregard, embedded distortions of interpretation about other people and what things mean, and the like, apply to individual interchanges and to group interchanges. For example, because psychoanalytic theory, which informs relational theory, was developed in the context of White middle- or upper middle-class clients and clinicians, there is a tendency to fuse clinical thinking and practice with elitism and the politics of dominance and submission. Caro Hollander, in her books, *Love in a Time of Hate (2007)* and *Uprooted Minds (2010),* takes issue with the association of psychodynamic therapy with Whiteness and oppression. She sees clinical process as a pathway to reversing what Foucault (1980) previously characterized as disavowal of histories of oppression and subjugation of any personal narratives.

Relational theory in psychoanalysis derived from Greenberg and Mitchell's (1983) dissatisfaction with classical theory's elevation of an unconscious straw man to be toppled and instead concentrated therapeutic action on exploring the here-and-now communication and enactments between client and clinician. Similarly, encounters between clinicians and clients of different backgrounds and situations require real-time attention to content and exchanges that reveal problems and solutions in their existing cultural idiom. Diversity denotes identified and self-identified distinctions that can too readily become explanations, but not resolutions, of in-group and out-group misalignments (Altman 2000; Berreby 2005; Bhopal and Donaldson 1998; Brodkin 1998; Buck 2010). The motivation to form connection creates a powerful pull toward assumptions that confirm alignment or protect against painful misalignment. Shared identifiers invite assumptions of shared experience, and unshared identifiers invite expectations of unshared experiences. In this way, diversity clinical social work brings relational theory into the spotlight: the practitioner can, and must, apply the triumvirate of empathic attunement, interpersonal interaction, and experiential learning (Borden 2009; Aron 2001) with specific intention and awareness in establishing a truly helping relationship.

The clinical social worker and her client may or may not share self-identifiers, such as race, religion, sexual orientation, or a pivotal life experience, and a multitude of less obvious factors, real or projected. The relational practitioner is alert to these features and their potential to support or derail interpersonal alignment. Additionally, client and clinician specifically do not share their identified roles in the clinical practice process. All clinical encounters therefore must confront the significance of apparent sameness and difference in forming connection. What unifies or divides them in their pursuit of the meaningful help? The clinical social worker's knowledge of how to pursue authentic alignment using the relational approach is the subject of this book. Authenticity includes abandoning illusions of

preexisting templates to which clients' ways of expressing feelings, concerns, and options may be referred. For example, a classically defined oedipal conflict expressed in angry behavior at the boss would better be explored openly in search of feelings of disrespect, culturally inappropriate communication, and means of redressing these wrongs in ways that are empathically resonant yet address likely and desired outcomes. The ways the client experiences equivalent misunderstandings and behaviors in the relational clinical exchange would be central to revealing and, most importantly, expressing the disturbances leading to a life problem.

In addition to empathic attunement to the client's immediate experience, mutuality in the construction of goals and methods, and continuous monitoring of the state of communication, the relational clinician makes use of mishaps and gaps in the treatment interaction as opportunities to illuminate and repair maladaptive responses that have become embedded in the client's psychosocial functioning. Reparative work resides in the immediate clinical interaction, wherein the relational practitioner embraces difference and disconnection as a road to shared discovery. As Bromberg (2011) states, "There is no true dialogue that does not emerge from some collision between subjectivites…" (p. 67). True to the core principles of social work as a profession, relational clinical social work starts where the client is and takes mutual responsibility for finding meaningful understanding and methods of moving to a place of greater internal satisfaction and interpersonal success (Tosone 2004).

Applying Relational Theory to Practice with Diverse Populations

Relational social work makes the interpersonal process central in clinical practice. Drawn from object relations (Fairbairn 1954; Winnicott 1958), self-psychology (Kohut 2000), and psychodynamic theories of development (Safran 2008; Jordan 2008; Fletcher and Hayes 2005), among other two-person psychologies (Mitchell 1993, 1997; Stolorow and Atwood 1992; Stolorow et al. 1987; Altman 2010; Aron 2001; Kiesler 1996), relational theory focuses on present interpersonal functioning, particularly as revealed and developed in the clinical relationship. Experience classified as "diverse" is inherently at risk for a non-neurotic but nonetheless non-cohesive quality of experience (Chu 2007).

