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Assessment in Pastoral Care

Principles of Assessment

Lawyers, clergy, physicians, teachers, psychologists, social workers and all those whose "objects of attention" are primarily people learn to assay, evaluate, diagnose and assess their objects or fail themselves professionally. They would also fail their prized objects of service, be they clients, patients, parishioners, students or counselees. By the time one has become a client, patient, student, or counselee, good or bad judgments, decisions, diagnoses, and functional contracts have been enacted by the professional and his or her client.

For pastors, pastoral counselors, chaplains and mental health clergy this diagnostic work is both excitingly critical and at the same time largely unexamined. It prompted one of us in the 1960's to feature concepts of assessment in a book on psychiatry and pastoral care that were expressed primarily in the basic section of that work, entitled "Pastoral Diagnosis." (We recommend this reference, both as an initial comprehensive effort to understand pastoral diagnosis and assessment and as the locus for innovative additions and utilizations by others.) In this book processes of evaluation are seen as being necessarily followed by "Pastoral Treatment" and finally "Religion as a Human Resource" (Draper, 1968).

Today we use religious ideas and behaviors to diagnose psychological/spiritual problems, religious history to understand personal history and religious developmental steps to document developmental assay of adults and children.

Given this, we will therefore seek to fulfill two objectives in this chapter: (1) add new historical developments influencing the diagnostic or assessment arena of pastoral care, and (2) elaborate on foci of assessment which are new, or have not received, in our opinion, sufficient attention, or which offer special promise for the future.

Historical Developments

As Dr. C. Knight Aldrich, former chairman of psychiatry at the University of Chicago, pointed out in the 1950's and 1960's, psychiatric social workers and clergymen—especially the pastoral counselor—have much in common, both professionally and as willing targets for teaching by psychiatrists, especially those psychodynamic psychiatrists interested in teaching psychotherapy. In those days, psychiatry prided itself as the queen of the clinical sciences. Most psychiatrists then were psychodynamic in orientation; most training centers of worth prized psychotherapy and were dominated by psychoanalytic therapists, psychoanalysts or psychoanalytic theory. The romance between psychodynamic psychiatry, social work, pastors and pastoral counselors was intense, exciting and productive for many years. Although not over, these relationships have changed.

For multiple reasons, psychiatry has changed since the 1950's in practice and in its training direction from a psychotherapeutic speciality toward a "remedicalized" specialty, a favorite term of American Psychiatric Association leadership (Sabshin, 1977). There are a number of factors which have brought a new eclecticism to training centers for psychiatry; they include: the impacts of psychopharmacology (neuroleptic drugs) in the 1950's, community and social psychiatry of the 1960's (following the dictum of St. James: "Be ye *doers* of the word and not hearers only"), and decreased federal support to psychiatric education with greater emphasis in training on consultation to other physicians, decreased resident applications to psychiatry, diminished third party payments especially for psychotherapy, mushrooming of private psychiatric hospitals and hospital chains, and the development of competing theoretical systems including behaviorism in the 1970's.

Thus, many currently emerging graduates of psychiatric residencies do not carry the same dynamic psychotherapeutic zeal of their predecessors in the 1940's and 1950's when the pastoral care movement was beginning. In those days pastors, chaplains, social workers, pastoral counselors and many psychologists were being supervised and trained as willing students and supervisees. Today, treatment by psychotherapy, (whatever its moniker, whether called "pastoral counseling," "case work," "marital counseling") continues to be of value, interest and daily practice. Nevertheless, it is being increasingly examined for effectiveness, including time and cost effectiveness.

In those early days of the pastoral care movement, "the organically oriented," "biological" psychiatrist was not sought out any more than any other physician because what he taught, or was interested in, was not of

professional use to "clinical" pastors. The early leadership of pastoral care found psychodynamic psychiatrists encouraging and eager to teach. That leadership launched the pastoral care movement toward enough success to develop its own systems of training, to place departments of pastoral care or their equivalents in all "forward-looking" seminaries, to create a bank of clinically oriented chaplains for general and psychiatric hospital services, and as "side effect," to offer new professional identifications as "therapists." Some were viewed and viewed themselves as "overtrained" or as casualties of "overskill." Many left the ranks of the clergy partly because there simply were not enough positions in seminaries or in churches or chaplaincies for many of this new generation of liberal clinical clergy.

