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## CHAPTER 10

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### Sustaining a Collaborative Practice in the “Real” World

In this book, I have emphasized the importance of how we approach clients and highlighted conceptual models and clinical practices that help clients and families envision and develop preferred lives. However, the full enactment of these ideas requires attention to the context of clinicians' work. The organizational cultures in agencies shape workers' interactions with clients. A relational stance of an appreciative ally is enhanced by institutional structures that support an appreciative organizational culture. Much of my more recent work has focused on helping community agencies develop institutional structures and organizational cultures that support collaborative clinical practice. In the process, I've encountered three interrelated challenges. First, collaborative approaches run counter to many dominant professional assumptions and practices. In that context, they can seem strange or unusual, and workers embracing these ideas can feel as though they are working “against the current” or somehow breaking unspoken rules or conventions. They may come to question themselves, become tentative in taking up these ideas, and slide back into old habits. It is difficult to support a shift in clinical ideology in isolation.

Even when clinicians feel confident and solidly rooted in these ideas, there are pressures and demands that can pull them away from collaborative, strength-based practice. The documentation requirements of licensing agencies and current reimbursement structures direct workers' attention toward problems and away from resourcefulness. Taken-

for-granted professional ways of speaking privilege professional expertise and certainty over collaboration and curiosity. And managed care policies and the current push for evidence-based practice emphasize pre-established, replicable procedures over thoughtful and flexible clinical principles and can lead to a simplified conceptual process that erodes clinical imagination. These pressures force clinicians to become, in a sense, “bicultural,” pursuing preferred practices while responding to existing organizational demands.<sup>1</sup>

Finally, high workloads and dwindling resources lead to increased job stress and make it difficult to engage in reflective practice. Organizational responses to funding cutbacks (such as moving from salaried to fee-for-service positions, reducing supervision time, and cutting training budgets) exacerbate this situation by increasing professional isolation and reducing opportunities for learning and reflection. These effects show up in worker complaints such as “I don’t have time to think” and “I’m working too hard to work smart.” In the midst of organizational turmoil and competing demands, taking time to reflect on preferred practices may seem like an unattainable luxury. However, unless we periodically step back and reflect on the intentions, hopes, and preferences that bring us to this work, we run the risk of losing our mooring and becoming automatons. In this final chapter, I examine these interrelated challenges and offer beginning ideas to shape our efforts in addressing them.

### **MAINTAINING A REFLECTIVE PRACTICE**

The Introduction to this book began with the story of Kire, a relatively new family therapist who faced a challenging clinical dilemma and wondered, “What the heck do I do now?” The Introduction continued by emphasizing the importance of taking time to reflect on larger questions such as why are we meeting with families, what is our purpose in meeting with families, how are we relationally positioned in our conversations with families, how are we thinking about families and problems in those conversations, and, finally, what are we saying and doing (and not saying and not doing) in those conversations?

The proposal that we take up these questions amid organizational frenzy may seem like an absurd suggestion. I contend that it is a basic necessity that actually saves time. I admit that this proposition can require a leap of faith, but teams that have taken that leap uniformly report that it is time well spent. One example is a team of child protective workers in an impoverished urban area who moved from crisis management to reflective practice. The team members committed to a

weekly group supervision that focused on how they thought about families and emphasized the values that organized their work. They looked for successful interactions with families and traced out their small, daily practices in those interactions. The group members also recognized that their decisions with families had consequences and attempted to anticipate possible consequences and adjust their practice in advance. This led to a profound shift in which they came to encounter very few unpredicted crises and to have better relationships with families, with significantly fewer children in placement (which meant less collateral work and paperwork and more time for contact with families). Their motto became “Nothing is a crisis” (quite an accomplishment in child protective services), and they had a very low staff turnover rate over 5 years, which contributed to further stability and tremendous cost savings to the department.

Reflection does not have to be time-consuming. It is possible to do it in brief stints. For example, my spouse and I have different approaches to housecleaning. I prefer to do it in large 3-hour stints, whereas she prefers to do it in small 2-minute stints (in between making toast or coffee). She is able to find significantly more 2-minute stints and accomplish much more cleaning. Similarly, in our work, we can develop brief daily practices of reflection (e.g., briefly noticing the sky or trees around us and taking a breath when we step outside, or taking a 1-minute pause before meetings to briefly consider “What is my purpose in being in this meeting, and what tendencies or ways of responding would I like to bring forward and hold back to help me accomplish that purpose?”). I invite readers to consider what small, daily practices could help to slow down your day or offer a momentary break from a frenzied pace. Beginning here helps us to develop a foundation for addressing these other challenges.