The evolution of psychoanalytically informed theory in relation to a White, middle- or upper-class, European population makes it suspect regarding applicability to other populations. Contemporary thinkers have aggressively widened the framework to embrace the sociopolitical universe (Kleinman 1988, 1995; Altman 2010). In the process, definitions of intrapsychic structures and the role of interpersonal experiencing have sometimes vied with dimensions of self and social context, so that divergent areas of study have emerged. Social work clinicians remain aware that culture, race, and traumatic life experiences, and the like, are inseparable from assessment of self-experience and the mechanisms of treatment (Berzoff et al. 2008; Tosone 2004; Rosenberger 1999). The contributions and language of classical psychoanalysis (unconscious process, separation and attachment, narcissism, and so on) persist but are transformed into the two-person framework of practice.

Combined attachment and mutual exploration in relational practice promote the drive toward integrity of the self (Balint 1968; McWilliams 2011). Reactions are visceral, in the realm of unformulated experience (Stern 1997; Levenson 1983), as well as conscious and cognitive. Experience classified as "diverse" is inherently at risk for a non-neurotic but nonetheless non-cohesive quality of experience. The development of both attachment and mutual exploration in relational theory address this incoherent potential because they are responsive to what object relations theorists posit as a central drive toward integrity of the self (Balint 1968; McWilliams 1999). The clinical interpersonal field, then, will in practice reflect and address the points of collision and congruence stemming from the two individual, culturally informed, selves. Each individual simultaneously enacts experiences of development and reflects current interactional contexts (Caro Hollander 1997). The clinical interpersonal field thereby reflects and addresses points of congruence and incongruity stemming from the two individual, culturally informed, selves (Bromberg 1998; Hoffman 1998; Symington 2007; Fonagy et al. 2004).

Emergence of Relational Theory for Clinical Social Work Practice

Relational theory is a natural and valuable fit for clinical social work and especially for clinical practice with diverse populations. It reflects the pro-social principles that define contemporary clinical social work without sacrificing intrapsychic understanding. An uneasy relationship exists between psychoanalytic theories that articulate intrapsychic dynamics and itemized practice competencies (Council on Social Work Education 2010). While not overtly contesting the validity of developmental and clinical aspects of psychoanalytic theory, social work educators have at times been concerned that emphasis on internal and historical experiences of the client could eclipse attention to presenting problems and their social determinants.

This uneasiness was particularly acute when Freudian drive theory looked to unconscious conflict stemming from early fixations as the explanation of presenting symptoms and complaints. Ego psychology (Hartmann 1958) was initially embraced in social work as more inclusive, with its proposal of "conflict free" functional attainment. Pearlman's (1957) seminal work on "social casework" emphasized solving problems of social functioning (p. 4). This functional problem approach elevated adaptation without adequately critiquing the social realities to which adaptation was being made. From a relational theory point of view, both drive theory and ego psychology missed the essential therapeutic role of the clinical relationship itself, seeing what Greenson (1967) called the "working alliance" as a mechanism to permit the real work to be done, viz*.,* interpreting unconscious conflict and developmental barriers (as in an oedipal conflict fueling an adult's conflict with an authority). As Bromberg (2011), a relational theorist, has said, particularly in such cases, "conflict interpretations are useless or even worse" (p. 101). Trauma, catastrophic or

insidious and cumulative, typifies the life experience of marginalized and oppressed clients as well as many individuals in personally demoralizing circumstances. The problems that afflict the majority of social work clients may indeed contain intrapsychic conflict but are inaccessible in the absence of interpersonal alignment with a clinician who is experienced as an authentic person whose interests are collaborative with the client's goals and real-life situation.

Social work practitioners and social work as a profession remained split between those interested in intrapsychic dynamics and those concentrating on direct action with clients to ameliorate problems. An intermediate wave of psychoanalytic theorists broadened psychodynamic thinking in varying directions but shared "overlapping concerns, emphasizing the roles of relationship and social life in their conceptions of personality development, health, problems in living, and therapeutic action" (Borden 2009, p. 146). Still, the contributions of relationship and social life were viewed as impacting the client who remained the subject of the clinician's concern without directly involving the clinician as a subject of equal concern. Clinical social workers were encouraged about but still wary of the hierarchical and authoritative stance of the psychoanalyst. Licensing distinctions and advanced training selections (whether to train at a psychoanalytic institute; whether such an institute accepted social work trainees) increasingly separated clinical social workers from their peers. This schism also became linked to concerns about addressing diversity: that psychoanalytic theory was being elaborated mainly by White, Western men working with private clients was seen as implicitly segregationist and patriarchal. Clinical social workers studying and working with psychoanalytic orientation were on the defensive or dissociated from social work as a whole, which unfortunately replicated the arbitrary and conflict-laden positions that psychoanalytic theory was seeking to redress.

