

The Collaborative Relational Diagnosis

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Abstract. In the practice of Social Work, the traditional concept of diagnosis refers to a simple formula: a professional with a certain competence linked to knowing and doing, issues a judgment in which the nature and magnitude of the difficulties have been synthesized and interpreted -needs of a person, family, group or community. This vision does not incorporate the relational and cooperative dimension of the encounter between the professional and the person in the framework of a helping relationship. From second order cybernetics, that of observing systems, what professionals believe, think and value (as professionals and as people), influences the vision that we are going to build of the person / family. If subjectivity occurs, what prevents the assessment of the problem situation from being able to co-construct it collaboratively between the professional and their clients? From this perspective, we can speak of collaborative diagnosis. The work collects the results of the practical application, under experimental conditions and in the daily practice of professionals, of the criteria to develop a co-diagnosis. It is useful to guide conversations with clients and is open to the adjustments that each relationship needs in its context.

Keyword: *Diagnosis; Co-Diagnosis; Relational Social Work ; Narrative practices; Collaborative practices.*

A. INTRODUCTION

In the practice of Social Work, the traditional concept of diagnosis refers us to a simple formula: a professional with a certain competence linked to knowing and doing, issues a judgment in which the nature and magnitude have been synthesized and interpreted. of the difficulties-needs of a person, family, group or community (Herraiz & de Castro, 2013).

This dominant view about the concept of diagnosis, a term which we usually refer to in the professional and academic world as «social diagnosis», frequently does not incorporate the relational and cooperative dimension of the encounter between the professional and the person in the framework of a relationship of help. It is usual that the idea of diagnosis is related to the interest in knowing the state of a difficult situation, with the intention of doing or proposing to do something with it to modify it. If we think about the logic of the administration of services and benefits, typical of the management of social services, the chronic financial precariousness and an almost permanent deficit of programs and projects that make it possible to cover gaps and difficulties, force us to refine the distribution of scarce resources. In these territories, it is logical to speak of "collecting data", of measuring and evaluating needs through inventories or other instruments that group variables. They are useful systems to "collect and group" the professional's assessments and thus guide classic diagnoses. However, they leave aside the interrelationships and the singular meaning that each person gives to events.

From the perspective of the helping relationship, this dimension, so frequent and tragically forgotten and that, in our opinion, gives meaning and nature to the practice of Social Work, thinking about the diagnosis in classical terms implies not consider the epistemological developments that have been raised from the perspective of complexity (Morin, 1981), the theses of Constructivism (Piaget, 1971), Social Constructionism (Goolishian & Anderson, 1996) or the van-guards of the Social Work practice (Selekman, 1993).

In all cases, current advances in epistemology have a special impact on the relationship between knowledge and power. From Critical Theory (Torres, 2007) to post-structuralism

(Yela, 1998) power relations have been considered in human interactions. From the perspective of Social Work, the latest van-guards especially linked to narrative practices (White and Epston, 1990) and dialogic (Madsen, 2007), already raise the criticism of the classic idea of diagnosis. This criticism begins with the considerations that are developed in the analysis of the power implications that the formulations of the first and second cybernetics entail.

From the perspective of first-order cybernetics, that of observed systems, the idea of the existence of an objective reality that can be taken, apprehended, is maintained. The role of the “neutral” professional is to identify and diagnose it and then modify it from unidirectional help processes, in which the starting point is a value judgment that will be supported by the dominant social narrative. Uncritical confidence in social consensus about what is right or wrong or what is normal or pathological is present in this vision of the professional role and its diagnostic practices. Second-order cybernetics, that of observing systems, states that it is not possible to know (make observations and measurements) of a given system, regardless of the observer. In other words, what we believe, think and value as professionals and as people, influences the vision that we are going to build of the person / family. This position moves away from the supposed neutrality of the observer professional and recognizes that the observation of every problem situation is biased by an ideological, cultural, gender and biographical theoretical load (Feyerabend, 2003). Our vision of what is happening, which is no longer necessarily the only or the correct one, is broadened by introducing the vision of the other with the same value as that of the professional. In this sense, the vision is adjusted and co-built in a cooperative help process with the person / family.

