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Assessment in Practice

I remember this bullheaded psychologist who gave me a small-print IQ test and told my mother that I was retarded. What he had really tested was my ability to read small print. Even my mother knew that his diagnosis was not correct. After all, why would someone give me a small-print test when he knew I couldn't read small print very well? Because I was very determined to go to regular school, my mother told the resistant school officials, "You'll have to fight with her. She wants to go here." So this bull-headed psychologist then said to my mother, "Well, we'll let her go here so she can learn about failure." So my mother says, "Yeah, OK." She only had an eighth-grade education, but she understood intuitively that I was brighter than they gave me credit for.

—Brenda Premo
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STUDENT LEARNING OBJECTIVES

1. To understand the implications and limitations of medical/professional-based assessment models that utilize a pathological/dysfunctional frame of reference
2. To develop an understanding of the social model of assessment based on the social-ecological model of human development, with its origins in strengths-based practice and the independent living movement
3. To understand the various layers of the social model of assessment, including the biosocial, psychosocial, and social structural domains
4. To learn to apply the social model of assessment, considering multiple systems sizes in the assessment process

A routine and critical component of human service practice is assessment. Assessment occurs at all system levels, from the individual and personal to the institutional and societal. Hepworth, Rooney, Larsen, Rooney, and Strom-Gottfried (2005) state that assessment provides a foundation for contracting, goal setting, and interventions and that the effectiveness of interventions is contingent on accurate assessments. Effective assessments are

multidimensional and purposeful. Assessments can be both process and product oriented. *Product-oriented assessments* are assessments that result in the creation of a report or document. For example, a medical history and physical are required when patients are hospitalized, and mental status examinations and their results concerning emotional and cognitive functioning are documented. *Process-oriented assessments* do not necessarily produce a finished product; they are primarily tools used to guide ongoing relationships to direct activities and plans. Of course, assessments frequently overlap in their nature and purpose.

In this chapter, we discuss the implications of the types of assessments in which human services professionals engage. We start our discussion by illustrating assessments as products. We discuss traditional pathology-based assessments, which are often required to justify the need for professional involvement. We also discuss the processes of assessment. We then discuss the social model of assessment based on the social-ecological perspective.

PROFESSIONAL ASSESSMENTS/EVALUATIONS AS PRODUCTS

Assessments of individuals and families can be divided into three components: information and history, impressions and evaluations, and plans. Information and history comprise the *what* section of an evaluation. What is important to know about the people and situations being evaluated? The second section, the *so what* section, organizes and gives meaning to the history and information. What is the meaning of the information one has received? The third section, the *now what* section, outlines plans. Based on the situation at hand, what should be done and what are the desired outcomes? Figure 13.1 provides a skeletal outline of a tool to develop an assessment product.

The first component focuses on people's histories, background information, and current situations and the reasons that bring them into contact with practitioners. This information can be referred to as the *social history* portion of the assessment. Several elements are relevant to this section. Identifying information includes demographic information such as age, gender, ethnicity, onset and type of disability, and living conditions. It also includes the reasons disabled individuals and their families are using professional services. Family background can include information about the person's family of origin; current relationships with family and significant others; and past, present, and anticipated living situations. Social history can include information on a person's educational and work history, friends and relationships, culture, places of residence, substance use history, and involvement with the legal system. Since persons with disabilities are especially susceptible to financial problems, the history should include information on financial

FIGURE 13.1 Assessment and Evaluation Tool

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| <p>I. What?</p> <ol style="list-style-type: none"> 1. Identifying Information (age, gender, ethnicity, residence, etc.) <ul style="list-style-type: none"> Reason for admission, clinic visit, or agency involvement Reason for referral to social work 2. Family Background <ul style="list-style-type: none"> Family of origin or childhood Current relationships Adult family and significant others Living situation—past, present, and anticipated 3. Social History <ul style="list-style-type: none"> Educational history Work history (including military background) Friends—relationships Cultural influences Places of residence Substance use history Legal involvement 4. Financial Status <ul style="list-style-type: none"> Income, expenses, obligations Insurance—medical coverage and needs 5. Psychosocial Situation <ul style="list-style-type: none"> Cognitive status Emotional/psychosocial status Psychiatric—mental health history Family reactions, relationships, support, and adjustments Sexuality concerns (e.g., questions, orientation, problems) Judgment/planning—behavioral situation Other relevant issues 6. Tools <ul style="list-style-type: none"> Genogram Ecomap <p>II. So What? Impressions</p> <ol style="list-style-type: none"> 1. Personal strengths and limitations 2. Social supports 3. Resources <p>III. Now What? Plans</p> <ol style="list-style-type: none"> 1. Counseling and direct services—individual and significant others 2. Social interventions, planning, advocacy 3. Micro, meso, macro interventions 4. Anticipated outcomes |
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status. This includes income, expenses, and financial obligations as well as insurance, medical coverage, and costs of medical needs. The person's psychosocial situation may also be important to discuss and may include the person's cognitive and emotional status. Sexuality concerns may be ascertained. Information about the person's history with mental health professionals and the mental health system may be relevant. Family reactions and supports should be considered. Information on the person's relationships within the community may be gathered. Strengths in judgment and planning are also relevant to the person's psychosocial situation. Genograms and ecomaps can be valuable tools for developing comprehensive histories. The information gathered in the social history component of an evaluation varies greatly, depending on each person's circumstances and each person's social and family context. In addition, the settings in which assessments are performed affect the areas highlighted in assessment. For example, the foci of human service assessments in school, hospital, and mental health contexts differ in priority and scope.

In the second section of psychosocial assessments, *evaluation* or *impressions*, the human service practitioner and consumer consider the meaning of the information gathered in the social history. For example, a person who has had strong family relationships is likely to be able to rely on family for continued support. An individual who has had multiple marriages and divorces might expect less family support than one with strong long-term relationships. An individual from a background of poverty will likely have fewer resources available than a person who comes from wealth. The evaluation section should include information about people's strengths and their realized and potential capabilities as well as their needs and limitations. It considers individuals' social supports and their ability to affect people and organizations in their lives. The level and adequacy of personal and environmental resources are also evaluated.

The final section of psychosocial evaluations, the *plan*, is based on the evaluation section. Plans should be explicit and goal directed. In the plan, the person and professional determine desired outputs and outcomes. Outputs may include services that professionals may provide (e.g., counseling, advocacy, referrals) and actions in which consumers may engage. Outcomes focus on the results the consumer and practitioner wish to achieve in their work together. Attention to micro, meso, and macro elements of people's lives is a critical element in effective plans.