The emergence of three bodies of psychoanalytic thought – object relations theory (Winnicott, Fairbairn, Klein, Kahn), interpersonal psychoanalysis (Sullivan), and self-psychology (Kohut) – led the way to what Greenberg and Mitchell (1983) distilled and refined into contemporary relational theory. Spurred on also by feminist theoreticians (Baker Miller 2012), the psychoanalytic orientation became egalitarian, experience-near, and closely linked to the social realities of individual lives. The drive to connection became clearly defined as treatment dimension in which both parties negotiate their understanding of problems and solutions.

A helping relationship was redefined as one in which empathy, direct interaction, and experiential learning through clinical interactions are the therapeutic agents (Borden 2009). Thus, the relational clinical practitioner was supported in directing her work to forming and using meaningful connection with the client's direct presentation. Tosone (2004) has articulated that this reaffirms central principles of social work: starting where the client is and addressing real-life factors shaping client problems and clinician options that are the bases of meaningful assistance.

The central importance of human relationships is spelled out in the National Association of Social Work mission statement (Hepworth et. al. 2006). Relational

theory expands this statement to explain how the human relationship between social work clinician and client creates a therapeutic experience. In addition to Greenberg and Mitchell (1983), two other bodies of theory support relationship, rather than interpretation, as the agent of healing and enhanced self states. Neuroscience is confirming more quantifiably the therapeutic impact of identifying and addressing ways in which actual experience has shaped, and can reshape, patterns of relating. Etiology of increased affective vitality by relational treatment is tracked to confirm that neurologically "what fires together, wires together." This phrase summarizes the establishment of existing patterns of affective aliveness and also shows that there is an open future of affective experiences (Schore 2003a). Wired in to both client and clinician are historical relational paradigms and their behavioral expressions. Through interaction and mutual influence, key dimensions of direct social work practice (Hepworth et al. 2006), experiences are refired and thereby eventually rewired (Schore 2003b; Schore and Schore 2008).

The feminist movement also championed the centrality of relating over informing as an enhancer of quality of self-experience as well as style of functioning. Baker Miller (2012) conveys the feminist perspective in her description of "Five Good Things":

Growth-fostering relationships empower all people in them. These are characterized by:

1. A sense of zest or well-being that comes from connecting with another person or other persons.
2. The ability and motivation to take action in the relationship as well as other situations.
3. Increased knowledge of oneself and the other person(s).
4. An increased sense of worth.
5. A desire for more connections beyond the particular one.

Zest, growth, motivation, self-knowledge, self-esteem, and a desire for connection and community all are proposed by the feminists as a measure of health that could be pursued directly through relational interchange, rather than as a by-product of interpretation and conflict resolution. Quality of living was the goal and outcome of the quality of relating in the therapeutic process.

All these and many other contemporary contributors demonstrate the integrity of relational theory and clinical social work practice: the relational clinical social worker seeks connection with her client in ways that allow the client to recognize and relinquish, as necessary, embedded patterns and establish new ones according to a framework brought by the client. Psychoanalytic theories help the clinician comprehend and articulate her understanding of the client's subjective experiences. Clinical social work methods help the clinician organize this process of mutual discovery and directions for change. The relational theory outlines these interactions across individual differences as the mechanisms of the therapeutic process.

Key Concepts of Relational Clinical Practice

While each theoretical model has its own language and explanation, the relational theory has distilled key concepts that, appropriately, mark points where differing theories converge. These include:

1. Empathic attunement and engagement
    This concept, drawn primarily from self-psychology, requires an understanding of empathy as encompassing all self states of the client. It is emotional recognition and reflection that includes aggression, despair, dissociation, and all forms of self-experience, including experiences of the clinician's misunderstandings or inadvertent injuries. A relational clinician therefore follows closely and attempts to acknowledge all that a client brings, which creates a container for cohesion-building and experiential learning through the interpersonal dialogue.