Thus, to speak of an objective diagnosis and free from a biased look on the part of the professional, is to speak of a fantasy. Assessing the result of a blood test is not complex for a trained professional; assessing what aspects interact in the problem situation, what interaction there is between the problem and the person / family, what happens to them and what is the meaning that this gives to their situation, is more complex. The subjectivities of the actors come into play who value, who values the problem situation? The objective, rational and neutral professional of the first cybernetics? Or the help system constituted by professional and client? If subjectivity occurs, what prevents the assessment of the problem situation, traditionally called a diagnosis, from being co-constructively collaborative between the professional and their clients? (Romesin & Garcia (1997), would probably tell us that living beings and therefore people, are capable and autonomous to maintain and develop their own self - organization. It is the autopoiesis, the self-regulatory capacity of the aid system, which governs the ethics, organization and pragmatics of development and its shared history. From this perspective, it is not possible to speak of diagnosis, but of collaborative diagnosis, of co-diagnosis.

As a profession, we have been changing language and discourse (Rodríguez, 2013), integrating concepts of the second cybernetics. However, epistemological change has not yet been introduced in daily practice, in how we develop practice, understood as a cooperative helping relationship. Without renouncing our origins, perhaps this is a good time to introduce new cartographies and reorient the direction of practice towards a relational and cooperative Social Work.

In the proposal we present, the diagnosis has a relational and collaborative dimension. It is part of a process aimed at building a helping relationship with the person / family, understanding it as a meaningful relationship based on alliance and built on a collaborative framework.

B. METHODS

How to collaborate with people has been one of our concerns in recent years. The proposal presented is the result of a systematic study process of the main authors who, from

the vanguards of Social Work (Riojas & Cisneros, 2013), have expanded and innovated the narrative, collaborative and dialogic practices also formulated by Niemeyer (2004), Marin et al., (1999), or Matsen (2007) among others. These contributions have been synthesized and operationalized to be applied in a controlled experimental context, within the framework of the University of the Balearic Islands. The results of this experimentation have been developed in diverse work contexts, and its application has allowed experimentation in the generation of cooperative spaces through conversations and questions.

We have not sought to establish classifications or categories that can be grouped together, because we understand that this procedure obscures the voice and the unique characteristics of people and because the influence of culture and social context in people's lives is not visible. Our intention is to share with the readers a critical reflection, as well as a guide that has been useful for us to organize and systematize the co-constructed knowledge throughout collaborative conversations. This has allowed us to build a relational and cooperative diagnosis where people's voices and meanings are reflected, since from the beginning of the helping relationship, the process has been woven cooperatively.

C. RESULTS AND DISCUSSION

1. Relational Foundations that Have Guided Cooperative Conversations in The Helping Relationship

Generating a cooperative conversational space translates into generating a territory where the person perceives that the helping relationship is fluid, based on respect, trust and affection. This prompts us to introduce changes in the way of observing, thinking and intervening. In this sense, Bolaños (2008), states that

“Building a cooperative space is something that goes far beyond the techniques used to frame the process. This space is not the requirement for changes to occur, it is change itself. It is a new reality built together”.

Next, we go on to describe the criteria that have guided us to establish a cooperative framework in the helping relationship and that therefore, support that the process of construction of the diagnosis in Social Work is relational and collaborative. These criteria are based on the work of various authors (Pastor, 2012), and on our own experience. We go on to describe them:

1.1 From the first contact, a relationship of respect is generated with people, giving them a leading role in leading the help process and placing them as experts in their lives. It is about redefining the family's expectations about our role as "expert professional" by encouraging them to actively participate in their process of change and re-establishing ourselves as professionals who collaborate with them. From the beginning of the helping relationship, their capacities and aptitudes are recognized and emphasized, giving them the same weight as our experience and professional training.

The Social Worker tries to generate a context of help based on collaboration and the alliance of help through practices aimed at: Stimulating the person to express themselves about their objectives and goals; explaining how the intervention could be carried out so that you can contribute your opinion and experience; stimulating their participation in the design of the aid process; valuing and amplifying every little change; generating small expectations and validating your subjective experience.