Notice that word "clinical" seeps in as an adjective before clergy, chaplains, ministers. Clinical refers to the diagnosis and treatment of persons (healing care) and does not imply a theory or method of cure. For professionals, including clergy, who are serious about themselves as "clinicians" the informed clinicians (family physicians, social workers, psychologists, chaplains, pastors or therapists of whatever theoretical belief system) are obliged to (1) make a diagnosis in their own theoretical formulation before treatment, (2) know those vectors of diagnosis available at their own level of decision making and discrimination, and (3) refer, if they find themselves over their treatment or diagnostic heads.

One historical impact of these developments means that pastors, chaplains, pastoral counselors, must now work at finding psychiatrists interested in them as "clinicians" or even as pastors concerned about the spiritual/psychological care of parishioners, or as clergymen with potent tools to help others. Another impact is that a sophisticated community mental health clinician, who knows how helpful pastors or pastoral counselors can be, is now prone to seek out the assistance and support of pastors for *their* counseling skills. Some of these clinical administrators, especially directors of mental health centers, view psychiatrists as "script writers," legally necessary physicians, more than as skilled psychotherapists; unfortunately, this is sometimes an accurate perception!

Another impact is that clinical clergy now turn to other professionals for training or collaboration, instead of their old allies (psychodynamic psychiatrists), especially if those professionals attribute value to psychotherapy whatever its methods, e.g., the behavioral schools of psychotherapy. Another impact is the likely decline of the thrust of the pastoral care movement in numbers and possibly in "esprit," since the movement has been so closely tied to psychodynamic psychiatry. Seminaries', churches' and hospitals' concerns with obtaining "clinically trained" clergymen will be influenced by psychiatry's new faces, priorities and functions.

One sign of the times is that the Committee on Religion in the American Psychiatric Association, of which one of the authors of this paper (E. Draper) is chairman, recently appealed to the APA, at large, to request the Joint Commission on Accreditation of Hospitals (JCAH) *not* to discard their own previously established standards regarding the job descriptions, qualifications, and performance of chaplains in American hospitals. These standards were an important and hard-won achievement of the pastoral care movement and seemed to be a reflection of enlightenment by hospitals and JCAH. How did our committee learn this JCAH intent? Through our own liaison member to the American Health Clergy, Dr. Clark Aist. We should add that few hospitals, few medical centers and few M.D.'s find the JCAH a *highly* useful standard-bearer for truly good clinical care of patients. But, "It's all we got." As such, however, its cavalier decision to remove hard-won standards for clinically trained chaplains is not just a reflection of JCAH, but also a reflection of the times. Chances are good that if our A.P.A. Committee on Religion was less sophisticated, negatively biased against religion, or theoretically biological, our successful efforts to reverse JCAH's intent to remove clinical standards for chaplains would never have occurred.

Things have changed since the birthing days of mental health clergy. They will continue changing. The issues related to greater sophistication in assessment, diagnosis and assay (or whatever term is used that means evaluation of persons by clergy) will eventually be decided over the long haul by "organized" religion, by our professional clinicians of whatever ilk, and by the clinical/psychological standards the public wishes for its clergy. Even though we can't speak for any of the above named groups, we *can* outline, in the light of these historical developments, some aspects of evaluation that are likely to remain important in "pastoral diagnosis."

Psychodynamic Legacies

If we don't know where we've come from, we have great difficulty in knowing where we are going. The legacies of the psychodynamic movement to pastoral assessment and pastoral care movement are so multiple and monumental that we can do little more than acknowledge those contributions in wholesale fashion. For instance, the analogy used in my (E. Draper) chapter on "Pastoral Diagnosis" owes much to the psychodynamic mode of diagnostic thinking. The analogy described a farmer who needs to know his soil (culture), climate (family influences), seed (genes, stock), growth processes (development), plant composition (personality/charac-

ter), strengths and weaknesses of the plant (the self's strengths, weaknesses, signs and symptoms), if he is to assess (diagnose) conditions and if he is to provide for the harvest of a successful crop (effective solution of "therapy").