Five questions that provide a framework for assessment activities can be asked as practitioners develop human service assessments. First, What is the reason for the assessment? This helps practitioners evaluate people's needs and their reasons for engaging in a relationship with a human service agency and professional. Second, What is the scope of the assessment? Scope is determined by a variety of factors, including people's needs, agency

mandates, and social conditions. For example, the reasons for and scope of an employment assessment in a vocational rehabilitation agency differ from those of an assessment performed during the course of family therapy. A third question is, Who receives the information and knowledge gained as a result of the assessment? In an individual and family therapy agency, assessment information is usually kept within the confines of the practitioner and family relationship. However, if family therapy is taking place within a medical and/or psychiatric facility, the information is generally more widely disseminated to other professionals and to third parties. A fourth question is, What are the sources of knowledge that will be needed in order to engage in the assessment? This will determine how information is obtained. Some assessments utilize only one source of information, whereas others utilize multiple sources. Court-ordered assessments for substance abuse offenses may utilize numerous informants as well as court records. On the other hand, assessments for participation in an educational group may rely exclusively on an individual interview. Fifth, What will the assessment be used for? For example, if assessments are being paid for by a third party, especially in managed care settings, a clinical (pathology-based) diagnosed assessment is often necessary to obtain reimbursement (Strom, 1992). Medical and psychiatric settings require pathology-based diagnoses. In contrast, assessments performed in independent living centers focus on consumer definitions of needs and problems.

PATHOLOGY AND ASSESSMENT

Traditional assessment models focus on the presence or absence of pathology (Schuler & Perez, 1991). For example, medical histories and physicals required when patients are admitted to hospitals determine whether findings are “within normal limits” or there is pathology. Strengths are not considered. There are several reasons for the diagnostic, problem-focused emphasis in professional evaluations. Persons seeking professional help do so to receive assistance in treating or solving problems. For example, people see physicians to treat or cure illness. Professional training and sanctioning centered on pathology have traditionally driven models of practice. Medical specialties (e.g., neurosurgery, cardiology, rheumatology) concentrate heavily on treating pathological conditions, and there is relatively little emphasis on preventive and health-maintaining specialties (e.g., family practice, epidemiology). Similarly, mental health training primarily focuses not on maintaining mental health, but on treating mental health disabilities. To justify intervention, a *DSM* diagnosis must be provided. The focus on pathology has been driven, in great measure, by financial interests. Funding is institutionally based in places such as hospitals and nursing facilities, and service providers are paid only after diagnosing and treating pathology.

Certainly, the focus on pathology is essential in many situations (Blotzer & Ruth, 1995). A person taken to an emergency room with multiple injuries from an automobile accident requires immediate assessment and treatment for injuries sustained. Empathy is not particularly a high-priority skill in an emergency or operating room. Similarly, a person experiencing an acute psychotic episode needs immediate protection and treatment. However, an exclusively pathological focus is inadequate in the long term. This is especially true in human services.

By attending primarily to problems, assessment can fail to account for individual strengths. A deficiency focus can lead to the devaluing and, in some cases, dehumanizing of people (Cowger, 1994). For example, in reviewing old patient hospital records, one of the authors repeatedly found the notation "FLK" in the records of children with mental retardation. Upon investigating the meaning, he found that FLK was an acronym for "funny-looking kid" used routinely to refer to patients with mental retardation. FLK was originally used as a type of medical shorthand, because children with intellectual disabilities can have atypical facial and body features. However, the term "FLK" devalues the people it supposedly describes.

The individual pathology focus also fails to recognize the complexity of experiences and relationships (Salzinger, 1996). This is illustrated in the case of a Native American patient hospitalized in a rehabilitation center with an acute spinal cord injury. Nurses and therapists became increasingly frustrated with his lateness for therapy and his nonparticipation in the general milieu of the center. They attributed his behaviors to denial, resistance, and noncompliance. They failed to realize that he had been raised in a remote community on a reservation. He was overwhelmed, not just with his spinal cord injury, but by his surroundings. The rehabilitation center employed far more people than lived in his community. He had never owned a watch, yet they expected him to follow a tight schedule. He was a night person, yet he was expected to begin his day at 7:00 A.M. There were also language and cultural barriers. However, the staff focused only on "fixing" his behavior so they could provide the therapies they determined he needed. A more holistic assessment would have led professionals to assess ways they could change their expectations of him and modify the environment in such a way to better meet his needs while ensuring that he received the medical and physical attention he needed. For example, times for breakfast and therapies could have been modified to meet the demands of his lifestyle. The staff could have taken the time to get to know the patient and learn about his culture.

MEDICAL AND SOCIAL MODELS OF ASSESSMENT

In the last generation, the adequacy of traditional medical assessments based on pathology has been challenged. For example, Trieschmann (1980) compares two models of assessment and service delivery for persons with spinal

cord injuries—the medical model and the learning model. Trieschmann points out that “in the medical model, the behavioral equation for rehabilitation success consists of: $B = f(O \times p)$. Behavior (B) is a function of treatments to the organic variables (O) unless [these are] hindered by underlying personality problems (p)” (p. 24). In the medical model, an individual’s organic, physical, and medical problems are the primary assessment targets. Personality and psychosocial status are assessed in the context of the obstacles they create for the treating professionals. Strengths are not assessed—only the absence of pathology. The unit of assessment is the individual, problems reside within the individual, and treatment plans center on fixing the individual. In addition, professionals are responsible for assessment and treatment decisions. While this model may be appropriate in crisis situations, such as during a medical or mental health emergency, it has limited benefit in the long term.

Condeluci (1995) discusses the limitations of individual pathology assessments that focus on disabled persons’ problems and ignore the social obstacles that prevent them from being productive. Condeluci states: “Today, in the human service world that surrounds disability, a battery of tests and surveys attempts to identify and predict the economic potential of its clients. These tests look at aptitude, interests, skills, education, and deficits. It is mostly the deficits, however, that cast a shadow on the plan that is set up for the individual” (p. 72).

Trieschmann (1980) offers a more progressive model of assessment and intervention—the learning model—and contrasts it to the medical model. She advocates its use in rehabilitation settings, stating, “The behavioral equation for rehabilitation success is: $B = f(P \times O \times E)$. Behavior [B] is a function of the person [P], the organism [O], and the environment [E]” (p. 26). In Trieschmann’s learning model, “person” variables include personality style, coping mechanisms, and internal or external locus of control. Organic variables include age, health, and severity of disability. Environmental variables include family support, finances, and public policies. Assessment broadens to include psychological and environmental well-being. Individuals are still the focus, but assessment is used to help professionals determine how to educate clients to function better. Assessments are performed to identify knowledge and skills that clients need to function as independently as possible. Control still resides primarily with professionals, who act as educators. The learning model attends to internal strengths and social variables. It may be appropriate in the initial stages of disabilities, when persons with disabilities and their families are in need of knowledge and skill development. However, it is inadequate in the long run because the perception of problems and needs as well as the control of services still rest with professionals.

As long as professionals maintain control, people with disabilities are vulnerable to their biases. For example, Condeluci (1995) observes that in

the employment arena, people with certain types of disabilities are likely to be stereotyped and that the experts “push people with certain disabilities toward job areas thought to be best with disability groups” (p. 74). For example, people with intellectual disabilities are often pushed into custodial, dish washing, and bus-person jobs, whereas those with brain injuries are traditionally pushed into repetitive work. Assessment tools and interventions such as aptitude tests can be valuable aids in the quest for economic self-sufficiency. However, this model is similar to other models in that it focuses primarily on the individual’s deficits and possible interventions to overcome problems.