### **EXAMINING THE VALUES, ASSUMPTIONS, AND PRACTICES THAT SHAPE PROFESSIONAL LEGITIMACY**

Many clinicians committed to collaborative approaches have experienced their work at one time or another as being perceived by others (and perhaps by themselves) as somehow less “professional.” This undermining of the professional legitimacy of alternative practices occurs in a broader context of taken-for-granted professional values, assumptions, and practices. The concept of “discourse,” previously used to examine the influence of unspoken cultural values, assumptions, and practices on clients, can also be helpful in developing a better understanding of workers’ experience. Rachel Hare-Mustin (1994, p. 19)

defines discourse as a “system of statements, practices, and institutional structures that share common values.”<sup>2</sup> Professional discourses include taken-for-granted assumptions (e.g., effective therapy begins with a thorough assessment of the problem, ethical therapy requires appropriate boundaries, etc.), unexamined professional habits (e.g., the use of DSM diagnoses, the use of professional jargon, the ways in which meetings are organized, etc.), and the professional institutions within which these assumptions and actions exist. These are all intertwined. Taken-for-granted professional assumptions shape how we act, and our actions maintain prevailing assumptions. The interaction between assumptions and practices occurs in the context of economic, political, and cultural institutions that both support and are supported by this process. In mental health and social services, these institutional forces include such things as (among others) paperwork requirements, insurance forms, course work requirements in graduate school, questions on licensing examinations, conference workshops, materials in professional and self-help books, pharmaceutical advertisements, and television shows about mental illness. All of these contribute to a collective sense of how things “should” be.

Discourses function as a set of “truth claims” or invisible assertions that sit in the background of our work and are difficult to question. In our lives, we are subjected to multiple and often conflicting discourses (e.g., there is currently a push for both more strength-based, collaborative approaches and more medicalized approaches, each of which vie for legitimacy). However, over time, certain discourses become dominant and hold more sway in professional cultures. Dominant discourses both reflect prevailing social and political structures and tend to support them. For example, language such as “service providers and service recipients” both represents particular power relations between helpers and clients and perpetuates those dynamics. Professional discourses shape professional identity and how we, as clinicians, understand our work. Assumptions and practices that fit within dominant discourses make sense and are legitimized. Ideas and practices that fall outside dominant professional worldviews don’t “fit” and can be experienced as strange or weird. Often, this “lack of fit” is hard to put into words, but is experienced as a sense that something is just “not right.” In this way, discourses contribute to the construction of professional identity and constrain alternative possibilities.

Clinicians seeking to embrace collaborative approaches in traditional settings often find themselves at the center of conflicting pulls growing out of a medical model and a more collaborative approach. This experience can have disorienting effects on their professional sense of self and their interactions with colleagues. In my own work,

I've found it useful to place the challenges that arise here in a context of three sets of juxtaposed professional discourses (deficits and possibilities, professional expertise and collaboration, and protection and accountability). Although each juxtaposition could be seen as an oppositional dichotomy (either/or), I prefer to view them as differing pulls (both/and). The goal of these juxtapositions is to provide a framework for better understanding the challenges that practitioners can experience. Although the three are complexly intertwined, in the following discussion I separate them out and briefly examine each in turn.

### **Juxtaposing Discourses of Deficits and Possibilities**

The first juxtaposition is a discourse of deficits and a discourse of possibilities. An emphasis on deficits is reflected in the common assumption in mental health and social services that our job is to identify problems, discover their causes, and then intervene to cure or ameliorate those problems. This assumption is reflected in (and sustained by) the common practice of writing assessments with an emphasis on problem, precipitant, risk factors, and diagnosis. An example of this emphasis on deficits in action comes from the experience of a woman who recently started social work school. She describes a number of small classes that begin with unstructured check-ins and notes the following:

“Most people talk in check-ins about things that are bothering them, and I often wonder if they find these things because they look for them. I think we can invent problems this way. Sometimes I wanted to tell the class about the wonderful morning I was having or how excited I was to be on this journey, and I found myself worrying that they'd think, 'She's out of touch with her emotions and what is *really* going on for her.' ”

This drift toward emphasizing problems over possibilities (e.g., “Here's what I'm learning, here's what I'm excited about, here's who I'm becoming in this program,” etc.) reflects the operation of a discourse of deficits (the unexamined assumption that we “should” be talking about problems and the practices that accompany that assumption) as well as a subtle socialization of graduate students into that way of operating as professionals.