2. Mutuality in the dyad
    The clinical process is bidirectional. Neither party's individual perspective holds more value or power. The client is the authority on his subjective experience, including the experience of the helping process. The clinician is the authority on how to conduct the therapeutic process to enhance self-reflection and openness to possibilities, by application of the other principles of relational practice.

3. Co-construction of meanings
    Statements and other ways of conveying information are interpreted selectively by speakers and listeners alike. Interpretation can include speculation on past as well as present bases of meanings. Verification of understanding is shared in relational practice, requiring the social work clinician to be open about her understandings so as to be corrected, confirmed, or otherwise addressed as a collaborator in discovery rather than an authority about who the client is, of what problems consist, and acceptable forms and directions of change.

4. Not knowing and inquiry
    The relational clinician is not defensive about what she does not know. This includes asking for clarification or information can include dimensions of a client's cultural and social contexts and references. Inquiry bolsters the client's authority about his own life conditions and worldview, opening the door to the clinician's exploration of the impact of his background on presenting problems and their parameters of resolution.

5. Transference and Countertransference
    These concepts are reconceived in relational theory. Rather than being projections and distortions of the client and the clinician based on unresolved early life experiences, as in drive theory and earlier versions of object relations theory, in relational theory, transference and countertransference are seen as responses and creations in the real, ongoing interpersonal exchange in that dyad. Important

internalized and historical forces continue to shape relationships, including the transference relationship, but the emphasis in relational theory is on the actual elements of the clinical interchange that rekindle unconscious constructions. A special value of transference and countertransference in diversity practice is its surfacing of socially induced assumptions about how differences are predefining and often anxiety producing in the clinical pair.

6. Collaborative goal setting

Irrespective of the clinician's assessment of client dynamics during assessment, an explicit contract for clinical goals is necessary. While this contract may be modified during the course of treatment, including suggested modifications introduced by the clinician, the client's endorsement of the purposes of the relational clinical social work process is required.

7. Authenticity of the clinician as a person

The blank screen of classical psychoanalytic models is replaced in relational therapy by a more open sharing of the clinician's experience in the work. Self-disclosure does not mean unalloyed sharing of personal information. Rather, disclosure of the clinician's thought process, concerns, lack of information about unfamiliar dimensions of the client's social and cultural life experience, and the like are part of the development of mutuality in the helping process.

8. Affirmation of strengths

The client's issues brought for clinical attention are surrounded by many coping strategies that have maintained him. Overt acknowledgement of the effort and efficacy of client coping redirects the relational clinical process from pathology to whole-person understanding. Even when coping strategies are implicated in failures of problem resolution and need to be deconstructed to instill more effective ones, their intentions and contributions to survival are recognized.

9. Cultural competence

This concept is introduced here as a dimension of relational clinical social work practice to emphasize the cultural/social/political context of client lives as intrinsic to creating an effective relational clinical social work process. While cultural competence is often conceived of as knowledge about a specific cultural group – in other words, content information – the relational model promotes addressing the meanings of cultural identity to the client as an individual and as a participant in a therapeutic process. Competence in the clinician resides in acknowledgement of the power of group identity in the client's self-experience and outlook on clinical social work treatment with a specific clinician. Resistance based on cultural differences therefore is viewed as a pathway to understanding and construction of a larger arena of connection. Using all the concepts described above, the culturally competent clinical social worker introduces cultural discussion by hypothesis and inquiry when it is absent in the dialogue.

Guidelines for Practice

Guidelines for practice in relational social work are instruments for charting the course in the relational field; the goal is a treatment process that is mutual and adaptive rather than a prescribed protocol (Hoffman 1998). Techniques such as active listening, reflecting, or interpreting can be learned. Their application is in the service of achieving connection and an agreed upon trajectory of work. The negotiation of this trajectory, which constitutes contracting, requires an extra measure of tolerance by the clinician for a non-predetermined treatment profile (Pizer 1998). While now heightened in relational theory, the phenomenological perspective has been part of social work practice for decades: we need to believe what we see, not see what we already believe.