A social rather than individual approach to disability is the approach that best meets the needs of persons with disabilities. Hahn (1991) labels this approach the “minority group model” and states that social stigma is the major problem facing persons with disabilities, which is best “addressed through civil rights rather than social services. The minority group model also alters the view of the disabled person as defected or deficient. . . . [The] call for improvements in social services is a step in the right direction, but it should be expanded to include civil rights as the major focus for improving the lives of the disabled” (p. 17).

Condeluci (1995) emphasizes the importance of the economic aspects of people’s lives. From this perspective, problems lie in the person’s inability to earn a living. Professional assessment focuses on problems people have that prevent them from being productive. Condeluci labels this approach an “interdependence paradigm.” He contends that interdependence focuses on individual capabilities rather than deficits. Problems reside in systems rather than individuals, and actions are tailored to create environmental supports and consumer empowerment.

There are several elements in approaching assessment from a social perspective. A critical component of the independent living approach is that individuals identify their own needs (Mackelprang & Salsgiver, 1996). The minority group model, the interdependence paradigm, and the independent living approach have many similarities. For ease of use, we call our approach to assessment the social model.

Using Trieschmann’s behavioral framework, the social model of assessment might be diagrammed as follows: $B = f(P \times O \times E \times Pe \times C)$. Behavior (B) is a function of the sum of personal attributes (P), organic and biological characteristics (O), and social and environmental factors (E). In addition, we add internal and external definitions of personal characteristics and attributes (Pe) and control over life choices (C). When societal perceptions (Pe) are negative, choices are limited and people develop a tendency to internalize others’ messages, such as occurs with internalized ableism. Of course, the social model emphasizes the importance of individuals having choice and responsibility over life decisions.

On the personal (P) level, the social model emphasizes people's strengths and potential. Strengths encompass the knowledge and skills that an individual possesses (Saleebey, 1996). Potential refers to the potential abilities that people can develop with sufficient resources. Persons with disabilities can identify their own strengths, and sometimes professionals can help them identify strengths they may not perceive that they possess. With consumer direction, professionals can also consult to help them develop their potential. This is illustrated in the case of a young couple, both with neuromuscular disabilities, who requested assistance from one of the authors. This couple, both in their early twenties, had met and fallen in love in the nursing facility in which they resided. Their medical records, which focused on their physical limitations, clearly justified their continued stay in the facility. Initially, they came into contact with one of the authors because of their desire to get out of the nursing facility for occasional recreation. With increased community exposure, they began to realize that others with similar capabilities were not forced to live with their parents or in nursing facilities, with others directing their lives. Encouraged to identify their strengths, they began to believe that they could marry and have a sexual relationship if they chose. Both began to realize that their need for physical assistance in daily living activities did not mean they had to give up control over how, what, where, and by whom assistance was provided. Eventually, they each developed their potential and identified their strengths to the point that they left the nursing home to live in their own apartments with attendant care assistance. Their relationship evolved platonically; they maintained their friendship yet began to see themselves as sexual beings. Along the road to independent living, each person began to assess and develop strengths, eschewing traditional pathology-based models of assessment and treatment.

At the organism (O) level, the social model acknowledges that people with disabilities have atypical functioning or characteristics; however, disabled persons are not defined by their impairments (Fine & Asch, 1993). For example, people with mental health disabilities have many other traits, interests, and capabilities. Medical labels such as "schizophrenic" define individuals by their diagnoses. However, acknowledging that a person lives with schizophrenia recognizes that the person has other qualities and traits. People may choose to adopt a disability-first identity, wherein they embrace the totality of the disability as an integral part of themselves, not just the part that needs treatment and intervention. Using impairment as a person's defining characteristic is a natural outgrowth of traditional models that focus on problems and ways to fix problems. In contrast, the social model views the disability as one aspect of people's existence and, possibly, of identity.

In the social model, a critical element of assessment is the environment (E). For example, people who use wheelchairs for mobility face problems, not because they are "confined" to wheelchairs but because of physical barriers that limit their access to full societal participation. The fact that "persons

with disabilities tend to make up a disproportionate share of residents at the lower end of the economic scale” (Bryan, 1996, p. 17) has much to do with social policies and institutions that make it extremely difficult for them to be economically self-sufficient. Assessment emphasizes the availability and limitations of social and community resources and looks at ways to enhance opportunities

Another environmental element in the social model of assessment is the reversal of traditional medical model roles. Disabled persons are experts over their lives, while professionals act as consultants. Rather than professionals making decisions based on client information and feedback, consumers identify needs and problems and enlist the help of professionals to meet their needs. Professionals may not always agree with the individual’s perceptions, but this approach assumes that people with disabilities have the ability to recognize their individual realities (Condeluci, 1995). Unlike other approaches, the social model does not assume that professional perceptions are superior to those of clients. Rather, it assumes that the consumers of professional services understand their own lives.

The perception element (Pe) of the social model acknowledges that beliefs and values relative to disability dramatically affect the lives and behaviors of disabled persons. Negative societal perceptions lead to institutionalized oppression and devaluation of people with disabilities. Szymanski and Trueba (1994) offer the observation that “the difficulties faced by persons with disabilities are not the result of functional impairments related to the disability, but rather are the result of a castification process embedded in societal institutions for rehabilitation and education that are enforced by well-meaning professionals” (p. 12).

The “castification” that Szymanski and Trueba (1994) refer to is pervasive throughout societal institutions, even those that have been developed to serve persons with disabilities. Traditionally, long-term dependence on health or social services has been assessed as a functional individual problem. For example, in the United States, some disabled people are forced out of the job market by their need to maintain Medicaid benefits that are available only to those who are poor. Social model assessment acknowledges a problem in societal institutions wherein people are forced to choose between low-paying jobs and hazard losing health coverage or being financially dependent so they can maintain access to health care. Another example of this castification occurs in vocational rehabilitation agencies, where pressure to employ people quickly and with limited resources induces counselors to find the easiest sources of employment (e.g., dish washing, custodial work) and to exclude people with severe disabilities by labeling them unemployable. When societal perceptions are pervasively negative, people also internalize the ableism they experience daily. They can begin to accept the negative messages and incorporate them into their identities. In contrast,

social model assessment emphasizes societal elements rather than primarily individual concerns.

A major philosophical difference between assessments of people with disabilities based on the traditional medical model and the social model is that the social model assessment begins with perceptions of capability and the assumption that disabled persons are competent and have the right and responsibility to control their lives and to manage the professionals who enter their lives (DeJong, 1979). In contrast, other assessments begin with the assumption that professional assessment is needed to fix individuals' problems. The terminology used is an example of this contrast in assumptions. In the social model, independent living specialists consult with clients, who direct the interventions. In a traditional model, case managers assess and manage cases (i.e., clients, students, or patients). The locus of control resides with the person with the disability in the social model, and with the case manager in the traditional model.