1.2 The study meetings (study interviews) constitute a collaborative research , that is, a joint work that highlights the shared knowledge in the course of conversations. It is not a one-way exchange of information. The Social Worker knows that your point of view is one more, not the real one and consciously places himself in a collaborative space, of respect and inclusion

of the other, to understand together with this other. The final product is a woven reality, co-constructed in the transition from one encounter to another.

Recapitulate and adjust in each encounter, they become necessary steps to arrive at this final product. The Social Worker shares through a recapitulation his impressions about what happened in the meeting and about the process that has been carried out so far. Afterwards, adjust these impressions by asking the person if they want to introduce any aspect that has not been taken into account. With this practice, we place the person as an expert who collaborates actively. Your qualifications or differences are important to us and to the support process. In this adjustment with the other, the Social Worker performs an opening movement, relaxes his or her gaze and includes that of the other, these dance steps form the collaborative space where the helping relationship will be supported.

1.3 Take into account the influence of the cultural and the social and interactional context in the problem situation and in the identity of the people.

1.4 The definition of the problem and that of the objectives must arise from the conversations and questions to the family, not from the professional and their theories. Family participation is encouraged throughout the process, from the definition of objectives, planning and the methods used. From appreciative or collaborative inquiry, practitioners and clients initiate a process of joint exploration in which helping professionals pose questions in order to help clients visualize and realize the process and direction of change.

1.5 Focus the conversations on the achievements, capacities and resources of the person / family, thus generating competence through discovering, evoking and underlining what the family does well so that they can later transfer their knowledge to the problem situation. From the first meeting, it is about helping clients through collaborative practices. This means encouraging the discovery of their strengths, accessing their own knowledge, to involve them in their own process of change and help them find a "direction" to their problems. Through conversations and questions that enrich your story, discovering details that were overshadowed by the prevalence of the problem.

1.6 Actively listen to the effective and ineffective attempts made by the family, that is, their own theory of change and the problem, validating their experiences. Recapitulate and adjust in each encounter, they become necessary steps to arrive at this final product. The Social Worker shares through a recapitulation his impressions about what happened in the meeting and about the process that has been carried out so far. Afterwards, adjust these impressions by asking the person if they want to introduce any aspect that has not been taken into account. With this practice, we place the person as an expert who collaborates actively. Your qualifications or differences are important to us and to the support process. In this adjustment with the other, the Social Worker performs an opening movement, relaxes his or her gaze and includes that of the other, these dance steps form the collaborative space where the helping relationship will be supported and letting them show us what works for them and what hasn't helped them change. They are the ones who know about their lives.

1.7 In each of the help process meetings, request feedback from the person / family about our work, allowing them to disagree with our intervention and adjusting it based on their suggestions. Asking for feedback is a cooperative practice and as such, generates competence and proximity with the person and hope in the helping relationship. We convey that your opinions are important to us and to the process, and that we are also aware that our opinion about the meeting is partial and we need your feedback to adjust the way we are accompanying in the help process.

1.8 Question resistance to change, focusing our interest on investigating what must happen for change to take place, rather than focusing our efforts on combating the supposed position of no change. Resistance to change will not be observed unilaterally, but rather as a

bottleneck in the relationship of the aid system (Social Worker and family). Thus, placing ourselves in a collaborative framework will allow us to establish a connection, not only with people who are motivated, but also with those who are supposedly eacia. We are aware that the level of co-construction achieved will not be the same in all individuals / families, or in all professional contexts. Despite this, we maintain that the helping relationship should be guided in all cases, even in the most complex or vulnerable ones, by cooperative practices, making anchors at the connection points and expanding genuine curiosity towards small points of agreement. (Pastor, 2012).

1.9 Maintain a discreet professional practice. Finally, it is about questioning the implicit or explicit superiority of the professional over the person requesting help. Placing yourself in a professional position of "not knowing" does not mean giving up knowledge, but rather placing the role of the Social Worker in generating conversations and questions that help clients connect with their own knowledge and strengths, and from there, can visualize and define their own change process. Madsen (2007), warns of the importance of being cautious about when and how to offer our wine to customers. The knowledge of the person / family should be the first to stand out, later the knowledge built in joint meetings and finally, if deemed appropriate, the knowledge of their own professional or personal experiences would enter the conversation.