An emphasis on possibilities is reflected in attempts to help families envision and live into nonproblematic, preferred lives. There is a focus on *what is and could be* rather than on simply *what isn't and should be*. This assumption is reflected in (and sustained by) practices such as envisioning preferred directions in life and reauthoring conversations that

develop broader stories. Although an emphasis on possibilities has many beneficial effects on clients (outlined in Chapter 1 under “Advantages of a Belief in Possibilities and Resourcefulness”), it can also be experienced as minimizing problems and may leave clients feeling unheard. It’s important to strike a balance between problems and possibilities and to make sure that we address both. It’s also important to acknowledge that an emphasis on deficits receives significantly more institutional support than an emphasis on possibilities. Although there is growing institutional support for strengths-based practice, a discourse of deficits receives considerable institutional support from managed care requirements (the need to show medical necessity for reimbursement), clinic licensing requirements (the requirement of diagnosing clients), and professional training (the prevalence of courses that emphasize psychopathology).

### **Juxtaposing Discourses of Professional Expertise and Collaboration**

A second juxtaposition is a discourse of professional expertise and a discourse of collaboration. Many traditional approaches are informed by a medical model that positions helpers as “experts” who assess clients, develop treatment plans, and implement interventions designed to bring clients more in line with “appropriate functioning.” There is a privileging of professional knowledge that can invite practitioners into professional certainty with attempts to assign professional meaning rather than elicit client meaning. The assumption of professional expertise is reflected in (and sustained by) the ways in which assessments are conducted (who asks the questions and writes the assessment) and “cases” are presented (the encouragement of objectivity, professional distance, and certainty in delivering formulations).

An example of how the unquestioned acceptance of professional expertise has both seeped into and is supported by broader cultural assumptions comes from an encounter with an old neighbor from my own childhood whom I came across years later. When he learned that I was a psychologist, he remarked, “Oh, so when I say hello, you’re the person who knows what I *really* mean by that.” This assumption that there are experts who know more about a person’s experience and its meaning than the actual person can become quite problematic. It runs the risk of obscuring client knowledge, which limits our available collective wisdom. And it has potentially disempowering effects on clients as they are asked to “hand over” their expertise on their lives to professionals. This privileging of professional knowledge over client wisdom is supported by (and in turn supports) the social, political, and economic

institutions that constitute the mental health industry. An example of this is heard in a radio ad for a for-profit psychiatric hospital for adolescents. The ad listed a number of problematic (yet not uncommon) adolescent behaviors and concludes with, "Are you afraid that you are losing your child? Call us for a free consultation and we'll give your child back to you." The free consultation was with a clerk from the hospital intake department. This corporate construction of a product need has become a profitable enterprise that both supports and is supported by this highlighting of professional expertise.

An emphasis on collaboration honors the expertise of all involved parties. Clients are viewed as experts on their experience, with significant abilities, skills, and know-how, and clinicians are viewed as experts in hosting conversations that invite reflection, expand possibilities, and open space for the consideration of alternative experiences, views, and actions. This assumption is reflected in (and sustained by) practices like collaborative inquiry and a therapeutic stance of "not knowing" or cultural curiosity in which we approach each family as a unique culture and seek to understand its experience of the world. Although an emphasis on collaboration encourages client participation and involvement, it can also support a tendency to minimize the leadership role of clinicians in therapeutic relationships and obscure the power dynamics of those relationships. Again, it is important in our work to strike a balance between these differing pulls and simultaneously acknowledge that they respectively receive differing levels of institutional support. In our culture, certainty and expertise are often given more credence than curiosity and collaboration.

### **Juxtaposing Discourses of Protection and Accountability**

A final juxtaposition is a discourse of protection (professional responsibility *for* clients) and a discourse of accountability (professional responsibility *to* clients). A focus on protection is based on the assumption that clients are in a vulnerable position and that professionals have a responsibility to appreciate that vulnerability and ensure client safety. This assumption is reflected in (and sustained by) practices of confidentiality, involuntary hospitalizations, and the filing of neglect or abuse allegations when children are at risk. These practices are crucially important in our field and I am not in any way intending to demean them. A focus on protection can also be reflected in concerns about clients seeing their records (legal rights notwithstanding), disclosing diagnoses to clients, or having clients participate in clinical discussions. At times, this focus can have paternalistic effects as helpers take on increasing responsibility for making decisions about clients' lives. The ways in which helpers

respond to issues of client vulnerability and safety can be inadvertently disempowering of clients and undercut client welfare. While it is important to appreciate the positive intention behind a protective impulse, we can also critically reflect on possible paternalistic effects. Examples of such effects in a discourse of protection in action come from a therapist who encourages the parents of a developmentally delayed girl to lower their hopes for her in her life, or the head of a clinical review team who forbids a mother to attend a meeting because it might be too stressful for her. The purpose of these examples is to highlight the “voice of protection” operating in the background so that we can reflect on its effects and decide how we would like to relate to that voice. I am not suggesting we discard professional responsibilities, but that we carefully consider how we carry them out. A discourse of protection is supported by hierarchical professional relationships (“The doctor will see you now”), professional language (“cases” and “case managers”), and liability concerns (which have only grown as resources have diminished and more risky situations are being handled in the community).