The social model of assessment acknowledges that disabled persons have a right and responsibility to control (C) their lives and resources. Condeluci (1995) contends that "people must be deemed capable to be in control of their lives, and only challenged if family, support people, and advocates are convinced, beyond a shadow of a doubt that they are not" (pp. 102–103). Most professional approaches assume that people with disabilities must prove they are capable before others relinquish control. Unfortunately, those to whom control is relinquished often have conflicts of interest, in that their loss of control also means loss of their role and, possibly, their usefulness. For example, the nursing facility in which the previously cited couple resided had significant disincentives to discharge them—the most important of which was the loss of tens of thousands of dollars in annual revenue.

In the social model, disabled persons determine how and to whom resources are expended. For example, persons with intellectual disabilities in a supported living situation can determine what help they need with finances, but they may use social workers and independent living specialists as consultants to assist them in managing their affairs. Rather than having a home health agency employ attendants on their behalf, individuals with physical disabilities who need physical assistance handle their own financial concerns and employee decisions.

Both traditional and social models recognize that there are situations where people are not able to function independently. Traditional models, however, are inclined to impose professional control over individuals to fix their pathology. The social model, on the other hand, considers the need for assistance to be a part of human existence for all people. No one person is completely independent in today's society. DeJong (1979), in tracing the philosophic roots of the independent living movement, states that the movement "has steered away from destructive individualism. It has encouraged community support and mutual responsibility. The emphasis on self-help

and self-reliance has a communal as well as an individual component” (p. 50). People without disabilities use the expertise of others in everything from buying automobiles to purchasing groceries. Likewise, people with disabilities rely on others. People with severe intellectual disabilities may need assistance managing their money or using transportation. For decades, people with hearing disabilities used TTYs to communicate from a distance. Today, text messages, instant messaging, and e-mail are readily available to deaf and hearing people alike, who depend on functioning Internet and/or phone companies. Reliance on others, or what Condeluci (1995) calls “interdependence,” is a reality for everyone in society. Problems arise because of limited or absent resources, and people can meet their needs through empowerment and by creating adequate supports. Assessment is a mutual effort that goes beyond solving problems to assessing needs, ascertaining potential and identifying strengths, and finding solutions.

SOCIAL-ECOLOGICAL ASSESSMENT

Effective assessments are contextual; that is, the context in which the assessment occurs determines the nature and extent of the assessment (Miley, O’Melia, & DuBois, 1995). According to Rosenthal (1989), a comprehensive, holistic individual and family assessment includes the biological, psychological/emotional, and social domains. Fee (1994) adds to this the importance of the cultural domain in assessment. Bronfenbrenner (2005) provides a framework for looking at micro, meso, exo, and macro systems and has recently refined his conceptualization to more explicitly include human biology.

In chapter 2, we introduced you to the social-ecological model of human development and behavior. The application of the social-ecological model provides an approach that rejects the pathology-based medical and moral models in favor of what we have been calling the social model of viewing disability. We make this distinction to help readers avoid confusing the social model, which provides an overarching framework, with the social-ecological model, which is one approach to describing and explaining human behavior and which we are applying to human service assessment.

The biosocial, psychosocial, and social structural domains of the social-ecological model encompass the personal elements of traditional human services assessments as well as the social, community, and cultural spheres in which people live. Stated another way, assessments encompass the traditional micro level of the biological, personal, and family elements of the person in the environment; the meso-level influences that are involved in physical and social climates, social systems, organizations, and communities; and the macro-level systems of the environment, societal structures, and cultures in which people reside. Each of the three domains overlaps and is

interrelated with the others, as illustrated in figure 2.1 in chapter 2. In addition, influence is reciprocal; not only are people influenced by their environments, but people can help shape their contexts.

Biosocial Domain

The biosocial domain encompasses all of the body's systems. However, biological functioning does not define people. For example, people with spinal cord injuries have paraplegia or quadriplegia—but their medical diagnosis as a paraplegic or quadriplegic does not define them. In a social context, they may identify themselves as belonging to a group of “paras” and “quads,” as opposed to “walkies” or the “temporarily able-bodied,” or they may choose *not* to identify themselves as part of a disability community. Given opportunities, people with intellectual disabilities that are biologically based are no longer imprisoned in institutions and have strong vibrant communities and organizations such as People First. Biological characteristics have not changed, but their social contexts have.

The social-ecological model assesses biological functioning in the holistic context. Human service workers need to rely on persons with disabilities to identify their levels of biological functioning and the meaning of that functioning in their lives. The focus is on their strengths and capabilities. This can be illustrated using the example of a person with T-12 paraplegia. Traditional assessment focuses on paralysis and lack of sensation in the lower extremities and the genitals, lack of bowel and bladder functioning, sexual dysfunction, and “wheelchair confinement.” From this assessment, treatments are developed that are intended to make people closer to “normal.” Long leg braces for walking are often prescribed but rarely used. Interventions are developed that focus on helping people deal with their physical losses. In contrast, when assessing biosocial functioning, practitioners seek the meaning of paraplegia to the individual. Together, the individual and professional seek the meaning of paraplegia while assessing strengths and capabilities. Rather than viewing the person as confined to a wheelchair, the professional perceives the person as using a wheelchair for mobility. Sexual function is seen as different, but not as inherently dysfunctional. The gamut of emotional responses are jointly evaluated, with a focus on building strengths, not just fixing pathology.

At the intersection of the biosocial domain and the psychosocial domain is what we call the biopsychological component of human experience. In other words, biology and emotional, psychological status are interdependent and reciprocal. In the 1600s Descartes separated mind from body (Brown, Barrett, & Padilla, 1998), a philosophy embedded in Western medicine and culture (Mackelprang & Mackelprang, 2005). We believe this is a false dichotomy. As Damasio (1994) states, the physiological operations of the mind are structural and functional and can be fully understood only in the context of

our interactions with the environment. As Sapolsky (1998) states, “We have come to recognize the vastly complex intertwining of our biology and emotions, the endless ways in which our personalities, feelings, and thoughts both reflect and influence events in our bodies . . . and a critical shift in medicine has been the recognition that many of the damaging diseases of slow accumulation can be either caused or made far worse by stress” (p. 3).

We argue that physical and psychological characteristics are not distinct and separate; they are really the same. On an individual level, one of the authors has a disability that is associated with the structural differences in the area of his brain controlling motor function. The other author has atypical brain function that can also be shown by diagnostic tests showing atypical electrical-chemical activity in the brain. Professionals may “diagnose” his atypical brain activity and function as pathological, yet the author embraces the experiences and perspectives gained from these characteristics. As Sapolsky (1998) suggests, disease and illness associated with disabilities are stress related, often because of environmental influences that make life with a disability more difficult.

