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Assessment

ENHANCEMENT OF SOCIAL FUNCTIONING, facilitating people's ability to cope with their realities and to improve the quality of their lives are recognized goals of effective work with all clients. In the pursuit of these goals, practitioners must pay attention to culture as a factor in problem formation, problem resolution, and in the clinical process itself, which includes assessment, relationship development, intervention, and outcome. The perspectives, capacities, competencies, and abilities that enable practitioners to focus successfully on culture in their work have been identified in earlier chapters. Among them are the following:

1. The ability to be comfortable with difference in others (and thus not be trapped in anxiety about difference or in defensive behavior to ward it off
2. The ability to control, and even change false beliefs, assumptions, and stereotypes, which eliminates the need to use defensive behavior to protect oneself
3. The ability to respect and appreciate the values, beliefs, and practices of persons who are culturally different and to perceive such persons through their own cultural lenses instead of the practitioner's
4. The ability to think flexibly and to recognize that one's own way of thinking and behaving is not the only way, and
5. The ability to behave flexibly. This is demonstrated by the readiness to engage in the extra steps required to sort

pend on the theoretical base being used by the clinician, which, in turn, determines the kind of behavior and the areas of functioning to be focused on as factors which perpetuate the problem (Northern 1987). For example, if the theoretical base is psychosocial and the problem is school phobia, the child's early relationship with the mother and the separation process may be inferred as the cause. If the theoretical base is cognitive, behaviors that reinforce his wish to stay home and not attend school will be inferred as the cause.

Second, these inferences will depend on established norms or expected behaviors that define what is adequate or not adequate in the behaviors or areas of human functioning being examined, and because norms vary in different cultures, assessment of culturally different clients using traditional White middle-class norms, or norms based on the clinician's culture, may result in erroneous inferences. For example, to assess a Latino child as school phobic would have to take into account the fact that Latino families do not push the child to separate as early as Americans do.

To ensure that their own cultural lens is not the basis of assessment, practitioners should determine the nature of the problem, and the factors maintaining it, by asking the following questions (Jacobsen 1988; Lum 1986; Ho 1987).

1. To what extent is the problem related to issues of transition such as migration and immigration?
2. To what extent is the client's understanding of the problem based on a cultural explanation, for example, "evil curse," "mal ojo," and so forth?
3. Is the behavior that is a problem considered normal within the culture or is it considered dysfunctional?
4. To what extent is the problem a manifestation of environmental lack or insufficiency, or lack of access to resources and supports?
5. To what extent is the problem related to cultural conflict in identity, values, or relationships?
6. To what extent is the behavior a consequence of psychological conflict or characterological problems?
7. What are the cultural strengths and assets available to the client such as cultural values and practices, social networks, and support systems?

through general knowledge about a cultural group and to see the specific way in which knowledge applies, or does not apply, to a given client

The importance of these steps, which take extra time, effort, and energy, is illustrated in the following remarks:

> Yesterday a new client came in, sat down, and the first three words she said were, "I'm Irish Catholic." I didn't know what that meant to her, but I remember thinking is she struggling with conflict about her Irish identity, is she having conflict with her husband (her last name sounded Italian), is she questioning what I am, and does this mean she wonders if I can help her? Well, I later found out she was concerned with being accepted by me and in some way thought I'd see Irish as negative. I understood this when she said, "We don't drink or fool around and we're very quiet and moral."

Purpose and Steps in Assessment

Assessment, the initial step in the process of intervention, is completed with more accuracy when practitioners have developed these capacities. The work of assessment includes (1) gathering data on the client and his problem; (2) analyzing the data, identifying the most critical factors, and defining the interrelationships, i.e., inferring meaning; (3) developing an effective intervention plan. In order to develop an effective plan of intervention, the clinician should be able to determine what is the nature of the client's need or problem; what are the factors contributing to its maintenance; what are the client's perceptions, capacities, and strengths; what needs to be supported, modified, or changed.