2. Collaborative relational diagnosis. The process of building a co-diagnosis

In the previous section, we have pointed out the relational bases on which we have relied to build collaborative conversations. Now we will go on to describe how these configure the collaborative diagnostic process that we propose. This makes sense in a process of help that from the first encounters, is built from the active collaboration of the person / family. For us it is not simply a matter of making a diagnosis by systematizing the information as a final product. There is a key step, it is about creating a cooperative space in each meeting that allows sharing the co-built knowledge and that they, as experts that they are, can adjust and specify the information about their lives.

The help system will be in a position to co-construct a relational and collaborative diagnosis, if the study conversations (interviews) have been spaces for joint research, and these have made it easier for clients to access their own knowledge (Madsen, 2007); if they have allowed us to approach shared definitions of the problem and if they have allowed us to discover together the values, strengths and existing or potential competencies of people.

This moment of diagnosis is specified when we agree with the client that knowledge about the situation is sufficient to identify the influence of strengths and the problem in their life. If this knowledge is shared by the help system, it will serve as a platform on which to co-build the intervention project for change.

From the formulation that we present, the process of construction of the co-diagnosis involves different steps:

Order and systematize the knowledge and micro-knowledge built throughout the collaborative conversations, held in the study meetings (collaborative relational diagnosis).

Create a "shared story" based on this ordering. It must be a story resulting from collaborative conversations and it will be shared and adjusted with the person / family in a meeting that we call co-diagnosis.

Co-diagnosis meeting: sharing and adjusting "the shared history" with the person / family, thus building the co-diagnosis, and finally, agreeing on the professional intervention contexts on which the intervention for change will be developed.

In this article, for reasons of extension, we will focus on step 1 (Order and systematize the knowledge and micro-knowledge built throughout the collaborative conversations, held in the study meetings.

–Collaborative relational diagnosis), which in turn, focuses on axes and areas of study. Next, we will describe a guide for this first step

2.1 Guide to order and systematize the knowledge co-constructed in the collaborative conversations held in the study meetings (collaborative relational diagnosis)

Next, we present the four axes, which in a transversal way, should interact with the fifteen study areas that we will present in the next point.

Axis I: Obstacles that slow down or prevent change, shortcomings and needs, vulnerability.

What are the obstacles that influence maintaining the situation of discomfort and / or the problem ?; Which ones prevent the person / family from getting out of this situation on their own?

Axis II: Capacities, competencies, knowledge, strengths and values , if these are reinforced or enhanced, can they facilitate change?

In both axes, it is a question of balancing the contents of the conversations built in each of the study areas and assessing whether they influence maintaining the problem (obstacles that prevent progress or improvement) or influence in the form of dynamic constructive forces (personal resources assets or potentials) that if reinforced can facilitate change.

Axis III: Time spent in the situation.

The variable "Time" will directly influence the forecast of improvement or change. For example, a stable problem situation for ten years will probably have influenced the chronification of interaction patterns, ways of doing things that will require more complex and longer-term interventions than if we are faced with a circumstantial situation, a crisis with little distance in the future. weather. It is about assessing the influence of time in each of the areas. Has the problem situation persisted for a long period of time? (chronicity); In which areas has stability been maintained and the problem situation has not been established (strengths); Is it a stable (structural) situation or a circumstantial (critical) situation in the life of this person / family?

It is also necessary to consider the interaction of Axis III (time) with the other axes: how has the residence time influenced the other axes ?; Axis I: what has been installed in your life, which influences as an obstacle to change ?;

Axis II: what strengths, competencies, abilities have been maintained ?; Axis IV: How has the permanence of a long isolated period of time influenced its evolutionary development ?; What challenges could he not, can or will he live?

Axis IV: Family life cycle.

Each stage of the family life cycle needs particular conditions so that evolutionary development can be more or less fluid. It is about relating each of the areas with the necessary conditions that the family should have in order to follow its own evolutionary development. Are there conditions so that family members can continue to manage the challenges of their stages of development?