A focus on accountability assumes that clients are the best judges of the effects of professional actions on them and that our work benefits from taking client feedback into account. This assumption is reflected in (and sustained by) practices of transparency in which we share our organizing thoughts and assumptions in order to help clients become more aware of why we are asking what we are asking so as to help them participate on a more equal footing. It is also reflected in (and sustained by) practices that elicit client feedback in order to ensure that our efforts have empowering rather than inadvertently disempowering effects on clients. Although a discourse of accountability can have profoundly empowering effects on clients, it is also important to keep in mind client vulnerability and carefully consider factors that might constrain clients from speaking openly in giving their feedback. In responding to client feedback, it is also important to carefully consider our own thoughts and opinions, and to remember that working in partnership requires an appreciation of helpers’ voices as well as clients’ voices.

### **REFLECTING ON PROFESSIONAL DISCOURSES**

In reflecting on this juxtaposition of professional discourses, it is important not to view these descriptions as polarized dichotomies nor to misinterpret the discussion as simply a call to abandon “bad” discourses in order to step into “good” ones. We are all continually operating within a variety of discourses, and each may have both beneficial and negative effects on our work. The important point here is to acknowledge that

our taken-for-granted assumptions and practices have effects and to encourage reflection on those effects. At the same time, a focus on deficits, professional expertise, and protection receive significantly more institutional support in our field than a focus on possibilities, collaboration, and accountability. Ways of thinking and practicing that fall outside dominant discourses are often seen as weird, illegitimate, or downright strange, and can easily be marginalized.

Our work can be enriched when we examine the discourses that organize it and consider how those discourses fit with our preferred ways of relating to clients and families. Although professional identity has traditionally been rooted in client deficits, professional expertise, and professional responsibility *for* clients, it is interesting to ponder what a definition of professionalism might look like grounded in possibilities, collaboration, and professional responsibility *to* clients. The accusation of acting “unprofessional” has often been used to police professional actions. Imagine the effect if a definition of professionalism included accusations like:

- It is unprofessional to inquire about difficulties without having first built a foundation of competence, connection, and hope.
- It is unprofessional not to actively elicit client or family members’ wisdom that could contribute to resolving difficulties in their lives.
- It is unprofessional to use objectifying language in any clinical discussion without considering how clients might experience it or how it might shape our thinking about clients.
- It is unprofessional not to actively think about the ways in which our own assumptions about race, gender, class, and sexual orientation affect our interactions with all clients.
- It is unprofessional not to routinely solicit clients’ feedback about their preferences for the direction of therapy and the effects of our actions on them.

I invite you, as a reader, to consider other examples of “unprofessional” behavior within this new paradigm. The goal of this exercise is not to replace one set of professional specifications with another, but rather to expand our options in defining “professionalism” and increase our awareness of the discourses that operate on us all.

The following questions provide an opportunity for further reflection about the discourses that shape our professional identities:

- What are the taken-for-granted assumptions about what counts as “professional” behavior in your work context?

- What might be some of the effects of these assumptions on your relationships with clients, other colleagues, and your professional self?
- Which organizational assumptions and practices invite you to step into collaborative approaches, and which hold you back?
- In what ways have you continued to embed your work in collaborative approaches in the face of organizational assumptions and practices that make it difficult?
- How have you done that, and what has supported you in doing so?
- How can you draw on and further embed your work in organizational assumptions and practices that support you in developing your preferred clinical practice?

Finally, as has been highlighted repeatedly, the enactment of preferred directions in life and work is considerably enhanced by a community of support. The following reconnection questions can help clinicians develop allies for preferred ways of working:

- What would be included in your definition of “professionalism” (a useful format for this might be “I am committed to grounding my work in a spirit of \_\_\_\_\_”)?
- How did that commitment come to be particularly important to you? What does it say about your hopes and dreams for your work?
- As you think back across your life, who stands out as someone who would recognize and appreciate your efforts to keep your work grounded in this commitment? (Please feel free to search broadly in thinking about the answer. You might identify a current colleague; a person in your life outside work; a teacher, mentor, or fellow student in your professional training; someone who has passed on; an author or presenter whom you respect; a book or article you’ve read; a client you’ve worked with; etc.)
- How is this person important to you in your life? What does he or she know about you or what has he or she witnessed that would tell this person that this commitment is important to you? How do you think the person’s witnessing of this commitment may have touched his or her life? If this person were somehow listening in on your responses, what do you think he or she might be thinking about them?
- What’s it like for you to think about this person’s response and invoke his or her presence? What would help you hold onto this person’s presence (virtually or actually) in your work?