There are also special assessment tools, such as the ability to listen intuitively with the "third ear" (Theodore Reik), the understanding of the need to drape the professional with the antique robes of past parental figures (transference), the calibrated use of one's own reactions to others that leads to or confirms assessment accuracy, the search for the "straw that broke the camel's back" (precipitant event that sets off symptom formation), the spotting of the disabling behavioral patterns or repetitious failures, and, finally, a system for unraveling the mysteries of the peculiar motive and the strange act (unconscious, unintended, unwitting messages). All these and many more are products of the psychodynamic movement and related theories and practices (ego psychology, psychology of the self, existential psychology, etc.).

In psychodynamic psychology, too, tools were provided to understand the multiple psychological functions of religion which our study, "The Diagnostic Value of Religious Ideation" (Draper, 1965), has demonstrated. Although this study was done on fifty random psychiatric in- and out-patients, it has been successfully replicated on "normals," including divinity students, psychiatric residents and children. This study has established that an individual's belief or theoretical system, his religious ideas, behaviors, expressions, ethic and religious history are as useful pieces of data to understanding (diagnosing) him as any other data! This study (and others' creative utilizations or corollaries of this study) is still being used for teaching diagnostic principles to pastors and chaplains and for understanding parishioners who still like to talk in the language of religion.

The "latent language" of religion matches other "royal roads" from dreams to projective tests in understanding (diagnosing) individuals psychiatrically/psychologically/spiritually. Skillful users of their "third ears" in the religious framework of evaluation will be able to recognize well-known psychological signs or symptoms *or* psychological strengths in their patients', clients' or parishioners' communications. The greater the clinical skill and internal freedom from religious/theoretical bias, the more accurate the assessment (diagnosis).

Goals for Clinical Training

Effective "clinical training" for clergy ought to provide multiple capabilities. One, it should permit recognition of psychosis that is masquer-

ading in religious trappings. As examiners of the American Board of Psychiatry and Neurology, we regularly have the opportunity and privilege to examine physicians, who are board eligible in psychiatry. These physicians, who are seeking to become certified as board psychiatrists, have had at least four years of psychiatry and medicine after their medical degrees. When their "Boards" are passed, they are entitled fairly to the term "Board certified" as specialists in psychiatry.

At one recent oral examination (which requires previous written examination passage for eligibility) a video-tape of a patient was shown. The patient called himself "Jesus Christ, Superstar" and dressed and acted the part with some success. To the examiners and to those perceptive candidates viewing the film, there was no doubt that "Jesus Christ, Superstar" was psychotic, and most probably suffering from paranoid schizophrenia. However, among those who failed that portion of the exam, the patient was perceived as "very religious," or they noted, "Jesus Christ Superstar? I never heard of him," and/or said "He was an excellent actor" (those answers were but symbolic representatives of other fairly glaring inabilities that were found by examiners) whereas candidate psychiatrists who passed had little trouble immediately recognizing the patient's degree of illness and were not thrown by the "religious trappings" of the patient's pathology.

Two, training should help identify "religiosity," "religious" hallucinations, "scrupulosity," and "miracles" as non-supernatural. Three, the well trained should recognize magic, exorcism, voodoo, poltergeist, "advertised" E.S.P., living reincarnations (including double personalities), talking with the dead (even in the dying) as deliria (acute brain syndrome), primitive psychological regressions, defenses or cures of a terrestrial nature. Four, training should add perspective and differential diagnostic acumen to the assay of "religious conversion," "religious experience," "spells," fugues and dream states. Five, the trained clinician will allow parishioners flights into health, by whatever means effected, including by TV evangelists. Six, training should help one recognize that most espousers of the "power of positive thinking" are themselves depressed. Seven, it should provide a framework for character of personality assay that would, for example, "separate the men from the boys," "the women from the girls," the smooth sociopath from the socially skilled, the quiet schizoid from the inhibited reticent, the affectively bland schizophrenic from the frozen obsessive, the dull (deficient) from the dull (boring intelligent). Eight, training enables one to pinpoint the source of a parishioner's tears, whether generated from grief, allergy, depression (overt or masked), joy, anger, empathy, pleasure, foreign body (e.g., contacts), hysteria, tear-duct obstruction, emotional ability, or chronic sentimentality. Nine, the