2.2 Study areas to guide conversations

We now propose a set of study areas (topics for the conversations). In each of them we have introduced questions that could facilitate the systematization of the information constructed. These questions are aimed at awakening and enhancing the knowledge and knowledge of the person / family as well as generating a "joint investigation" on the mutual influence between the person and the problem. Each reader can expand or reduce the topic of the conversations according to the interest and / or need of the person / family.

Furthermore, due to space limitations, only in the first four study areas have we introduced, by way of example, self-questions that can help professionals to balance the axes with the study areas. We present these questions as balancing questions.

2.2.1. The working alliance generated in the helping relationship

We refer to the establishment of a helping alliance with the person / family as the common thread of a collaborative relationship. Without it, this whole process will not be possible. The relationship based on the help alliance builds a bond between professional and client. Both are important to each other, they learn from each other and this fact in itself is what generates the client's trust in a constructive relationship (Casement, 1989).

A relationship based on the therapeutic or help alliance entails stringing together four collaborative dimensions: a) engagement in the help process; b) emotional connection with the social worker; c) security within the help system, and d) sense of sharing the purpose of the helping relationship in the family (Friedlander et al., 2009). It involves offering a safe space where the person or family can trust, offering themselves as a close and available figure «be there for them», use an emotional tone in encounters and build an emotional bond with people. It implies establishing a common purpose on the issues that lead us to work together and expressing true motivation for it. Believe and see that change is possible in this family. It translates into visualizing ourselves accompanying the family from cooperation, as one more and finally, asking the person / family for feedback on how they perceive us, on our way of working with them (Gonzalez & Herrero, 2003).

The construction of the intervention context for change (Paola, 2012) and the construction of an aid alliance in the dimension of engagement defined by Friedlander, Escudero and Heatherington (2009), share relational practices that define the therapeutic intervention space. Through these practices, the person / family can perceive that their collaboration in the objectives and goals is stimulated and valued by the Social Worker. Perceive that their opinions about how the intervention is going to take place are taken into account, that their strengths are enhanced. You may experience that your person is valued differently from the problem and the problem as something different from your person. Experience that the small changes that are achieved in the course of the helping relationship are valued and amplified. Finally, the family may perceive that the climate that is generated in the helping relationship conveys hope and illusion that some kind of change is possible (Friedlander et al., 2009). We could ask ourselves:

How have we encouraged clients to speak out about their objectives and goals ?; How have we explained in detail how the intervention will be carried out ?; In what way have we left space for them to give their opinion and finally adjust the intervention to their preferences, as a result of their knowledge and previous experiences ?; How have we stimulated their participation in designing the aid process ?; In each meeting, in what way have we valued and amplified each small change that has occurred? How have we generated small expectations and validated their subjective experience?

Balancing questions:

Axis I. What aspects of the established relationship prevent change ?; What obstacles in the working alliance are influencing the non-change?

Axis II: How have we requested feedback on our way of conducting the helping relationship in each encounter? Since they are the protagonists of the process, have we stated that your input is important and necessary to us and to the helping relationship? From our point of view, it has generated an alliance of aid in the relationship? From the point of view of the person / family it has generated trust, respect, alliance ?; Trust, respect, the alliance built, does it play as an element that favors change?

Axis III. Is the relationship based on the work alliance helping to maintain stability in the family?

Axis IV: Has the aid relationship contributed to better management when moving to another vital stage?

2.2.2 Values and purposes that make up the life of the person / family

It is about talking about what the person / family gives more importance to, what they appreciate the most, what deserves their respect, what they treasure and do not want to lose because it is appreciated and valued. What purposes do you have for your life, what reasons or intentions lead you to want to change.

In the event that the problem is centered on a person or a relationship: What positive qualities best represent her, what gift does she have, what is remarkable about her ?; In what situations do these special qualities appear most ?; When did you first discover it and what did this discovery mean ?; From whom could she learn these virtues?; Are they family gifts and qualities ?; What other people share that the person possesses these special gifts and qualities?

Balancing questions:

Axis I. What detected values prevent the change ?; Which ones are influencing the non-change?

Axis II. Which ones are active and present ?; Which, if empowered, could facilitate change?

Axis III. Is some value or purpose influencing the situation to stabilize over time ?; What purposes and values have helped maintain stability in the family?