In determining the nature of the problem and the factors maintaining it, the practitioner must elicit the client's view of the problem and his response to the referral. She must understand how the client experiences the problem, the degree of distress being experienced by him and by persons with whom he interacts, what he has done to deal with the problem, and his response to the referral. The inferences she draws in the process of analyzing the data as she identifies critical factors and defines interrelationships depend on several factors. First, these inferences de-

Competencies Needed for Assessment

Practitioners are not only asked to work with a range of cultural groups, but within these groups, they must assist persons from a range of social classes, levels of education, and acculturation. These are contextual factors that must be considered in understanding the client's problem. Practitioners, thus, must be sensitive to a continuum of cultural beliefs and socioeconomic issues. They must use flexible thinking to sort out a variety of dimensions and be cautious in generalizing about a specific individual or family based on cultural knowledge of that group, since what may be characteristic of the group may not be relevant to that individual. Clients may be struggling with the issues of migration and the stressors of adapting to a new environment, where loss of family, neighborhood, or homeland, along with a change in culture and language, can be powerful stressors (Bernal and Gutierrez 1988).

In assessing these clients, practitioners must avoid "confusing a client's appropriate cultural response (to stress) with neurotic transference" (Brislin and Pedersen 1976) or confusing a response that represents culture shock with a response that indicates serious pathology. In one case a 15-year-old Puerto Rican male was erroneously diagnosed as schizophrenic by an Anglo clinician because he talked of seeing the devil who tried to get him to do bad things. Investigation by a Puerto Rican clinician revealed that this youngster, who had recently arrived in the United States, was experiencing culture shock, material deprivation due to reduced financial circumstances, trauma over separating from his father, and humiliation over his life situation. The diagnosis of stress reaction (adjustment disorder with mixed emotional features) saved him from being treated for schizophrenia, which would have required powerful tranquilizers and hospitalization in a long-term treatment facility, "possibly resulting in the development of more chronic emotional problems" (Ramos-McKay, Comas-Diaz, and Rivera 1988, p. 217). In such instances the presence or absence of a precipitating stressful situation preceding the onset of symptoms and the existence of symptoms that are labile would contradict the diagnosis of psychosis. When such behavior represents culture shock, it will abate quickly. In another case, an alert and empathic Anglo practitioner was flexible enough to change his idea that his Mexican-

American female client's punctuated speech and emotional intensity indicated a borderline personality rather than a culturally endorsed way of handling stress (Martinez 1988).

Behavior that is reactive to chronic stress as well as the acute stress of transition must also be assessed correctly. Behavior under these circumstances can also be erroneously diagnosed as psychotic. For example, a young man was assessed by the admitting physician as a "crazy Indian" who was impulsive and potentially violent. Strapped to the bed after being brought in by police, he was anxious and agitated. Upon learning that the evaluating psychiatrist was Indian, he relaxed and told his story. His four-year-old son was taken from him and placed in a White foster home by a judge's ruling, because they had been found sleeping beside a building after he had consumed a bottle of wine. They had camped for the night since they had become sleepy and, by nightfall, were still far from home. Totally without reserves and in a strange city, in his outrage over being separated from his son, the patient had threatened the judge, asserting that he was ready to die to teach the judge a lesson. The evaluating psychiatrist who saw this as a reactive condition was sure the patient would have been diagnosed as psychotic and/or alcoholic, deemed dangerous, and placed in a psychiatric ward by persons unfamiliar with the Native American experience (Thompson, Blueye, Smith, & Walker 1983).

Whether or not the behavior that appears dysfunctional or pathological to the practitioner represents dysfunction within the client's culture is a significant issue to be determined in the assessment process. Practitioners must be on the lookout for signs that indicate the meaning of the behavior being observed or described, since ordinary yardsticks cannot be used.