well trained will recognize that certain psychotic symptoms (craziness) may be caused by delirium (acute brain syndrome) or other toxic conditions and may need the immediate consultation of a skilled physician. For example, visual hallucinations of bugs, vermin, animals, bizarre creatures are more likely to be secondary to brain insult or toxic states than to functional psychosis (e.g., schizophrenia). Ten, training should help one assay, with some clinical skill, suicidal risk, but a pastor should *never*, however advanced his clinical training, decide without consultation with a competent psychiatrist that "this one's just a gesture." Physicians, in general, or general physicians do not do too well on this same issue, either. Nor does the computer analyst clinician who trusts statistics. Psychiatrists *ought* to be able to perform this evaluation or consultation more effectively than other specialists. My own barometric reading (Draper, 1976) fingers psychological pain as the primary focus for judging suicidal risk. The bottom line is: when no relief to his suffering, whether physical or mental (usually the latter), is visualized or fantasized, and no light at the end of the tunnel is seen, the serious suicidal risk turns to anesthesia as his only release. This state of reality distortion can be considered a *passing* psychotic state because reality perceptions, e.g., that others *do* care, are muted or obliterated. It is, also, a *transient* state which is amenable to help. A few "paradoxical" observations about suicide: (a) fortunately, most depressed people do not commit suicide, nor do the sickest of patients, e.g., hebephrenic schizophrenics except by accident; (b) even the terminally ill rarely kill themselves although newly diagnosed or chronic illness may be a precipitant; (c) homicidal people are good candidates for suicide; (d) many successful suicides have never sought help nor have been considered by others as "sick" although some "announce" their intentions without being heard; (e) most suicides are preventable if properly diagnosed and treated; (f) religious belief or denomination does not determine suicidal morbidity or mortality rates. (If the only thing keeping a person from suicide is "I'm Catholic and killing myself condemns me to hell," get him to a competent professional quickly.) Further, if suicide *fulfills* certain strongly held religious beliefs, the danger is enlarged, as with a person who believes that death will bring reunion with the one "already over there."

Eleven, training can alert the clinical pastor to another paradox: the undiagnosed physically ill person will often think he has new emotional problems and the emotionally ill will often think he is afflicted with physical disease—*both* trying to account for their symptoms by denial. Twelve, a solid foundation of training should prompt the assessor to the fact that one of the most common causes for memory and concentration loss, or headache or constipation or malaise or fatigue or sleep disturbance or un-

dieting (overeating) or addictions or feeling bad or failures is depression, a treatable syndrome. Thirteen, training skills should permit the perception of "who's the patient?" and recognize that family relationships, such as portrayed in Alice Walker's *The Color Purple*, do different things to children and adults than the influences of families that are less prone to incest, abuse, psychological slavery or ambition, shorn of people value.

Fourteen, a training background should introduce clergy to aspects of the psychopharmacological world. Fortunately or unfortunately, pharmaceutical houses are now much more intensely interested in "detailing" (selling, advertising their products) to all physicians, including psychiatrists. Anxiolitic, antidepressant, anti-psychotic drugs are now prescribed at top volume of *all* drugs prescribed. The *undesired* side-effects of these drugs can be (a) danger to life, (b) crippling, (c) disabling, and (d) bothersome to the patient enough to make compliance a recognized problem. Do we think everybody (patients, physicians, laymen, pastors), ought to know about these side-effects? Yes!!! (Note: We omitted lawyers.) Drug-induced (iatrogenic, if you will) parkinsonism, tardive dyskinesia, the "shakes," paradoxical psychosis, suicidal risk, addiction, neuro-muscular-disorders, etc., are all new "diagnostic" possibilities with our "curatives," not to mention the simple derivative side-effects, like dry mouth, sunburn, constipation, or more usual drug problems like allergic reactions or overdose. (Some of the neuroleptics are *especially* deadly in overdose.)