Axis IV. Do the values and purposes of the family hinder or allow the family to move from one stage of the life cycle to another?

2.2.3 Family structure and dynamics

It is the result of conversations held on their relationship map (genogram), which identify problems or situations of discomfort. These also motivate the family to talk about their own resources and strengths, highlighting the interactions that have reflected strength and competence between them, or those moments in which the family has stated that they have a good time when they share moments together, or simply sharing satisfaction with what the family says they do well.

It is advisable to explore: a) values, rituals and customs that the person / family has maintained despite the problem situation; b) rules, family myths and belief systems; c) family loyalties and delegations, family hierarchy; d) boundaries between members and outward; e) alliances, coalitions and triangles between subsystems, as well as patterns of communication between members and types of family cohesion.

Balancing questions :

Axis I. What limits and rules between subsystems prevent change ?; Which ones are influencing not to change?

Axis II. What alliances are present ?; What possible alliances, if strengthened, can facilitate change?

Axis III. How long that communication is kept locked / warm ?; C OW is influencing the situation stabilizes or becoming chronic in time ?; What rituals and customs have helped to maintain stability in the family over time, despite the problem situation?

Axis IV. Does the level of cohesion in the family make it easier for adolescents to exchange experiences with other young people?

2.2.4 Exceptions or isolated achievements

De Shazer (1990) defines exceptions as those times when the problem has not been present: In what situations has the person / family managed to avoid the problem ?; What did you do?; Under what circumstances have you been able to combat it, cope with it, and reduce its influence? What has this achievement, albeit temporary, represented for the person / family ?; Which people around you realized that, on this occasion, the problem had been superseded? And what did they see differently in them to know that something had changed ?; What have these isolated accomplishments meant in your life, something positive, negative, a little of both?

According to the person / family, what things should happen so that the influence of the problem in their lives is less, so that these isolated achievements become permanent in their life?

Balancing questions:

Axis I: Not applicable

Axis II. ¿ What he does family managed to dodge this time, discomfort ; What things, if they are enhanced, can influence increasing the occasions where the problem is not there?

Axis III. What was the last time the family experienced an achievement ? What circumstances or things are permanent in your life ? What things are able to maintain family stability?

Axis IV. Did this isolated achievement facilitate any experience of openness in the evolutionary development of the person or of any member of the family?

2.2.5. Emotional needs

We take into consideration Glasser (1975), who expanding Maslow's Theory of Needs (1954), proposes that, among others, the psycho-emotional needs of human beings can be synthesized in two. Their dissatisfaction will generate, according to Glasser, deep discomfort and significant personal and relational precariousness. In the first place, the author points out the need to love and to be loved, that is, the need to bond, to be confirmed as a subject, the need for belonging and inclusion, the need to feel meaningful to others. Second, the need to give meaning to our lives, that is, to give them a transcendent meaning in the concrete, to experience subjectively and relationally that our life has a meaning. Along this broad line, conversations can take place in the following territories:

What role does the socio-cultural context play in maintaining the problem or in the resources that facilitate change ?; What map of relationships has contributed to the construction of your current identity ?; What has been your history of relationships of attachment and detachment, of dependency or autonomy? What goals and purposes do you have for your life? What do you think you deserve? What is your vision of yourself? At present, what is your capacity to generate affective bonds on which to lean ?; What people, purposes, dreams, events, facts or circumstances have made it easier for the person to continue to function despite their suffering or discomfort ?; What helps or influences have you had to build a constructive vision of yourself (self-esteem) ?; Do you recognize and / or value the achievements you have made? (selfconcept)

2.2.6 Personal / family reorganization in the face of crises

Conversations held about how the person / family has reorganized in the face of a loss, a crisis typical of daily life, or a critical or traumatic event (Wainrib & Bloch, 2001; Froma, 2004):

What critical events does the person / family face that are typical of the life stage they are going through ?; How do you manage them, how do you deal with them? What is your usual style of conflict resolution or crisis coping (assertive, aggressive, introverted, or a little

of each) ?; What prevents you from coping with the situation on your own ?; According to the person, what internal and external resources would help him better manage the situation? What are the needs of the family life cycle that they go through and to what extent are they covered? Does the problem situation experienced by the family allow its members to continue evolving in their life or, on the contrary, should they postpone their development due to the influence of the problem?