The clinician remains open to what must be learned in the process about meanings and options that will be congruent with the client's agenda based on his population of identification. There is structure to remaining open and moving toward and through a mutually defined course of practice. This structure is spelled out in the stages of relational practice described below. In preparation for applying the stages and techniques of clinical practice with diverse populations, the clinician needs to be aware of how her own development and present context will be active in the building of a working alliance. Being the product of what is assumed to be the same population of identification initially can be reassuring and increase traction for engagement. At the same time, the clinician needs to be cautious: subjugation of an individual's narrative (Foucault 1980) can occur because of assumptions about similarity as well as difference. Countertransference distortion can be triggered by discomfort with any client narrative about him or the clinician that destabilizes the clinician's own construction of self-cohesion.

The relational clinician is distinguished by willingness to be active in articulating the purpose of finding clinical common ground and the problems that arise in seeking it. Rather than applying the familiar caveat to "interpret the resistance," presuming the client is defending against unconscious conflict, the relational clinician will "call attention to the dissonance." The dissonance may indeed reflect unconscious conflict in the client. From a relational practice point of view, however, micro-, mezzo-, and macro-level forces are at work; populations with which a person identifies shape self-identifications and together interact to create a worldview which is presented in the social work practice setting. Ambivalence in the clinical encounter is more likely than not and may attach to or be generated by diversity issues. Indeed, the absence of ambivalence can be a troubling sign of either developmental arrest (Mahler 1969; Mahler et al. 1975) or pseudo-connection (Benjamin 1988; Symington 2007). Maintenance of connection by acknowledgement of individual differences builds toward a cohesive self in the clinical process and thereby for the client within his own spheres of collective membership.

Being familiar with historical and present social forces impinging on people as members of a vulnerable population is an advantage to the clinician in helping the client feel understood. Starting from the manifest content of the client's presentation,

which may highlight his diverse population framework, the clinician conveys interest and allows herself to be educated about the client's view of the problems at hand. At the same time, the clinical assessment must include latent, unconscious components of the client's dynamics. In *Psychoanalytic Diagnosis,* McWilliams (2011) makes the case for psychodynamic diagnosis alongside exploration of the client's reported history and presenting issues. Talking with a person is a phenomenological, moment-to-moment process of discovery and clarification of problems, issues, and strengths, whereas diagnosis condenses a detached categorization which can become reified.

Clinical Social Work Stages and Techniques with Diverse Populations

In the application of relational theory to direct clinical practice with diverse populations, the social worker need not jettison previously learned frameworks for practice. Relational theory refers to the stance of the co-constructivist clinician in interaction with the client and the theoretical framework of promoting self-integration as fundamental to human functioning and vitality (Rogers 1961; Fromm 1998; Stern 2010). The structure of case practice is familiar to all practitioners, new and experienced, who were introduced to clinical social work through the work of Richmond (1918, 1922), Hamilton (1951), Woods and Hollis (1999), Goldstein (2001), and other social work pioneers. The translation of these seminal structural elements to work in a relational model with diverse populations is offered below.

1. Engagement

Engagement is framed as demonstrating to the client the understanding that his experience of self and his pressing problems are important to the clinician. With clients who are members of diverse populations, meanings may be constructed that have both universal and very culturally specific dimensions. The clinician facilitates engagement by establishing "potential space" (Winnicott 1971; Bollas 1987, 2008), meaning a place of safe communication where cultural idiom is welcome. Language differences are recognized as realities, not apologies. The clinician reflects and modifies as necessary her grasp of the client's problems, motivation, obstacles, and options, indicating her desire to construct a shared relationship.

2. Identification of Core Problems

Voluntary clients typically arrive with a statement of what is the matter. For mandated clients, a perceived core problem is being required to be in the social work setting itself (Hepworth et al. 2006). Involuntary status, even more than language difficulties, requires direct and immediate acknowledgement. Because involuntary encounters are assigned by outside forces, resistance, conscious and unconscious, occurs as an expectable response to a coercive situation. A relational practice response is for the clinician to acknowledge the coercive forces as part of beginning engagement. The clinician can express that she nonetheless would like to see

if there is some way she can be of help with the client's life and difficulties and thereby pursue definition of a core problem. Manifest content becomes a shared language for the relationship exchanges, even as the clinician reflects on latent dimensions such as developmental maturity, character, relational patterns, anxieties, and other content that will inform her assessment of how she can be of help (McWilliams 1999, 2011).