On the social or what Bronfenbrenner (2005) calls the micro-system level external influences on biosocial functioning are reciprocal; that is, relationships are dependent on the commitment and actions of interacting parties. It is critical to determine the nature and the levels of support (Crewe & Zola, 1983), including both physical and emotional supports. For example, some people may provide much physical support, such as personal attendant care or assistance with shopping. Others may provide no physical care but may provide emotional support. In addition to the strength of the support, conflict should also be assessed. Sometimes strong support comes at a high price when conflict is present; therefore, people should be encouraged to assess the biosocial benefits and costs of their social supports. The type of relationship is also important. For example, the connection people have with professionals who provide services is usually temporary and is much different from that of family and friends.

Psychosocial Domain

The psychosocial domain involves people’s emotional and cognitive functioning in their social environments. For professionals to justify their involvement and receive reimbursement for services, *DSM-IV TR* diagnoses may be required. If so, assessment is, by necessity, pathology based. In playing the reimbursement game, human service professionals may learn to engage in labeling an individual with an innocuous diagnosis, such as an anxiety or adjustment disorder (Saleebey, 1996). In contrast, the social model recognizes that individuals have problems, but assessments focus on strengths. Human service professionals work as consultants in conjunction with

individuals to identify strengths, potentials, and capabilities. They emphasize supporting people's capacities rather than fixing their problems. Workers rely on those with whom they work to identify their own needs. The individual's perceptions, rather than the professional's expectations, are paramount. The difference between the traditional and social approaches was repeatedly illustrated to one of the authors in his work with persons with neurological disabilities. The following example was typical.

Late one afternoon I received a call from a nurse and a resident physician to consult on the case of thirty-year-old Bill, who had paraplegia resulting from a fall. Bill was well known to me and had been doing very well during inpatient rehabilitation for his spinal cord injury. I had met with Bill, his wife, and their young children on a number of occasions in the month he had been hospitalized. However, the nurse and physician were very upset because Bill was nearing discharge and he had "not dealt emotionally with his paraplegia." When I asked them what they saw as the problem, they told me Bill was in denial. I asked how they reached that conclusion. They replied, "He has never been depressed and is too pleasant all the time." "Sounds good to me," I responded. "Yes, but he needs to begin to deal with his disability," they stressed. I replied that in repeated conversations with Bill and his family, they said that they felt they were coping with things well. I saw nothing to indicate anything different.

I expressed concern that their expectations of Bill placed him in a no-win situation. If Bill didn't become depressed, he was in denial. Bill could become psychologically healthy only by experiencing emotional states they considered pathological (e.g., depression, anger, anxiety). They assumed the lack of pathology meant pathology, and they would be satisfied that he was healthy only if he became depressed. Their latent expectations could even produce unnecessary difficulties.

In the months following this incident, Bill and his wife sought the author out on a number of occasions. In one instance, they asked for help finding social support from others with spinal cord injuries. On another occasion, they sought sexual education and counseling. Assessment and counseling were provided in the context of enhancing strengths rather than fixing dysfunction.

Although an acute disability such as paraplegia can be traumatic and produce a range of emotional responses, we reject the idea that disabilities automatically cause psychosocial problems. A social model recognizes the tremendous resources people possess in dealing with life's experiences. It acknowledges the importance and reciprocal nature of social supports people use. Individual coping problems are often a result of others' reactions to and expectations of disability.

Human service workers are cautioned to listen to individuals' personal perceptions of the emotional impact of their disabilities as well as the nature of their social supports, rather than assuming people will react in a certain way. This concept is illustrated in a study of persons with long-term spinal

cord injuries by Mackelprang and Hepworth (1987). Two of their findings ran counter to extant beliefs of professionals, and a third illustrated the impact of support systems (Mackelprang, 1986). First, it was widely assumed that the higher a person's spinal cord injury, the lower the level of adjustment he or she would experience. Instead, the study found that those with lower injuries (lumbar and sacral) had lower levels of adjustment than people with thoracic and low cervical injuries. Second, people with spinal cord injuries reported less emotional distress overall than was expected. Third, the study revealed that people with strong religious beliefs reported better levels of social and emotional adjustment than nonreligious respondents; however, they also reported that expectations and relationships with others in their faith communities were a source of significant stress. For example, some felt that others judged them because they had not had the faith to be healed of their "affliction." This study supports the notion that people's perceptions of their disabilities are the most critical factor in psychological assessment. The assumption that persons with disabilities are in greater need for professionals to determine their emotional status is an ableist notion.

Cowger (1994) offers twelve principles of assessment, all of which underlie the need for the human service practitioner to seek the perceptions of the person with whom he or she is working. First of all, the individual's understanding of the facts and issues is of foremost importance. Second, believe in the credibility and ability of the person. Third, look for what the person wants. Do not bring into the assessment process preconceived notions and biases. Fourth, move the assessment toward an emphasis on personal and environmental strengths. Fifth, look for strengths on a multidimensional level—address individual, family, and community strengths. Sixth, use language that the person understands and relates to. The use of professional jargon should be avoided. Seventh, make the assessment process a combined effort; this should be easy if you believe in the person. Eighth, and much related to the preceding principle, reach a mutual agreement on the assessment. Ninth, do not blame the victim. In working with persons with disabilities, it is easy to make their "laziness" or their "dependency" the cause of the problem that needs to be addressed. Tenth, avoid cause-and-effect analysis in assessment. Humans are far too complex for the human service practitioner to figure out the cause. Eleventh, "assess, do not diagnose" (Cowger, 1994, p. 267). Diagnosis assumes pathology and dysfunction. Last, see difference and uniqueness as strengths. This is easy to do when the cultural domain is addressed as it intersects with disability.

The psychosocial domain includes intersections between what Bronfenbrenner (2005) describes as micro systems and meso systems. Effective assessment is concerned with the impact of social systems on people's lives and the impact people can have on those systems. Psychosocial assessment should encompass neighborhoods, health care organizations, churches, schools, social agencies, and businesses in which people are employed. It is

critical that the influences of these systems be addressed in assessment. For example, Brown (1996) chronicles the low income and employment levels of persons with disabilities, which traditionally have been attributed to people with disabilities being less capable than persons without disabilities. However, it is clear that people with disabilities are denied opportunities and subjected to much discrimination in employment. Assessment of the psychosocial domain must include the opportunities and obstacles people face in their social and community contexts rather than focusing primarily on the individual. It is also important to assess the individual's ability to affect meso systems. For example, people now have recourse against organizations such as schools and businesses that practice discrimination. When institutional discrimination occurs, assessment can identify the sources of and factors contributing to discrimination and the resources to combat it. Initially, the individual with a disability may be the primary beneficiary; however, assessments that include meso-level influences have farther-reaching consequences when institutional ableism and societal barriers that affect others as well are identified. This is illustrated in the following example of a student seeking a degree in education.