It is important, therefore, that practitioners evaluate carefully. The client's behavior in the interview is one source of data for the appraisal. For example, an Italian client who speaks rapidly and shows a great deal of emotionality must be assessed as to whether her behavior should be considered culturally adaptive or unstable, hyperactive, hysterical, or controlling. A client's gift to her practitioner will not automatically be seen as a power move or as an expression of unworthiness (a traditional psychodynamic interpretation) but will question whether such a gesture represents a culturally endorsed expression of generosity and friendliness (Lum 1986; McGoldrick 1983). The self-care and re-

sponsibility that some Black parents demand of their children will be viewed as a possible adaptation to their harsh environment and not necessarily pathological. The knowledge that Puerto Ricans are highly spiritual and fatalistic helps the social worker think twice about whether her client who has a conviction that she will die is really suicidal. The behavior of the Irish client who came to the office to cancel her appointment with the psychiatrist will not be seen automatically as stemming from dependency needs but also will be considered in the context of the Irish values of obedience and conformity. If a clinician understands that Latinos value interdependence and that once they trust the helper, they expect support, he will not assume automatically that this expectation is an indication of a high dependency need or oral longing. Rigid machismo behavior in a Latino male will be examined further to determine whether it is a consequence of sex-role expectation, a result of social stress (for example, lack of work), or an aspect of developmental process. The Black mother's slow pace in planning her son's discharge from the hospital will become less frustrating to her social worker when she considers that while it may be an indication of ambivalence or rejection, it may instead be consistent with the adaptive values embraced by people who contend with social and political powerlessness by living in the present and not planning for the future. The nodding of a Japanese client will be recognized as communicating the message, "I'm listening"; it does not necessarily mean that the client agrees with the clinician's assessment or with the treatment plan under discussion (Lum 1986).

The practitioner who can think broadly and behave flexibly will remember that what constitutes pathological behavior can vary greatly among different ethnic groups. Thus, when the client is an Asian or Latino (groups that value affiliation), isolation or distanced relationships among family members may be a sign of greater stress and greater dysfunction than they would among Anglo-Saxons (who value independence). When stress reinforces rigidity and exaggerates the use of normal cultural practices, care must be taken to determine the degree of dysfunction that may exist. For example, when the affiliativeness valued by Latinos becomes exaggerated under stress, they may display intrusive behavior and overinvolvement that is not necessarily based on psychological dependency. When the individualism of American and Anglo-Saxon culture becomes exaggerated due to stress or

isolation, the alienation, anomie, and denial that people manifest may not be related to deficits stemming from developmental trauma. The severe punishment used by Black parents that can easily slip into abuse may not be a consequence of developmental deprivation.

Even the severity of alcoholism must be viewed in the context of cultural practices, its determination being a matter of an "internal comparison within that culture" (Thompson et al. 1983). At the same time, heavy drinking among Indians is associated with a variety of factors: dependency conflict, genetic predisposition, anxiety, feelings of alienation, helplessness, deprivation, frustration, and powerlessness related to change from an Indian economy of hunting and gathering with a low degree of social complexities and consequent entrapment in a culturally disadvantaged position.

Rigid, exaggerated behavior is an expectable response to stress. For example, among women, especially minority women, the role of supporter and nurturer can become characterized by exaggerated submissiveness to the male, overprotection of children, and sacrifice of self. Under stress, the culturally based tendency toward self-negation of Chicano mothers can become extreme (Falicov 1983). Afro-American mothers under such conditions often become intensely involved with their children (Hale 1980). Interference with the culturally prescribed role of provider causes minority males to experience stress, conflict, and poor self-esteem. For example, Asian males may perceive themselves as a source of shame to self and family lineage (Shon and Ja 1983). Under such stress they and others may exaggerate their dominant role, intensify demands for female accommodation, become less supportive, more unavailable, and even abusive (Pinderhughes 1986).

The degree to which culturally based behavior can be maladaptive is also important to assess. For example, maintaining a connection to their cultural groups is critical for minority group individuals, because it helps to buffer the effects of racism and oppression. But this need can also reinforce cultural prescriptions that prevent escape. In Asian families, for instance, separation and divorce are not viable options for Asian women who are ostracized and relegated to outcast status as a consequence (Shon and Ja 1983). Many, although intensely dissatisfied and frustrated, feel powerless to change either the behavior of those with

whom they interact or the oppressive circumstances that fuel it. Instead, when unable to change the situation, they blame themselves, often feeling that they are failures.