Fifteen, training also ought to alert pastors to other iatrogenic-induced illnesses or pharmacological agents that produce symptoms that can be recognized, such as from the anti-hypertensive drugs, so commonly dispensed. We are against hypertension. It can be a killer. "Essential" hypertension (unknown reasons for high blood pressure) seems to be associated with aging, obesity, alcoholism, stress, type-A personalities, salt retention, etc. Its pharmacologic *treatment*, unfortunately, is also *commonly* associated with mental and physical depression. This terrible side-effect is so common that the first question we have learned to ask our patients and to teach our medical students and residents in psychiatry when a patient presents with depression is, "What medications are you taking?" Physicians were alerted more than twenty years ago to the fact that rawulfia drugs can lower blood pressure (and *cause* depression). We, however, have only recently learned that all *major* anti-hypertensive drugs, even those without rawulfia, *also* can cause or precipitate depressions. It is also newly being appreciated that even the "minor" antihypertensive drugs, namely, diuretics and potassium-retaining drugs, also precipitate or aggravate depressions in vulnerable patients. Finally, appropriate pharmaceutical agents are marvelous when and if they are correctly applied, and the side-effects are negligible. But, if prescribed

incorrectly in quantity (dosage) or quality (correctness), they are deadly, poisonous substances. *Pastors ought to know these things!*

Sixteen, training should familiarize clergy with the "other" drugs that too often cause great difficulty, especially "with youth." Above we have cited problems caused by "clean" (legal, prescribed, counter) drugs. "Street" drugs deserve at least enough attention by pastors to arm them with diagnostic thoughts about these potential killers, psychosis inducers, and addictive substances. Wishes to stamp out illicit use of drugs and addictions to marijuana, cocaine, heroin, morphine derivitives, LSD, "uppers," "downers," "smoothers" (tranquillizers), tobacco, alcohol, caffeine, are useful desires of a society, let alone clergy. Also, effecting treatment for these street drug abuses is totally rational. But wishes to stamp out the users can be the sad consequence of invoking a "treatment" regime before diagnosis has been established. The basic question is "Why is this child or youth on drugs?" (My focus here on drugs and youth is for affective, not statistical emphasis since most drug abuse is not, in volume, the primary problem of teenagers. Drug abuse, whether with street drugs or with accumulating arsenals of "medicines" by the elderly, starts at any age.)

Finally, training can sensitize the pastor to differential diagnostic possibilities with the aging parishioner, including the "senile" patient. Much could be written about the aging patient and the importance of accurate diagnosis, including the necessity of the usual diagnostic process. Unfortunately the aging patient has drawn relatively little research attention. He has also drawn so little clinical attention as to make it necessary for medical educators to induce physicians-in-training to carry out their usually meticulous diagnostic processes with the elderly. The much too common assumption, by physicians, is that aging is an illness itself: that all senile-like behavior, including memory loss, disorientation, apathy, is caused by "cerebral arteriosclerosis" or "senility." This is incorrect! If our society has been guilty of "warehousing" the mentally ill, we are now no less indicted by "warehousing" the elderly. "Warehousing" pre-empts cures or amelioration of treatable conditions, e.g., pseudodementia (depression in an older person), by eliminating diagnostic processes. (For an ethical and economic examination of the "treatment" of the elderly, see Dr. Theodore R. Reiff's article, "It Can Happen Here" [as it happened there in Nazi Germany].)

It is certainly possible, and might feel justifiably comprehensive, to describe something like twenty or even fifty clinical diagnostic goals for the "clinically trained" clergy. However, since diagnosis is a *process* that has a beginning, and it ends *only* with assay of whatever treatment is applied, we will trail off, like renditions of rock 'n roll, with seventeen such goals.