Javier, a thirty-five-year-old Latino with a visual disability seeking a bachelor of science in education, filed an action with the ADA compliance committee of his university concerning discrimination he experienced in student teaching. He had been removed from his internship without warning. Reasons given for his termination were lateness in showing up for work, poorly prepared lesson plans, non-attendance of school functions, and failure to control students in class. Initially, Javier sought support to deal with his personal failure through a local organization for persons with visual disabilities. As the independent living specialist discussed Javier's situation, they jointly assessed a number of institutional procedural problems that hindered Javier's success. First, Javier had requested that the school accommodate his disability by finding a site near his home. Instead, he was placed in a school several miles from his home that had no public transportation access. As a result, he was dependent on others for transportation, which was inconsistent, and it was impossible for him to attend extracurricular activities. Second, his mentor teacher's style of mentoring was hands off; little attempt was made to orient Javier geographically. Finally, when students took advantage of Javier's visual disability, which limited his ability to teach effectively, the teacher did not consult with Javier to develop strategies to better control the class. Instead, the teacher stated that these problems were caused by Javier's disability, which limited his ability to teach effectively.

In spite of these practices, Javier initially internalized his mentor teacher's view of his failure and regarded his dismissal as being caused by his inadequacies. By exploring micro-level as well as meso-level factors of psychosocial functioning, Javier began to recognize the environmental conditions that contributed to his problems. He was also able to identify areas in which he needed to grow to become an effective teacher. However, he began to reject the notions that the problem resided exclusively in himself. As a result, he filed a complaint

against the educational department of his university because it failed to reasonably accommodate his disability. Had his counselor focused only on emotional adjustment, his problems would have been assessed as coming from a lack of personal adjustment rather than the school environment. Javier's complaint was successful.

Social Structural Domain

Effective assessment must include an analysis of societal values and the laws, policies, and structures that support and are supported by those values, or what Bronfenbrenner (2005) labels the exo-system and macro-system levels. Rounds, Weil, and Bishop (1994) address the need for a multicultural perspective in dealing with families of children with disabilities. Within assessment and practice, several elements must be applied in maintaining the cultural domain. Cultural diversity must be not only recognized but valued. Different ethnic cultures deal with disability in different ways. In most cases, these differences need to be accounted for and regarded as strengths. Culture affects when and how certain individuals or families seek assistance; it affects how individuals participate in the human service framework. Practitioners must also be aware of their own cultural perspectives and how that affects the assessment process. Human service practitioners must recognize and understand the different levels of culture and how they interact. Fee (1994) points out the myriad of cultural levels within human service delivery systems for persons with disabilities. There is the ethnic culture of the individual and his or her family, the culture of the human service practitioner, the culture of the human service system, and the culture of Disability. All these cultures play into the process of assessment.

An important tool at the social structural level of social model assessments is the ethnographic interviewing technique. Originally utilized by anthropologists to obtain objective information about various ethnic cultures, this technique has been expanded into an interviewing process that can help human service practitioners understand the worldview from any cultural perspective. Green (1982) defines an ethnographic interview as one that is used to provide a description of the problem of the person the practitioner is working with from that person's worldview. The person with whom the practitioner is working becomes the teacher, guiding the practitioner into an understanding of his or her world. The ethnographic interviewing process assumes that language is the bridge to understanding the various cultures that are a part of the service provision. Words may have meanings that are understood only within a certain cultural context, even though the word may be used outside that culture. The human service practitioner must explore these words to get an understanding of the person's worldview. An example from disability culture is the term *crip*. *Cripple* has a certain meaning to mainstream culture. If a person without a disability

refers to someone with a disability as *crip*, it is construed as pejorative. Within disability culture, however, when the term is used between persons with disabilities, it is one of kinship and belonging. Persons with disabilities may use the term in referring to themselves or to each other. But the term *supercrip* is one of disdain for a person with a disability. It means someone who is trying to prove that he or she is not disabled. To be called a *supercrip* by another person with a disability is not a good thing. Without this inside knowledge, the human service practitioner is at a loss to really understand the world of disability. But in order to find these pieces of information, the practitioner must ask within an ethnographic perspective (Green, 1982).

In the social component of assessment, it is important to recognize the many societal elements affecting persons with disabilities (Bilbao, Kennedy, Chatterji, Ustun, Barquero, & Barth, 2003) in terms of their biosocial, psychosocial, and social structural functioning. The flow of energy in support systems is also important—the social model recognizes that not only are people affected by their environments, but they affect their environments as well. The independent living movement is built around the concept of people affecting their environments. On the social structural level, Herling (1996) states that “only the systematic and intentional building of local organizations owned by, and dedicated to the empowerment of people with disabilities will change the societal structures that perpetuate injustice. [The] primary goal is to organize [people] with disabilities and empower them to take an active role in shaping their lives and circumstances” (p. 26).

Therefore, a systematic evaluation of the impact that people have—and have the potential to have—on their environments is crucial. This can be facilitated through a personal-professional collaboration in assessing all systems—biosocial through social structural.

Social-ecological assessment evaluates the impact of social structures and institutions on people’s lives. For disabled persons it starts with an acknowledgment of the power differences and social conditions that disempower them and make them vulnerable to abuse and devaluation (Sobsey, 1994). For example, in assessing the employment of a person with a health-related disability, it may be essential to evaluate the impact of health policies and practices, vocational agencies, and business. This is illustrated in the following case.

Erica was a twenty-seven-year-old woman diagnosed with schizophrenia who approached a vocational rehabilitation agency for help finding work. Since age twenty, Erica had been in and out of psychiatric institutions. She had a high school diploma, but few skills to make her employable. She had begun taking Clozaril six months earlier with very positive results. Hallucinations and delusions had subsided, and her isolation decreased dramatically. She became more social and desired to seek employment. Unfortunately, the social barriers were formidable. Erica was supported by SSI and received Medicaid, which paid for her Clozaril. Since she was unskilled and had a psychiatric history, she could

only find employment in low-paying jobs that had no benefits. If she took a job at this level, she would lose her SSI and Medicaid coverage. The costs of medication and ongoing mental health treatment made the price of employment prohibitive. When Erica sought vocational rehabilitation, she was informed that they could find her a lower-paying job but could not afford to provide her with the education she desired to obtain adequate employment.

An evaluation of the biosocial and psychosocial domains of Erica's life would focus on her mental health disability as the cause of her unemployment. A social structural evaluation, however, uncovers the institutional barriers to self-sufficiency. This assessment clarifies the lack of resources to reach goals. The federal/state Medicaid system makes it nearly impossible for some persons to work and live because working renders them ineligible for needed health and mental health coverage. The SSI system allows people to work for a short time, but ineligibility can be a significant deterrent. State and federal funding of vocational rehabilitation agencies makes people unable to procure essential services. Whereas individuals and small groups can have a relatively strong impact at the biosocial and psychosocial levels, it generally takes a collective effort to change societal systems, policies, and practices. Assessments of the environment by groups of people can lead to collective action and social change that is impossible for individuals alone to achieve. Passage of laws such as the Americans with Disabilities Act is an example of collective action. The movement of persons with intellectual disabilities out of institutions and into the community is another example of institutional change brought about by grassroots efforts and the collective voices of advocates.