3. Assessment

Assessment includes more than diagnosis; it is an understanding of the client's "overall level of personality structure and functioning" (Dane et al. 2001, p. 483). It weighs the impact of age, gender, sexual orientation, physical and mental health, family structure, conditions of living, and, perhaps most importantly in the area of diversity practice, past and present social forces shaping individual and group experience. The psychodynamic assumption that unconscious process will always shape manifest communication leads the clinician to listen for the latent content of developmental level and defensive style (McWilliams 2011). These universal considerations may be more difficult to identify with an unfamiliar population: individual populations share a template of normal and abnormal communication, relational style, degrees of openness about personal matters, and so on. A frequent area of dissonance between client and clinician is perception of appropriate roles. These are perhaps particularly likely to be grounds for transference and countertransference when culturally determined roles differ.

4. Authenticity and Not Knowing

Asking counter-balances assuming by both parties. A clinician's reluctance to ask for background or current information can reflect countertransference issues about hierarchy. For example, the clinician's professional identity can mask for both parties the goal of parity in developing expertise about the client's problems. Excessive compliance as well as evasion or hostility must be overtly recognized to establish authenticity. Courage to acknowledge not knowing, and needing to know, establishes the client's power to authorize the clinician's work (Altman 2007). Many clients find clinical attention alien and suspect. Particularly among oppressed populations, deception and misdirection may be self-congruent and socially necessary. The onus is on the clinician to explain how the requested information is relevant to a viable course of treatment.

5. Treatment Planning and Goal Setting

Assessment and problem identification will fall flat unless the treatment plan that results reflects goals that are meaningful to the client. The assessment has revealed aspects of character as well as urgent presenting problems. The client's desire for concrete solutions to practical matters is not resistance, in a relational model, but rather a starting point for the clinician to reframe problems in ways that can lead to productive action. Client motivation is enhanced by a treatment plan that is goal directed (Woods and Hollis 1999; Dane et al. 2001).

Demonstrating willingness to engage the presenting problem must be balanced with empathic recognition of what the problem means to the client interpersonally, intrapsychically, and socioculturally. Solutions that destabilize the familiar

situation, and call for self-awareness, provoke ambivalence (Mitchell 1993). Change also can mean potential loss of support and recognition in the present social reality (Rosenberger 2011). Goal setting therefore has to have an attainable future direction. The relational clinician demonstrates not only empathic understanding but commitment to helping the client find a safe and tolerable treatment plan. Family therapy, including extended family, pastoral counseling, home visiting, support groups, and the whole armamentarium of social work interventions can be conjoint with a core clinical relationship. Interpersonal security inspires and also protects, and the psychodynamic underpinnings of relational practice help the clinician convey that the client brought the problem, however hesitantly, for an important purpose.

6. Forming a Contract for Clinical Work

A contract for social work practice rests on mutual definition of purpose and scope, as well as practical arrangements (Woods and Hollis 1999). A contract for clinical social work practice includes diagnostic thinking and a socially conscious mental health agenda in its purpose and scope (Brandell 2011). The contract thus must reflect both the client's biopsychosocial functioning and the plan for addressing his functioning in his social context. The relational clinical social work model therefore draws on attachment theory in a socially conscious way (Brandell 2011). The contract is a hypothesis about why the problem exists and the most likely way to effect change. The contract emerges by consensus, built on relational attunement, about problem definition and pathways to seeking problem resolution.

7. Into Action: Following the Treatment Plan

A particular strength of clinical social work practice is the multitude of settings in which training and practice occur. Diversity is the norm. Therefore, the relational clinical practitioner acquires professional skills that infuse concrete problem solving with psychodynamic depth, and vice versa. The observant relational clinician receives resistance to intrapsychic exploration in contracting as a means of clarifying to the client's paradigms of help receiving and help providing (Kleinman 1988). Additionally, the relational clinician assesses her own resistances and countertransferences, whether or not they are co-members of the client's population of identification. Relational social work practice recognizes the significance of the social context of the client, balancing insight with real sociocultural options and consequences of change (Akhtar 1995; Kleinman 1988; McWilliams 1994).