We would like to note that the diagnostic process in psychiatry and in

pastoral care *is* a process and still is *in* process. In the 1940's and 1950's and 1960's, in graduate and undergraduate education in psychiatry, the diagnostic process was *perhaps* overfocused toward psychological assessment, psychological theory, psychological applications, psychological technique and treatment by psychological therapies. A famous analyst teacher, Dr. Michael Balint, led a regular and controversial case-conference at the University of Cincinnati, Department of Psychiatry, in the 1950's. At one such meeting, a competent resident and colleague presented a case during the course of which the young psychiatrist noted that the patient called attention to a small mass in the patient's thyroid region, inferring a request for the physician to examine it. To this, Dr. Balint blurted out, "Did you interpret it?" The resident's reply, "No, I examined it," precipitated peppered discussion the rest of the session (and more). Dr. Balint's point and the young psychiatrist's response give hint of the dialectic that demands diagnostic and treatment perspectives that range broadly and still command depths and precision in assessing the mind, body, soul, spirit—a person.

Because we grew up in an earlier era when Benny Goodman and Glenn Miller ended their pieces with definite percussive conclusions, this chapter would not be complete without mentioning that there are now excellent psychiatry texts that can be helpful references (Kolb, 1977; Goodman, 1984). The American Psychiatric Association has relatively recently published the *Diagnostic and Statistical Manual III* (American Psychiatric Association, 1980) in large and small paperback, which outlines psychiatric diagnosis from A to Z. As noted above, however, diagnosis is a process, so that already there are redactions, rethinking, restudy, and regroupings that harbinger the future entrance of DSM IV.

Finally, most of our medical students, plagued by inundation of memory challenges, find associational methods to help their recall. For example, freshmen (M-1's) learn a jingle verse which begins "*O*n *O*ld *O*lympus' *T*owering, *T*op—." Recalling this twelve worded statement allows the student to use the first letter of each word as a recall stimulus to remember the twelve cranial nerves. "O" stands for Olfactory, "O" for Optic, "O" for Ocularmotor, "T" for Trochlear, "T" for Trigeminal, etc.

The mental status examination is both a portion of the diagnostic process and a method for documentation of a patient's psychological functioning. It forms a similar core of examination and recording for psychiatrists as the review of symptoms and the orderly elements of the physical examination do for the internist. To assist the attention of the medical students, especially, and to give them a handle for recall of all primary elements of the mental status, we introduce them to a certain Mr. **J-I-M M-O-T-S-I-G-A**. "He" helps the student recall **J**udgment, **I**nsight, **M**ood,

Memory, Orientation, Thought processes and content, Speech, Intelligence, General appearance and behavior and Affect, when assessing a patient. The clergyman, including the clinically trained, may not find JIM MOTSIGA necessary to recall the salient factors of the mental status exam, but *some* kind of framework for his diagnostic process and its documentation would probably be helpful.

While we have suggested one such model, it should be stated that many others are currently operative. For example two of the present coeditors have suggested a "BASIC" approach to mental status interviewing (Wicks & Parsons, 1984). These authors note that a mental status interview is designed so as to acquire data essential for the basic understanding of the clients' current situation—their *basic* resources, *basic* style and coping method. The authors use BASIC as a mnemonic device for the types of information sought. That is, in each such interview, the interviewer needs to pay close attention to the client's Behavior and physical appearance, Affect and emotional state, Sensorium or information reflecting the functioning of the client's central nervous system, Intellectual functioning, and Cognitive Processes.

Items to be considered for each of the listed domains have been highlighted by Wicks and Parsons (1984) and are presented, in part, below.

Behavior and General Appearance. The interviewer needs to develop a clear picture of the client's general style and manner. As such, information is recorded which reflects the client's demographic characteristics, such as name, age, address, marital status and description of physical characteristics (e.g., height, weight, posture, obvious physical disabilities, etc.). In addition to such demographics, the interviewer should take note of the client's body motion, gate, unusual movements, tics, expressive mannerisms, both verbal (e.g. "ooops," "you know," "ah . . .") and non-verbal (tongue protrusion, lip smacking, blinking, etc.).