Clinicians must also be alert to the fact that behavior observed in the interview may be a critically based maneuver to cope with stress. Avoidance and detachment may then be evaluated as possible indications of mistrust of the interviewer which the client entertains based on his societal experience (Lum 1986, p. 156). The clinician, then, will be less likely to assume that behavior manifested in the interview is the essence of the client's behavioral style rather than a sign of this mistrust. Since silence can be a culturally valid way of responding for Asians and since taboos exist against freely discussing physical and emotional problems, a client's reluctance to answer questions, his guarded affect, and flatness must not be considered routinely a sign of depression or mental illness. And even when the client's perceptions and responses are determined to be a sign of dysfunction, the practitioner must monitor his own responses to make sure there is no distortion or projection that is fed by his own need. (Greenson discusses his struggle to recognize that the experiences described by his analytic patient were real, not fantasies or a sign of paranoia which he himself had wanted to believe [Greenson et al. 1982]).

Clinicians who are self-aware and who understand their own cultural baggage, including their power needs and responses, will have no problem in considering environmental support or insufficiency as a factor in the etiology of the problem to be addressed. The stresses related to deprived minority group status are frequently related to socioeconomic factors, not cultural ones (Leighton 1982). In the case of minorities and the poor, clinicians will refuse to ignore the effects of the societal projection process upon both their minority clients and themselves. Knowledge of these realities will not threaten and immobilize them. Relationships to the wider society will be assessed to determine the degree of exposure to negative valuation (and thus to the hazard of developing feelings of low self-esteem and powerlessness) that can occur as a consequence of cultural group membership (Solomon 1982, p. 166). Despite the fact that practitioners may have been beneficiaries in the societal process that victimizes their clients, they must be able to look honestly at those effects upon the client.

In one child psychiatry clinic, information nee[illegible]to complete an assessment required that the clinician make a home visit. The trainee assigned to the case refused to make such a visit, first claiming that the family was "too resistant," then that the visit would cause him to miss his scheduled patients and seminars, and finally admitting that he was "too afraid," even when offered a guide. Since home visits were made at the discretion of the clinician and the department in which he was a trainee, his resistance was not seen as a "problem," and the home visit was not made in spite of efforts by the Afro-American team member to the contrary (Wyatt 1982, p. 142).

Despite responses on their part of guilt, shame, or fear concerning the advantages their position has granted them, clinicians must strive to assess clients' situations accurately. Unless clinicians can manage their responses to their own societal position, they may not evaluate correctly the contradictory nature of a minority client's social role, which, as we have seen, may have sustained stability and tranquility for the practitioner while reinforcing tension, conflict, and contradiction for the client. For example, in work with minorities clinicians will not shrink from evaluating the affronts and assaults that are associated with the client's societal role (Solomon 1982, p. 176). Nor will they fail to assess the way in which experiences with institutional racism can influence how clients see the world and how they handle life cycle events. They will recognize the enormously contradictory demands with which clients as victims of the societal projection process are confronted. Despite being faced with ongoing conflict, confusion, and contradiction, minority clients are called upon to function competently and with organization, sustaining family solidarity and cohesion. And despite being surrounded by a hostile, nonsupportive environment, they must find ways to maintain intimate, caring relationships, to raise children to be loving, competent, and strong, and to secure a sense of esteem for self and group.

Significance of Strengths and Adaptive Behavior

Assessment of culturally different clients is never complete unless it includes an evaluation of the strengths that enable people to cope with such conditions. Clinicians must be free to focus on

these strengths. When they have been beneficiaries in the social system and are unaware of its significance for them, they may find this hard to do. Their role in societal processes can seduce them to view the behavior of their clients, who are members of victim groups, in stereotypical ways. They will thus tend to see behavior in terms of weakness or pathology. They may also remain unaware that the beliefs they hold can be stereotypes representing unacceptable impulses existing within themselves that their position in society permits them to project onto persons from victim groups, and that their clients may be such persons (Ferguson 1982, p. 217). As we have repeatedly illustrated in the examination of the experiential data, stereotypical thinking allows the thinker to stabilize and tranquilize himself, because he can disavow rejected aspects of himself and see them as existing in the other. In so doing the thinker can ward off anxiety about these impulses in himself and anxiety about the situation of difference between himself and another. The use of stereotypes to understand the client-victim may make practitioners more comfortable, reinforcing for them a sense of tranquility and stability. Thus, they may be unaware that they engage in such thinking about a client or that the purpose of such thinking is to make themselves feel more comfortable. This explains some practitioners' readiness to interpret cultural differences as deficiency (Lum 1986, p. 164). It also explains the tendency for practitioners to formulate diagnostic and dynamic questions in such a way as to validate their own false beliefs and to elicit information that will support these beliefs (Ferguson 1982, p. 217).