UNIVERSAL DESIGN AND UNIVERSAL ACCESS

To fully assess people in their environments, a comprehensive assessment of the environment is critical. A fair question to use to guide assessment is, To what extent are communities and society designed to be inclusive of people and groups with diverse characteristics, both typical and atypical? Social policies upon which affirmative action and reasonable accommodation practices are based have been critical to the advancement of devalued groups, including persons with disabilities. Implicit in affirmative action and reasonable accommodation is the need to redress or provide relief to people who have been disadvantaged by society. When special laws and policies are needed to provide equal opportunities, it is assumed that laws and policies disadvantage them in the first place. We argue for the promotion of a society that uses universal design and promotes universal access for all. Rather than creating a society for those who are considered normal, then making special accommodations for those who differ from the norm, we should embrace people of all diverse characteristics, which could lead to a society universally accessible to all. For example, curb cuts and power doors

were originally designed to accommodate people with mobility disabilities. However, these accommodations make society more accessible for parents pushing strollers and people whose arms are full. One of the authors has excellent hearing but routinely uses captions to watch television when working out at his fitness club. The first functional typewriters were developed to help blind persons communicate; however, keyboards are essential in the lives of most people who are reading these words. Recently, when traveling through Europe using the Eurorail, one of the authors, who is monolingual in English, was relieved to find universally accessible signage that guided him to trains—thus negating his need to read German, Italian, French, Swiss, Flemish, Danish, and Dutch.

The principle of universal access grew out of the concept of universal design, which was developed in professions such as architecture and engineering and applied to the physical world. Ron Mace, a physically disabled wheelchair-using architect, is credited with coining the term *universal design* to describe environments and communities that are designed to be accessible to the greatest extent possible to everyone, regardless of their age, characteristics, capabilities, or status in life (North Carolina State University, College of Design, 2006).

Mace, an advocate for disabled persons and a proponent of universal design, saw the benefits of universal design extending far beyond the disability community. He became internationally recognized as an architect, product designer, and educator whose philosophy challenged convention and provided a design foundation for a more usable world. Shortly before his death, Mace (1998) spoke of his belief that universal design benefits everyone. Universal design's "focus is not specifically on people with disabilities, but all *people*. . . . We tend to discount people who are less than what we popularly consider to be 'normal.' To be 'normal' is to be perfect, capable, competent, and independent. Unfortunately, designers in our society also mistakenly assume that everyone fits this definition of 'normal.' This just is not the case."

Mace joined forces with a working group of architects, product designers, engineers, and environmental design researchers at the Center for Universal Design at North Carolina State University who define universal design as "The design of products and environments to be useable by all people, to the greatest extent possible, without the need for adaptation or special design" (Connell, Jones, Mace, Mueller, Mullick, Ostroff, et al., 1997). Their seven principles of universal design, listed below, were initially developed for the physical environment but have wide applicability. In the two examples of each principle, note how the principles of universal design benefit not only disabled users, but a wide range of people.

1. Equitable use. The design is useful and marketable to people with diverse abilities. Designs provide identical or equivalent use for all,

with privacy and safety in mind, and without segregating or stigmatizing diverse users.

- Bathrooms with stalls that are large enough for wheelchairs
 - Men's and women's bathrooms
2. Flexibility in use. The design accommodates a wide range of individual preferences and abilities.
 - Ramp and power doors in a public library
 - Power doors in a grocery store for shoppers with large bags of groceries
 3. Simple and intuitive. The design is easy to understand and use regardless of the user's experience, knowledge, language skills, or current concentration level.
 - Web site with alt tabs to guide visually impaired users
 - Web site with prominently marked graphics to guide users
 4. Perceptible information. The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.
 - Captioned television for deaf persons
 - Television marketing ad in which a phone number is simultaneously spoken and shown on the screen
 5. Tolerance for error. The design minimizes hazards and the adverse consequences of accidental or unintended actions.
 - Spell checks for people with cognitive disabilities, who tend to confuse the letters *d* and *b* and *p* and *q*
 - Keyboard that corrects spelling errors before documents are printed
 6. Low physical effort. The design can be used efficiently and comfortably with a minimum of fatigue.
 - Bathrooms with under-sink access for wheelchair users
 - Baby diaper changing table in men's and women's bathrooms
 7. Size and space for approach and use. Appropriate size and space is provided for approach, reach, manipulation, and use regardless of the user's body size, posture, or mobility.
 - Drinking fountains of multiple heights accessible to people of short stature
 - Drinking fountains of multiple heights accessible to children

We believe an accurate social-ecological assessment based on the social model must include a critical analysis of the extent to which communities and societies are constructed and organized to welcome the broadest range of diversity, including, but not limited to, all types of disabilities. Principles of universal access are a way of measuring this goal against the current reality.

SUMMARY

Human service professionals working with disabled persons invariably engage in assessments. Traditional assessment models have focused on the presence or absence of pathology, and an assessment of problems is essential in many contexts. However, the exclusive focus on pathology has had negative consequences in long-term involvement. This is especially true in human services. By attending primarily to problems, assessments can fail to account for individual strengths. A deficiency focus can lead to the devaluing and, in some cases, dehumanizing of people. The individual pathology focus also fails to recognize the complexity of experiences and relationships.

The approach that best meets the needs of persons with disabilities takes a social model rather than individual pathology approach to disability. Effective assessments are contextual; that is, the context in which the assessment occurs determines the nature and extent of the assessment. There are several elements in approaching assessment from a social perspective. A critical component of the independent living approach is that individuals identify their own needs. In the social model, a critical element of assessment is the environment. The social model emphasizes people's strengths and potential. It acknowledges that disabled persons have impairments but contends that they are not defined by their disabilities. The social model of disability emphasizes the importance of institutionalized oppression and devaluation to which people with disabilities have been subjected. It also acknowledges that disabled people have the right to control their resources and to determine how resources are expended.

We have introduced you to social-ecological assessment, which is based on the social model. Social-ecological assessments attend to the multiple and interrelated influences on people's lives: biosocial, psychosocial, and social structural. Finally, we introduced you to the concept of universal access. Ultimately, to fully embrace diversity, we cannot settle for a society that is designed for the majority and makes allowances for those who do not fit the mold. Instead, we must strive for a society that is set up for all: minority and majority, disabled and nondisabled.

DISCUSSION QUESTIONS

1. What are some of the issues around a medical model of assessment? What are the advantages and disadvantages of using it in work with persons with disabilities?
2. Explain the individual components of a social model of assessment. How could you use it if you are working in a health facility that requires a pathologically based assessment model?
3. Relate the micro, meso, and macro components of the social model of assessment to Cowger's (1994) statement "Assessment that focuses

on deficits provides obstacles to clients exercising personal and social power and reinforces those social structures that generate and regulate the unequal power relationships that victimize clients” (p. 264).

4. Compare the following two assessments in terms of descriptions of disability, impairment, and function:

Mr. Anderson is an African American male, age nineteen, with an average IQ, who was severely injured in a motorcycle accident. Mr. Anderson never completed high school. His injury resulted in partial paralysis of both his arms and legs. He has limited hand movement. Mr. Anderson suffers chronic depression, for which he takes medication.