Affect and Emotional State. The client's expression of emotion and their awareness of their own emotional state are important areas of focus during such a mental status examination. Identifying any incongruency between the client's self-identified feelings and the interviewer's impressions should be noted, as should any abrupt changes or inappropriateness of the affect expressed (i.e., in terms of degree or kind).

Sensorium and Functioning of the Central Nervous System. Throughout the mental status examination the interviewer should be alert to record evidence of impaired general alertness or consciousness, orientation, memory and concentration. Such impairments may be suggestive of neurological or organic involvement in the presenting complaint. Wicks and Parsons (1984) suggest that interviewers should be attentive to any inconsistency or fluctuations in the client's ability to be responsive and alert

throughout the interview. As previously suggested, the interviewer needs to evaluate whether the client is oriented to person (his own name), time (hour, day, month, year) and place (being interviewed by . . .).

In addition to such general orientation, the client's short and long term memory needs to be assessed either through formal testing (e.g., Wechsler scales, Memory for Designs test, etc.) or by having the client repeat digits or phrases posed by the examiner.

Intellectual Function. Insight and Fund of General Information. A number of standardized intelligence tests could be used to tap such general intellectual functioning. When such standardized tests are not available or practical, the interviewer notes vocabulary for intelligence assay and could pose general questions of geographic orientation (e.g., Where is Brazil?) or common cultural concerns (e.g. How many senators are there? or How far is it from New York to Los Angeles?").

The last area of focus in such a "BASIC" interview is the client's *Cognitive Processes*. Taking note of the client's form, speed and content of expressed thoughts will provide the interviewer with insight into the client's cognitive abilities and judgment. Being sensitive to the speed with which the client can make decisions, resolve problems and use conventional, logical means for such resolution will provide the interviewer with invaluable information regarding the client's ability to function. By attending to such "processes" the interviewer can assess the degree to which the client's thoughts are "reality" based, or represent delusional or hallucinatory responses.

In addition, all too often, in our eagerness to resolve problems, we fail to fully appreciate the "place" the presenting complaint has in the overall pattern of the client's life. An historical interview can provide the counselor with the needed information to fully comprehend the etiology, duration, severity of the presenting problem and the client's "natural" resources for problem resolution.

It is important that we establish the client's current concern (i.e., presenting complaint) while at the same time seeking to identify the client's level of awareness about the nature, course and impact of the current presenting problem. In addition to obtaining a detailed description of the presenting complaint, it is helpful for the interviewer to place this complaint within the psychological history of the client. Gathering information regarding previous psychological problems and types of treatment experienced is not only important for determining the severity and diagnosis of the problem but may also provide insight into the client's expectations about "counseling" and the forms of treatment to be used. The counselor should ask the client to sign "release of information" forms, allowing the counselor to acquire records on such previous counseling and, where in-

dicated, medical records. Such records might provide the needed elements for the counselor's understanding of the nature of the client's presenting complaint.

The client's current level of functioning and presenting complaint needs to be reviewed within the light of the family history and current environment. Tracing the client's family history will aid in the determination of the time and conditions surrounding the initial onset of the problem and may provide insight into the significant factors (e.g., genetic, family role models, current work or family climate) which might play a role in the etiology or maintenance of the current condition.

Finally, the evaluative interview, skillfully done, will usually in its *natural* process evoke essentials of the mental status for "JIM MOTSIGA" or for "BASIC" *without* recourse to unnatural questioning, e.g., "What day is it?" or "Who's President?"

Freud's diagnostic curiosity prompted him to jump to conclusions but rarely. In one of his earliest contributions, "Analysis of a Phobia in a Five-Year-Old Boy" he requested, "For the present we will suspend our judgment and give our impartial attention to everything there is to observe" (Freud, 1955, p. 23). In conclusion then, if a person in ministry is to make a pastoral diagnosis with sophistication, he will have worked out his own process of assay including a "spiritual status" that pre-empts a reflex grasp for a "treatment" action to solve an undiagnosed problem—fitting for the "medicine man," questionable for the clergy.

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