One social worker, accustomed to the dependent and helpless posture some Blacks have used to gain access to societal resources, evaluated a "short, solidly built man with a strong, deep voice, a forthright posture, a very self-assured and stern personality" as aggressive (Weaver 1982, p. 112). Another social worker admitted a greater readiness to "focus upon pain and suffering" than on coping skills and strengths. Another admitted being so "devastated" by the struggles and deprivations faced by her client that she saw her client as having no strengths or coping abilities, as having no choices available. Greenson has suggested that the contempt of some Whites whereby they see Blacks as lazy, stupid, etc. can hide an envy of their strengths—in his work with a Black analysand he identified such feelings in himself in relation [illegible]e issue of sexual prowess (Greenson et al. 1982). Finding

weakness and pathology in others is consistent with the role of expert and competent one and it reinforces such a self-image.

Among the strengths that clinicians must be able to identify in clients are coping abilities, natural support systems, problem-solving abilities, and tolerance of stress (Lum 1986). Identification of support systems is a major issue in assessment. People from groups that have been victimized by societal projection are especially vulnerable if they are isolated. Among Mexican-American psychiatric patients, for example, the most disturbed were disconnected from their religious life (Martinez 1988, p. 191). Isolation from extended families and the community supports that can help neutralize the consequences of their societal position and enable them to fulfill family, work, and other roles can also have destructive effects. Strong group connections can nourish self-esteem and the ego strength needed to cope effectively and to achieve personal and social goals (Solomon 1982, p. 171). Careful attention to the strengths and nutritive quality of these supports means that the practitioner must be able to see the positives in many seemingly negative situations.

When practitioners are able to focus on strengths they can understand even problematic behavior as the client's adaptive attempt to survive the paradoxical imperatives of his systemic role. Passive aggression and dependency have been cultural adaptations used by Puerto Ricans to cope with the powerlessness they have experienced in relation to the impact of colonialism and their denigrated societal status (Ramos-McKay, Comas-Diaz, and Rivera 1988, p. 213). Even dependency can be seen as a strategy for coping with powerlessness since it represents a way of being close to a source of power (McClelland 1975).

Many of these behavioral strategies for survival have given rise to stereotypes. Examples include the passive and stoic behavior of the Asian, obedient and carefree behavior in Blacks, the quiet, smiling presentation of the Asian-American, the sleepy demeanor of the Mexican, the stoic behavior of the Native American, all of which are behaviors "covering despair over social, economic and political oppression" (Lum 1986, p. 74). These are not cultural adaptations in the sense that they are a part of the ethnic fabric that facilitates group cohesiveness and individual integration in a people; rather they are a consequence of socioeconomic conditions (Leighton 1982). These should be recognized as people's attempts to cope with powerlessness and achieve some degree of comfort. Paradoxically, the need for comfort and a sense of power may be such that people's attempts to gain it can even include assuming negative attributions and stereotypes in the extreme.