The development of a community of support can provide clinicians with a strong foundation for pursuing preferred practices in the face of implicit pressures to “fit in.” It is important here for clinicians not to contribute to the development of an “us and them” mentality in which they develop a community of support in order to ignore and discount concerns raised by colleagues. Rather, the purpose of these questions is to help clinicians respond reflectively to others’ feedback without being undermined by that feedback. The questions above are an important start to help us, as clinicians, to shift our relationship to professional discourses that marginalize collaborative practice. However, we can go further and develop institutional structures that actively support collaborative practice.

### **BUILDING INSTITUTIONAL SUPPORTS FOR A CLINICAL PRACTICE OF POSSIBILITY, COLLABORATION, AND ACCOUNTABILITY**

Just as clients benefit from a supportive community standing behind them, the full development of a collaborative clinical practice requires organizational support. Community agencies committed to this approach can support it by developing organizational cultures that embed clinicians in an atmosphere of respect, connection, curiosity, and hope. To offer beginning steps toward this goal, the next sections examine ways to shift clinical discussion formats, clinical and administrative paperwork, and quality assurance practices to help institutionalize this atmosphere.

### **RETHINKING CLINICAL DISCUSSIONS**

As a result of a workshop about parent involvement, a protective worker insists that a mother attend a team meeting about her son’s future. At the meeting, six different team members in turn begin describing their respective observations about the mother’s difficulties in relating to her son. Their language is filled with acronyms and professional jargon. The conversation increasingly becomes a meeting of helpers talking about the family rather than a meeting with the family about services that might be helpful to them. The worker becomes concerned about the mother’s reaction to this intense scrutiny of her incompetence as a parent, but doesn’t quite know how to interrupt the process. She begins to wonder whether this idea of parents being present at professional meetings is a huge mistake.

There has been an important increase in parent participation in professional meetings. However, we need to move beyond parents being *present* at meetings to parents being a *presence* in meetings. Ann Turnbull and Jean Summers (1987) have likened this shift to the Copernican revolution in the natural sciences. Copernicus suggested that the sun rather than the earth was the center of the universe and revolutionized science. The parallel revolution in mental health and social services would be to place the family at the center of the universe and view the service delivery system as one of many planets revolving around it. In this reorganization, we move from parents attending meetings to families being at the center of meetings and helpers moving into a primarily supportive and facilitative role (with space also being made for the sharing of professional wisdom as one of multiple knowledge sources). Some important first steps in this revolution would be to dramatically expand our efforts to include clients in meetings, to remember that ultimately the goal of such meetings is to help clients in *their* lives, and to organize our meetings in ways that increase client influence and participation. If clients can't attend, we can outline what is likely to be discussed, ask how they would like their voices brought into the meeting, and jointly develop ways in which we can bring the conversation from the meeting back to them. Although these are crucial initial steps, the task of fully supporting parents in becoming a *presence* in meetings about their lives requires a shift in our meeting formats and the ways in which we speak about families, both in meetings they attend and in those they are unable to attend.

### **Clinical Meetings as Definitional Ceremonies**

Broadly speaking, we can identify two types of clinical meetings. One type may be generically classified as "determination meetings," in which there are efforts to generate a particular direction in the work. Examples of these meetings are educational plan meetings, foster care review meetings and residential discharge meetings. Another type could be generically classified as "formulation meetings," in which helpers, or helpers and a client, attempt to develop or clarify their thinking about the client's situation. Examples of these meetings include intake meetings, case presentations, multidisciplinary teams meetings, and group supervision or consultation meetings.

Based on the repeated assertion that every interaction with clients holds the potential to invite the enactment of particular life stories, we can view clinical meetings as definitional ceremonies or public rituals that shape client identities (Meyerhoff, 1978, 1982, 1986). With this in mind, it is important to consider the process as well as the outcome of

these meetings. We can continually reflect on the life stories that clients are being invited to enact in our meetings with them and how that fits with the stories we would prefer to be inviting. This is not to suggest that we gloss over uncomfortable or hard topics, but rather that we have difficult conversations in ways that encourage experiences of competence, connection, and hope as much as possible.