Is the person / family willing to ask for outside help ?; Can you introduce flexibility in the face of possible needs that you must face? Can you temporarily make changes in your life to cope with the situation ?; What is your strength in the critical situation you are going through ?; What sustains them ?; How do you manage to maintain a relationship with hope, that things will improve? and What is your vulnerability?

2.2.7 Interpersonal relationships

Presence or absence of experiences of resilience and contribution of significant figures to their life, It is the result of conversations about his relationship map (eco map) with figures who have been significant in his life. We have taken special care not to construct questions in only one dimension. We seek to introduce questions that allow us to go from a unidirectional to a bidirectional story, in the sense that the person was not a passive recipient of the help of these significant figures, but that she also contributed in their lives (White, 2016). These significant figures saw something in the person, who helped her and in this help, they also enriched their lives.

Another aspect to take into account is to broaden the concept of a significant person. We generally refer to real, living people who are part of our life. People who are no longer here but continue to exert an influence on us, as well as fictional characters or heroes who have inspired values or inspired us in our lives are also part of our lives and influence it (White, 2016).

What kinds of relationships do you have with your network of friends, co-workers, and neighbors? What is the quantity, quality and frequency of these relationships ?; What is the nature of the relationships you maintain (independent, passive, submissive, dependent... a little of each one of them) ?; What people are significant in the life of the person / family and who can also count on them at this critical moment ?; What relationships and supports.

Does the person believe that it is necessary to maintain, strengthen or reactivate in his life? Were there significant figures in your life who contributed to your values, aspirations, dreams ?; What values helped you ?; How did they contribute to life and the formation of your identity ?; What did these figures see and recognize that was not valued or visible to their family? In what aspects did the person contribute to the lives of significant others ?; Is there awareness in the person about what it could mean for them to help them? What was it about her, as a person, that helped these figures notice her and help her? Is there the consciousness that was not a passive recipient of the help of these significant figures, but that it also contributed in their lives ?; At present, are some of your values still present and are they testimony to the experience shared with these people? What values and knowledge do you treasure by sharing experiences with these people, do you want them to continue to be present in the future of your life?

2.2.8 Attribution, meaning, experience

Do you attribute the problem situation the person is going through? It is about building conversations about the place that attribution occupies in your life (internal and external locus of control), or if, on the contrary, you attribute that the problem is due to aspects related to your person, external causes or a little of both (Bandura, 1999):

What weight does this attribution have in the process of change ?; How does it work or how to overcome ?; What meanings and consequences does the problem have for the person, for his family, for his network, for the society in which he currently lives? What meanings and consequences does the problem have in your culture, in your community of origin? How do you live this situation ?; Like a temporary pothole, like a personal failure ?; What attempts at solutions have worked for you ?; What attempts were unsuccessful ?; What is your general attitude to life and to this specific situation?

2.2.9 Influence of the community environment and personal network

Conversations in this area refer to knowledge about the influence of the neighborhood, the community environment, and the relationships in the problem situation. It also explores how the person's participation in the community, their associative life or, on the contrary, their isolation, are linked to the development or maintenance of the situation:

Do you have meeting spaces, associations, facilities ?; How does the neighborhood lifestyle influence your values, your identity ?; How I know their participation in community life concrete ?; Is your participation valued by the community ?; What value does this participation represent for the person ?; What does it bring you ?; What are your interests ?; How or in what things do you spend your free time? Do you like it or do you find it satisfying?

Social perception / social acceptance of the problem situation that the person / family is going through: drugs, alcohol, prostitution, abuse, poverty, mental illness, rare diseases, disability, school delay, marginalization, delinquency.

How does isolation influence the problem situation ?; What is the degree of isolation ?; How is it related to isolation (good, bad or a little of each) ?; How long ago has isolation settled in your life ?; What motivated it ?; Does anyone know of his isolation?