Practitioners must be able to identify these and other strategies that people use to cope with the powerlessness associated with low cultural group status and to gain a sense of comfort in surviving their harsh conditions and paradoxical realities. Such strategies include the practice of assuming negative attributions and stereotypes, the extreme use of aggressive accommodation, and aggressive passivity (Cheetang 1972), turning around the meaning of negative attributions (Draper 1979), using paradox, humor, subtlety, deception, and various forms of manipulation, emphasizing struggle and power in relationships. It is important to identify these maneuvers and to assess the degree to which these behaviors are rigidly adhered to because, for the most part, they represent a reactive, defensive response to the initiative of others (individuals, groups, or the larger social system). When these behaviors constitute the total repertoire of an individual, he will be unable to behave with initiative, self-assertion, and leadership. His only choice is to provoke others so that he can then engage in the reactive behaviors with which he is familiar. He thus has no possibility of being able to pursue his own goals or develop a sense of mastery and competence, because all his energy is consumed in reacting to the initiatives of others. It is the rigidity with which these behaviors are used that makes them so destructive. If people employ the behaviors at one time but at other times are able to make choices, assume leadership, to set their own goals and pursue them (even with assistance), then such behavior should not be considered dysfunctional. That individual is able to demonstrate healthy flexibility.

When a practitioner is himself a beneficiary of the very process that induces these rigidified responsive behavioral manifestations in his clients, he may find it hard to assess the behaviors objectively as survival mechanisms, which may be effective at some times but costly at others. But to assess correctly, to plan effectively, and empower his client, he must manage the feelings mobilized by this recognition of his own beneficiary status and eschew the vulnerability to behave rigidly himself, summarily viewing these behaviors as pathology or failing to check out the client's capacity for flexibility.

While balancing all these factors in the equation of clients' problems, the flexible thinker will not overlook i[illegible]nal factors. To do this would be as inappropriate as ignori[illegible]he external. Jacobsen (1988, p. 145) discusses a case where a focus on the client's cultural adjustment during a two-year treatment period ignored a "biological diagnosis" of "mania and depression." This is a distinct risk for clinicians when they become knowledgeable about cultural dynamics. They "overculturize" (Leighton 1982) when they automatically view behavior as culturally based and fail to consider other factors such as internal functioning and trauma due to developmental process. When psychological and characterological problems appear to exist alongside issues of transition and cultural conflict, more sorting out is needed. The role of psychological conflict and the degree to which it is reinforced by elements of culture (and vice versa) must be assessed.

There are hazards too in working with persons from one's own cultural background. For example, there is the danger of overidentification, which can cloud the thinking of competent clinicians so that they misperceive the severity and extent of the problem. We have already encountered many examples of this in our examination of the experiential data. A Jewish psychiatrist who treated a Jewish female patient failed to diagnose her thought disorder and to treat her appropriately. The client, a 25-year-old daughter of Nazi concentration camp survivors who were the lone survivors of their families, became depressed at age 17. In an interview, she manifested symptoms of severe dysfunction, loose associations, blocking, bizarre affect, auditory hallucinations, and poor concentration. At age 21 the patient was treated by a psychiatrist because of persistent school difficulty and problems in maintaining relationships and holding a job. Her parents now reported that earlier she had been given medication and there was no further contact. Now that her symptoms had returned, her parents were seeking evaluation from another psychiatrist. A phone call to her original psychiatrist revealed that he had been reluctant to diagnose the patient as having a thought disorder, had treated her for a milder condition, and never pushed for a follow-up because he strongly identified with her father's concentration camp experiences and felt sorry for his plight (Jacobsen 1988, p. 142).

How does one go about ensuring that these inbuilt vulnerabili-

ties in clinicians due to their cultural group identity and experiences do not interfere with the assessment? Strategies do exist to help decide whether behavior represents a cultural response to stress, indicates serious pathology, or symbolizes mistrust within the therapeutic relationship. As already noted, practitioners must faithfully check out their own responses and be open to recognizing when they are using stereotypes. They must keep an open mind, examining possibilities other than the ones that first have come to mind. In interviewing, they will use "techniques which encourage the patient to tell his own story in his own way, ensuring that the client explains what otherwise might be taken for granted" (Leighton 1982, p. 12). Being careful to tune in on feedback (to really listen!) and to modify their initial hypothesis, they faithfully monitor the client's responses to comments, interpretations, suggestions, and advice and recognize that "each party may have to process messages twice before real communication takes place" (Ferguson 1982, p. 218). They will explore the cultural dimension in assessment or get assistance with what may be culturally related treatment difficulties from a colleague or consultant of the client's ethnic background (Jacobsen 1988, p. 145; Lum 1986, p. 156).