8. Termination

Termination ideally is planned from the outset, as part of the assessment process (Brandell 2011), reflecting interventions that are culturally congruent. The authenticity of the working relationship in relational social work carries through from acknowledgement of limits of familiarity with a diverse population to direct discussion of any interpersonal practice disruptions to the clarification of the boundaries in time, frequency, and length of the clinical process. The code of ethics (NASW 2011) calls for this transparency in treatment planning for all social workers. The practitioner's authenticity in sharing her limits of certainty about the client's sociocultural perspective offsets the possibility that the work becomes another arena in which the

client is pressured and controlled to act in ways that are inherently incongruent with the sense of individual self (Symington 2007; Kohut 2000; Hoffman 1998). Establishment of a mutual, respectful, and attuned therapeutic process, however short or long, creates hope; it also creates attachment and the feelings of loss at its ending (Basch 1995; Mann 1977, 1980).

Clients of diverse populations often have endured multiple losses as well as ongoing alienation in the dominant culture. These factors make the achievement of a meaningful clinical social work relationship all the more difficult to leave. With this in mind, the social work clinician leaves ample time for the termination process. The relational approach guides the clinician to return to her assessment appraisal of the client's patterns of dependency and history of separations and thereby anticipate and articulate the reemergence of these issues in the face of this new loss. Ambiguity and ambivalence in completing termination is unavoidable (Sanville 1982), but adequate time to reflect and review the achievements and incomplete aspects of the practice process are dealt with in a direct and transparent manner. In work with diverse populations, this summing up step may very well refer to the cultural explorations, learning, and negotiations that have taken place: this approach anchors the diversity dimension to the interpersonal dimension wherein the integration of differences into a larger whole has taken place.

Conclusion

Clinical social work with diverse populations is an extension, and a model, of the relational approach to a co-constructed, mutually conducted, and personally authentic therapeutic process. As a profession, social work has evolved toward a less hierarchical, more interpersonally congruent model. Conducting practice in light of a client's values, circumstances of living, and range of opportunities has become the hallmark of contemporary social work, and clinical social work has focused on the individual's intrapsychic experience with those social realities (Brandell 2011). Diversity practice heightens our core social work awareness of the significance of the client's developmental and continuing circumstances. It embraces open communication about what the client and the clinician do and do not know about their populations of identification. It directs the clinician to timing and stance in her own use of self as an extension of her understanding of the client's cultural idiom. What is meaningful and relevant to the clinical problem at hand is gathered in the assessment stage, including individual developmentally determined issues in tandem with socially created issues based on the client's specific cultural context and experience as part of a marginalized and oppressed group.

Theorists of the two-person psychologies, beginning with Fairbairn (1954), Winnicott (1958, 1965b), and others, up to the present-day writers (Aron and Harris 2011; McWilliams 1999, 2011), have offered a metapsychology and clinical theory that collectively underpins modern relational theory (Goldstein 2001; Wachtel 2008). The common elements are the mutuality of exploration to establish a treatment

focus that is congruent with the client's social as well as psychological reality and the use of an open dialogue throughout the clinical process so that both participants help maintain the therapeutic course. Diversity practice makes central the incorporation of sociopolitical and cultural realities that inform clients' development, present problems, and future options (Altman 2007; Caro Hollander 2010; Berzoff et al. 2008; Hartman 1992). Representing the fundamental social work ethic of individual self-determination (NASW Code of Ethics 2011), relational clinical social work joins the micro-, mezzo-, and macro-levels of client dynamics and realities in a structured yet nonhierarchical model of practice particularly suited to work with diverse populations.

Study Questions

1. The change in expression of a core social work principle from "client in situation" to "client and clinician in situation" is reflective of relational theory. Explain.
2. Diversity is a natural fit with relational theory because of its emphasis, among other principles, on mutuality and co-construction of meanings. Give an example of how mutuality and co-construction of meaning bridged a cultural difference in your practice.
3. Choose one of the stages of treatment, as outlined in this chapter. Give an example of applying one or more relational social work principles in this stage of a case.
4. Relational theory helps resolve historical distinctions between clinical social work and psychoanalysis. Explain, with an example, how an interaction with a client reflects how both of these traditions inform the practice exchange.
5. Explain how relational theory conceptualizes the use of transference and countertransference in practice.
6. Cultural diversity embraces more than demographic categories. Summarize in one paragraph how relational social work expands cultural diversity thinking.

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