2.2.10 Influence of the professional network on the maintenance and / or change of the situation

It refers to the conversations about the relationships established with the different professionals (eco-map) at the present time or those that at some point in the past helped them, the type of link established and the influence it had on their improvements or maintenance of the problem situation:

What messages issued by professionals does the person / family remember that have contributed to their identity ?; What kind of relationship do you have with the professionals and services (Systems Larger than the Family –SMAF)) with which you are currently connected ?; How does professional ecology influence the maintenance of the problem or, on the contrary, in the development of its competencies for change ?; How does the intervention and the relationship between the different professionals who are present in their life influence the life of the person / family?

2.2.11 Family economy

Knowledge about the organization of the family budget, the use and value that is given to money. Does the family income allow meeting the basic needs for their survival and development ?; Does said income allow family security ?; How is the family budget organized ?; Is there a dependency on services to survive ?; What meaning does money have in the family unit ?; Who manages the money in the house?

2.2.12 Housing as a relational space

It refers to the conversations held about the family home and also to the impressions shared with the person / family as a result of a home visit, linking home as their relational space, as well as housing as a social right.

It seeks to talk about the house: Is it a space that facilitates or hinders privacy (overcrowding) ?; What is the housing tenure regime ?; Does the space have habitability conditions (precariousness, shanty town) ?; Is said house adapted to the physical conditions of the people ?; Does its location allow fluid contact with the neighborhood / community? It is also important to know the social policies of the municipality on housing and the possibilities or impediments to accessing it.

2.2.13 Work, occupation, job training and skills

Referring not only to sociological data on whether or not they have a job and the duration of it, but also to work as a source of recognition or frustration. The conversations would be about knowledge about the employment situation of family members, their relationship with the labor market, professional qualification, training, educational level, skills and abilities for the development of certain jobs , if there is any disability and / or impediment and how they manage it.

At a more relational level, to know what does the work they are doing mean to the person ?; A means of subsistence only ?; Is it a space where you can develop your skills and abilities? Do you find recognition and support, or is it a space of discrimination and isolation?

2.2.14 Degree of motivation for change and expectations of success to overcome / manage the situation

Referred to conversations that seek to share the expectation of success in relation to the change process (Bandura, 1999).

What are your expectations of success that your situation can improve ?; What level of confidence do you have in being able to get out of the situation you are going through? What experiences of success and failure do you carry behind your back? Do you think you can do something to make the situation change or improve ?; Are you aware of the effort and sustained motivation you will need to change or improve your situation ?; What is your level of hope in yourself, in your relational environment, and in the helping relationship?

2.2.15 Relationship that the person / family maintains with health and illness

On the one hand, it refers to the conversations built on the person's relationship with health. Identifying the guidelines, however small, that make up your healthy lifestyle.

On the other hand, there are the conversations built on the relational history of the disease, not only as something that affects the individual and subjective, but also how it impacts their close and social relationships, family, friends, and society. society:

How does the person / family experience the disease in their daily life ?; How did the disease come into your life ?; What interrupted or did not allow to start ?; How does the person relate to what happens to their body ?; How do you live it ?; How does treatment affect your life ?; How does the experience of the disease influence your vital energy, your relationships, your lifestyle, your aspirations, goals, dreams? What impact does the disease have on family, friends, at work? What is your degree of mental and physical dependence ?; How do you live it ?; Is it a circumstantial, chronic, terminal situation ?; What place do shame and envy occupy? Are they experienced as elements that facilitate or block social interaction with "healthy" people? Can you share these emotions with your family, friends, health professionals ?; Do you need external caregivers ?; How do you experience dependency ?; What expectations and

desires accompany you in your life at this time ?; What teams of health personnel do you have ?; What is the social stigma of the disease you suffer from?

D. CONCLUSION

The collaborative help relationship is built on a process of conversations in which there are no impositions of work plans and there is no room for labeling or categorizing problems. The conversations we contemplate mean creating a framework of mutual discovery. Social Workers are co-participants in the creation of processes that generate new meanings and alternative truths where people's identity is discovered and visualized from their own knowledge.

Unlike the classical diagnosis, the relational and collaborative diagnosis is woven and co-constructed with the other. Professionally, it involves consciously generating an open space, making room for the voice and the meanings of the other. It implies not only a change in language and way of thinking, it also implies a change in the ways of doing things in daily practice. Ultimately it is, from our point of view, to recover the essence of the practice

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