As there are many different types of determination meetings, it is difficult to outline structures that would apply across contexts. However, the following questions offer broad evaluative criteria that can help organize such meetings:

- Where are we, as professionals, positioned in this conversation? Is this where we would prefer to be positioned? How can we talk about difficult subjects so that we are more likely to be experienced by clients as appreciative allies without sugarcoating the topic?
- As clients participate in this meeting, are they more or less likely to experience themselves as being in a relationship with a problem rather than having or being a problem? How can we talk about problems in ways that support clients in viewing themselves as being in an ongoing and modifiable relationship with the difficulties in their lives?
- Is this meeting organized around an agreed upon focus that represents a proactive shared vision? How can we begin meetings by developing agreements on preferred directions in life (or acknowledging and discussing differences when they exist)?
- As clients participate, are they more or less likely to experience this meeting as a collaborative inquiry process? How can we organize our discussions in ways that amplify rather than constrain client influence and participation in this meeting? If we desire to deliberately constrain client influence and participation in this meeting, what is the rationale for that and how can we do that as respectfully as possible?

### **Reformatting Formulation Meetings**

Although this section primarily focuses on a format for formulation meetings, the overall format can also be adapted for determination meetings. Efforts to help families envision preferred directions in life, identify supports and constraints to preferred lives, and draw on their resourcefulness to address those challenges can be best supported by following a parallel process in clinical discussions. The following consultation questions support such a parallel process<sup>3</sup>:

- Who is in this family, and what are its members like outside the problem that brings them to you? Can you help us develop a three-dimensional picture of them and the context in which they live? What do you like about them, and what might they like about working with you? What do you feel proud of in your work with them (even if it is just a glimmer of pride)?
- What safety concerns would be important for us to not lose sight of in this situation? What has helped the family acknowledge and address these safety concerns?
- In 25 words or less, what would family say they're working toward with you?
- How would they say the work has been going (on a scale of 1–10)? What would they say is contributing to things going well? What would they say is getting in the way of things going better?
- How would you say it's been going (on a scale of 1–10)? What would you say is contributing to things going well? What would you say is getting in the way of things going better?
- What is it like for you working with this family? What do you like most about working with this family? What is the hardest thing about working with this family? What are you learning from working with this family?

This format begins by eliciting a picture of the family and clinician outside the influence of the problem in order to obtain a fuller picture of the situation. Throughout the questioning process, supervisors, consultants, or team members can look for elements of competence, connection, safety, and hope. In this process, it is important to not lose sight of moments in which families and/or therapists may feel incompetent, disconnected, unsafe, or hopeless. It is crucial to have a thorough understanding of elements of risk. At the same time, threads of competence, connection, and hope are the foundation on which safety is built. The first two sets of questions attempt to construct such a foundation and set a tone for the remaining conversation.

From here, we can ask questions about where therapy is headed from the family's perspective. The question "In 25 words or less, what would family members say they're working toward with you?" has three distinct elements. The phrase "In 25 words or less" asks for a concise summary, attempting to preclude a descent into a recitation of voluminous details. The phrase "family members" invites the therapist to step into the family's perspective, supporting an attitude of cultural curiosity. And the phrase "working toward with you" implies both a future orientation and a collaborative partnership. Inviting therapists to step into client experience and consider a proactive focus for their work can in and

of itself be quite useful. At the same time, when clinicians have difficulty with this question, it can direct attention to the need to develop an agreed-upon focus to guide collaborative work.

The remaining questions assess both supports and constraints for therapeutic effectiveness. Throughout this process, we can look for both forward movement (as defined by the family and clinician) and constraining interactions and beliefs. As constraints begin to emerge, supervisors, consultants, or the team can help workers shift their relationship to those constraints. If we think about constraints as separate entities, we can draw on externalizing conversations to examine therapists' relationships with those constraints. This process can then be thought of as a reauthoring interview to help therapists shift their relationship to those constraints. Conceptualizing this process as a reauthoring interview represents a different way of thinking about it. The focus is not on offering suggestions about what to do, but rather helping workers shift their relationship to constraints that hinder their effectiveness.

Workers who have reordered clinical discussions in this way describe beneficial effects. For example, consider one worker's response to such a format:

“It felt great to build on what I was doing right rather than to have people tell me what I should be doing instead and then try to correct their misperceptions. I'm walking out of this meeting with much more energy and confidence, and I think I will carry that into my work with the family. It's got a momentum of its own now.”

At the same time, old habits die hard, and as professionals we have a lot of work to do in developing more respectful ways of speaking about clients. An important step in addressing these habits is to increase our sensitivity to the possible negative effects of taken-for-granted ways of talking about clients. The next section offers a way to help us in this endeavor.