A critical issue in the assessment of clients is the significance and meaning of cultural identity and the degree to which it is positive and not marked by fragmentation or conflict. Practitioners must be aware of and empathic with the paralyzing effect of identity conflict, which can cause clients to experience confusion, a sense of fragmentation, isolation, and alienation. Value, role, and identity conflicts are risks for many Americans who have roots in pre-American cultures. Persons-of-color are particularly vulnerable to such conflicts for two reasons: First, their exclusion from total participation in the American mainstream prevents total connection and identification with it. Second, the difference between the values and behavioral practices of their own culture and those of American culture are great. There is "American individuality, freedom of choice, and self-determinism on the one hand, and collective decision making, family obligation, and self-restraint on the other" (Lum 1986, p. 149). Affiliativeness, collaterality in relationships, and interdependence are values that are emphasized by all these groups. Such values support extended family and cultural group cohesiveness and contrast sharply with American values of autonomy

and independence. For example, Native Americans may see the individualism of American culture as requiring competitiveness that allows only one or a few to succeed, often at the expense of others (Attneave 1983). The Chinese may equate American values with selfishness (Ryan 1985). The necessity of having to relate to more than one culture is a primary cause of cultural identity conflict. There are few possible adaptational responses to this cultural imperative. Among them are: (1) striving to melt or assimilate into the mainstream; (2) striving to remain separate from the mainstream while embracing one's culture of origin in a positive way ("preserving or revitalizing"); (3) striving to integrate the culture of origin with the mainstream; (4) remaining marginal to both (Spiegel 1984). The third option usually offers the best chance for reduction of value conflict. Marginality involves alienation, isolation from both cultures, fragmentation, and confusion. The other two options also involve conflict, since they require renunciation of one of the two cultures at the same time that contact in some form is practically compulsory. Integration, which is the most desirable option, is not available to people-of-color because of their excluded position in American society. They thus must exist in a state of biculturalism, relating to two worlds but being unable to totally integrate them. This means that people-of-color must remain permanently in a state that is only transitory for White ethnics who experience this condition only as immigrants. Their total acceptance into the society means that they later can become free to integrate (take from each) the two cultures. People-of-color, on the other hand, must find ways to live with this duality and to minimize its destructive potential.

Conflict in values and roles can breed disharmony in relationships; promote intergenerational clashes within nuclear and/or extended family members; fuel internal identity conflict, negative identity, and self-esteem; and destroy ethnic cohesiveness. Culture conflict is manifest in cultural and family roles, defensive behaviors, self-hatred, negative identity, and marginality and is a common source of the problems clients bring. The toll that Black children may pay for cultural conflict can be great if they are separated from cultural ties, the extended family, and systems that interpret the meaning of their culture and, at the same time, are unable to replace this with "something of equal psychological value." In such instances the pressure at scho~l for ac-

ceptance, which is based on how much they fashion themselves in the image of the melting pot, if succumbed to, will result in education coming to mean giving up of their sense of self to "blindly find new identity" (Powell 1982, pp. 308–309). How much clients have developed the internal skills and knowledge that will facilitate a well-balanced positive cultural identity and how much they have available to them cultural practices and kinship patterns that facilitate survival in their societal role must be assessed (Lum 1986, p. 149).

While biculturalism can certainly take an extensive toll, it must be remembered that under some circumstances it also can foster amazing strength in people. Whether or not it is a strength, whether the ambivalence and conflict can be managed without extensive toll are critical factors to assess. Also to be determined is the degree to which this duality is (1) backed up by the sound use of coping mechanisms such as cognition, intelligence, judgment, reality testing, coherence, flexibility, and high self-concept, and (2) guided by ethnic values and beliefs about living (Lum 1986, p. 73) that enable people to cope with the consequences of their societal position.

The freedom to assess these factors accurately depends on practitioners' clarity and understanding of themselves and their own cultural identity, including the societal position of their own cultural group. To use diagnostic thinking that transcends stereotypes, is flexible, and is marked by appreciation of cultural difference means that in the assessment of their clients practitioners must also assess themselves.