Mr. Anderson is severely limited in his mobility. He is confined to a wheelchair and totally dependent on attendants or family members to prepare his food, bathe him, attend to his bowel program, and so on. His family was uncooperative in his rehabilitation. They missed appointments. They did not follow through on suggestions to make the apartment more accessible. Mr. Anderson appears to have limited ambition toward education or employment. He rarely gets out in the community, other than in his immediate neighborhood. He does not take advantage of community resources made available to him.

Mr. Anderson is a nineteen-year-old African American male with partial paralysis from a motorcycle accident who lives with his mother and his younger brother in a housing project. Several of his relatives live in the same project, and they stop in frequently to visit. His family is very close. They agreed that that he will stay with them rather than be institutionalized or live on his own. Mr. Anderson has trained his family to provide his attendant care under his supervision. Attendants from a local agency also provide personal care. With assistive devices, he is able to feed himself and transfer between bed and wheelchair. His emotional status has improved significantly since he began using antidepressants.

Mr. Anderson gets along well in the neighborhood, using a wheelchair for community mobility. The apartment building is wheelchair accessible; however, he lacks financial resources to make his bathroom completely accessible. He uses a portable commode chair to make do. He visits other family members frequently. He gets out into the neighborhood quite often, and various store owners watch out for him.

Mr. Anderson visits the local Radio Shack, where Ralph Henderson, the owner, takes time to show him how to use a computer on display. Mr. Anderson is giving Ralph \$10 a week toward the purchase of a computer. Mr. Anderson has talked about obtaining a GED and is thinking about going to school to learn computer programming.

What assumptions are being made in the first assessment? What are the assumptions in the second assessment? What things are left out of the first assessment? What components are missing in the second assessment? Which assessment more accurately reflects the perceptions of the person in question?

5. Martin and Julie Torgesson are proudly awaiting the confirmation of eight-year-old Martin Jr. Martin, a deacon in the congregation, and Julie, who is active in the women's auxiliary, anticipate that much of their community will attend the Sunday picnic following the confirmation. Martin's parents are active in preparations and fondly recall the confirmations of their three older children, of whom Martin is the second son. Though the confirmation will be attended by their families and a few other members of their congregation, the Torgessons have worked with Pastor James and the church board to invite lapsed members and non-church members to the subsequent festivities in the hopes of engaging them in church and community fellowship. Martin Jr.'s sister Bryn was confirmed only eighteen months earlier, when she turned eight, and his younger siblings, twins Marj and Damon, look forward to their confirmation in three years. Of course Esther, at age two, is too young to understand what was happening but could still feel the excitement in the air.

Like the other children, Esther was born at home, but soon after her birth, Martin and Julie were informed that she had trisomy 21, otherwise known as Down syndrome. The Torgesson's consider Esther their "little gift from God" and once a week take Esther to a program for children with intellectual disabilities in the city, an hour's drive from their home. Costs for this program are covered under the Individuals with Disabilities Education Act. A major concern for the Torgessons, however, is that they just learned Esther needs heart surgery to correct a defect associated with her Down syndrome.

To understand the Torgessons, let's take a look at their family and community history. Of proud northern European Protestant heritage, Martin Sr. is the fourth-generation son to take over operation of the five-hundred-acre grain farm from his father in their northwestern community of 1,200—if you include the outlying farms. Julie is a third-generation community member whose parents ran a farm just ten miles from Martin's. While Martin manages the farm's commercial operations, Julie is responsible for the household and also the large garden, chickens for eggs, the steer butchered annually for beef, and the milk cow.

Martin and Julie moved into the family home when Martin took over operation of the farm, and his parents, who are in their sixties and both in good health, still reside there, though they travel frequently. Julie is the oldest of four siblings, and her parents, who are in their fifties, still operate their farm. Martin and Julie knew each

other from their childhoods and within a year of Julie's graduation from high school, two years after Martin's, they married. Both had looked forward to continuing the farming family tradition since their youth.

Though excited about the upcoming event, there are several stresses the Torgessons are facing. Though they are moderately self-sufficient in raising their own food, their farm's survival lasts year to year. First, small farms have become increasingly rare as large conglomerates buy land and operate on smaller profit margins per acre. Second, crop prices fluctuate from year to year, and the weather is always an uncertainty. Thus, the Torgessons are frequently forced to borrow money every spring in the hopes that their harvests will cover expenses each fall. And now, they are faced with Esther's impending heart surgery.

In addition to stresses with the farm, recent family events are affecting their lives. Martin's mother was just diagnosed with breast cancer. Though it is stage 1 cancer and highly treatable, the costs will exceed Medicare coverage, and the diagnosis has rocked their world. In addition, Julie just received news that her younger sister Ruth has just separated from her husband and moved back to their parents' home with her two daughters, ages seven and five. Circumstances of the marriage and separation were especially distressing. Ruth met her husband in high school when their respective schools, located twenty-five miles apart, played each other in basketball. Ruth was a cheerleader, and her future husband, Troy, was a player for the other team. Both were seniors when they met, and by April, Ruth was pregnant. They married shortly after graduating, and Ruth moved in with Troy and his parents, where they lived until they had their first baby. Subsequently, Troy obtained work at the town's paper mill, working there until the present time. Ruth's marriage has been rocky for years; Troy has repeatedly abused alcohol, and there have been domestic violence incidents. However, recently problems worsened when their oldest daughter told a teacher that her daddy had touched her in a bad place. Ruth has always been considered rebellious by the family (who had never been fond of Troy), but although her return home has increased family stress greatly, she was welcomed home with open arms. A final stressor is related to Martin's older brother Reuben, who is in the military. As the oldest Torgesson son, Reuben had the option of taking over the family farm; however, from a young age he expressed his desire to "get out of Hicksville," and he joined the Marines immediately after his eighteenth birthday. Reuben's grandfather had served in the army in World War II, and an uncle in the Marines in Vietnam, and Reuben was proud to follow in a family tradition—as well as to see the world. Reuben has been deployed to

the Middle East in the “war on terror,” but his exact whereabouts are classified. The family does, however, assume Reuben is in harm’s way.

Your task is to engage in an evaluation of the Torgesson family. Assume a role as a human service worker in one of three contexts: (1) you are a counselor seeing Martin and Julie for marriage counseling; (2) you are a health care worker involved in Esther’s case relative to surgery; (3) you are a financial aid worker for the state.

- a. Assess the biosocial, psychosocial, and social structural domains relative to this family.
- b. Outline the three elements of an evaluation: history (what), evaluation (so what), and plan (now what).
- c. How would the application of the principle of universal access to health care affect your evaluation?
- d. Now, assume that you are a loan officer at the local credit union, and Martin and Julie are approaching you for a loan to purchase a new tractor to replace their current dilapidated tractor. How would the current social structural policies and practices influence your decisions relative to loaning them money?

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