### **Integrating a “Client Voice” in Clinical Discussions**

The idea of integrating a “client voice” in clinical discussions is based on the social constructionist assumption that identity is shaped in social interaction and our conversations with and about clients have subtle, but powerful effects on clients' experience of self. With this in mind, it becomes important to carefully consider how we organize both the conversations we have with clients and our internal conversations about them. Our internal conversations about clients are often shaped by clinical discussions with other professionals. If clients cannot attend these

meetings, we can structure such discussions in ways that include “client voices” by having someone on the team sit off to the side, listen to the discussion in the role of the client being discussed, and subsequently be interviewed by the team about his or her experience of the discussion (Madsen, 1996, 2004).

This process can be facilitated in a number of ways. A typical format follows. After a discussion about the usefulness of therapeutic practices being accountable to the clients they are designed to help, participants are asked whether they would be interested in engaging in a process designed to increase their sensitivity to possible positive and negative effects of taken-for-granted ways of talking about clients. If they are willing, the process can proceed through the following steps:

- A clinician is interviewed about a family or presents information about the family to the rest of the group, who listen and then ask questions of clarification. One member of the team is chosen to sit to the side in the role of a particular family member who represents the “client voice” and listens but does not participate in the discussion.
- The group conducts a reflecting team discussion about the material presented.
- The clinician reflects on the team discussion.
- The group interviews the person who has listened in the role of the client voice about his or her experience of the discussion.
- The group debriefs.

Questions for the person listening in the role of the client voice often include examples such as:

- What was this process like for you, and what reactions did you have to it?
- What about the process felt respectful and empowering? What effects did that have on you?
- Were there parts of our discussion that felt unhelpful, disrespectful, or disempowering? What effects did that have on you?
- How could we have had the discussion in a way that addressed difficult issues and yet minimized those effects?

Many participants have found the process very intriguing. In addition to participants receiving valuable direct feedback from the person in the role of the client voice, clinicians in the role of the client have found it to be a powerful experience, gaining firsthand knowledge of both positive and inadvertent negative effects of common professional practices.

The power of this format grows over time. As more participants spend time in the role of the client, the voice becomes a stronger presence in the room. Although the primary purpose of utilizing the client voice is to provide participants with constructive feedback about taken-for-granted professional ways of speaking, many groups have found that the voice often provides an interesting and useful contribution to the clinical discussion as well.

The process has also had interesting ripple effects. A student in a seminar that utilized a “client voice” process began raising questions at his practicum site about how clients would regard team clinical discussions. An outpatient therapist referred to the use of this process to open a conversation with her supervisor about how they could talk differently about clients in supervision. A mental health case manager who learned about this process in a workshop suggested it for a larger systems meeting that a mother could not attend. As the client voice becomes stronger in clinical discussions, participants become emboldened to respectfully advocate for clients in other settings.

### **Considerations in the Use of the “Client Voice”**

It is important that participants fully agree to participate and authorize use of the client voice to give them candid feedback. It’s also important that team members who are discussing a client have permission to be inadvertently offensive in their comments as long as they are willing to receive feedback about and address the effects of those comments. It helps when there is a foundation of trust in the group. At times, the person in the role of the client voice has spoken bluntly and passionately, and this process works better when it is done lovingly and in a way that honors clinicians’ best intentions.

One danger of this format is that it can have silencing effects on clinicians, who may respond by saying only “nice, positive” things about clients. The intention in this process is not to sanitize clinicians’ conversations about clients, but to help them increase their sensitivity to the effects of unexamined professional ways of talking and to find respectful ways of having difficult conversations about clients. In fact, the format can be seen as an opportunity for practice, with the team members receiving feedback from the client voice that both acknowledges what they are doing well in the process and offers suggestions for continued improvement. The process flows more smoothly when team members are clear that critical feedback from the client voice is offered as a critique of taken-for-granted professional practices, rather than a critique of individuals, and such feedback is offered with a recognition that all are trying to develop more respectful ways of discussing hard topics.

There are also times when using a client voice might be less useful; that is, when a clinician wants to examine difficult personal reactions to a client, and the conversation is focused more on the therapist than the client. This format is based on a belief that the person at the center of the conversation should have a say in who is to be involved in that conversation. If the conversation is primarily about a clinician rather than a client, it makes sense that the clinician determines who participates in it. At the same time, it is important to keep a clinician-centered discussion focused on the clinician and ensure that the conversation does not drift into a focus on the client.

We can also reflect on whom to include as the client voice. Generally, teams have either picked a family member whose perspective would be useful to hear or have sought out the most marginalized voice in a clinical situation. Often this voice is not a family member. Some of the more interesting “voices” have been those of other helpers with whom a clinician has difficult working relationships. Although we have generally listened to one voice (in the interest of time), it is possible to enroll several voices. For example, Harlene Anderson (1997) has described a similar process using multiple voices, which she refers to as an “As If” exercise. This format has also been used constructively in management discussions about workers and academic discussions about students.

This format can have a lasting impact on participants. One student reported that as a result of this process, she now carries two voices in her head when she does therapy. She experiences a “supervisory voice” reminding her to be a good diagnostician and conduct a thorough assessment, and a “client voice” reminding her to be an authentic human being and develop a strong relational connection. According to her report, the two voices usually complement each other. This is an intriguing comment. Although it is a fairly common experience to internalize a supervisory voice, the additional internalization of a client voice holds the potential to shift how we think, talk, and act with clients. Our efforts to shift clinical discussion formats and make those discussions more accountable to the people they are designed to serve offer ways to develop a more respectful clinical atmosphere. The next section examines ways to shift the context of writing about clients.

### **RETHINKING CLINICAL PAPERWORK**

A licensing auditor was examining records in an agency as part of a site review. As he reviewed the record of a teenage boy diagnosed with bipolar disorder, he noticed, much to his dismay, that one of the treatment goals was that the boy would raise his reading level

(the boy was barely able to read). In a conversation with the program director, he criticized that goal, saying it had nothing to do with the boy's bipolar disorder and hence was inappropriate for a mental health organization. He went on to give examples of appropriate goals: helping the boy become medication compliant, helping the family accept and understand the boy's disorder, or helping the boy develop a better awareness of his disorder in order to manage it more effectively. The director replied that the goal was in the chart because the mother had requested it, believing the boy had to learn how to read in order to support himself in the future. As part of the program review, the auditor met with the mother. When he asked about how the program had been helpful to her family, she immediately responded, "They've helped us help him learn to read. That's been the most important thing anyone has ever done for him."

If we want to support clinicians in making their work relevant and important to clients, we need to develop ways of documenting the work that supports this endeavor. These days, there is a lot of talk about involving consumers in treatment planning and utilizing treatment planning to "drive" the treatment. However, if the definition of what constitutes an acceptable goal remains unexamined, we may inadvertently drive treatment in a direction counter to our preferred values. Alternatively, we may simply go through the motions in completing paperwork and then do the "real" work outside that process, creating additional work and contributing to a lack of accountability in our work. Much of the paperwork we use in the field is based on a medical model and organizes our thinking in particular ways. It decontextualizes and medicalizes people's lives. Carole Warshaw (1995, p. 75), a physician who was originally trained in internal medicine and later completed a residency in psychiatry, reflects on the effects of the medical model in examining problems in living:

The medical model in fact is designed to extract information from the context of the patient's life that gives it meaning to her or to him and transform it into medical events that have meaning for the clinician. It reduces information to categories that can be readily handled and controlled, transforms symptoms into disorders that can be treated or managed, and dismisses anything that does not fit the diagnosis or treatments that are known and available to that particular clinician or specialty. There is no room for the patient to say: "This is what is important to me."

When paperwork requirements direct attention away from those issues that are important to families, we risk developing *form-centered services* rather than *family-centered services*. It is important that we

develop paperwork that supports and enhances our work rather than simply documents it. The assessment process is a profound intervention. The questions we ask in assessments shape the stories clients tell us about their lives and their experience of self in the process. With this in mind, it's important to structure assessment questions in ways that both highlight client resourcefulness and invite descriptions of difficulties in nonblaming and nonshaming ways. Although this challenge may seem difficult, given the licensing requirements that guide many clinics, it is not impossible. Chapters 2, 4, and 9 highlight generic outlines for assessments, collaborative therapy plans, and termination/consolidation summaries that fit licensing requirements and accomplish this. These outlines are summarized in Appendices A, C, D, and E.

The process of assessment can also be reconsidered. There are several inherent risks when one party assesses another. Clients, as the objects of assessment, may feel objectified and disempowered. The process of assessment may also encourage distance and disconnection in the relationship between the assessor (clinician) and the assessed (client). One way to use the assessment process constructively is for therapists to shift from a role in which they, as professional experts, assess clients, to a role in which they and clients together draw on their mutual expertise to collaboratively assess problems that have come into clients' lives. In this process, the concerns raised about an assessment process can be used to mutual advantage. As therapists and clients externalize and jointly assess problems, they increase the possibility that problems will become objectified and disempowered. A joint assessment of externalized problems may also encourage a distancing in the relationship between clients (the assessors) and problems (the assessed). This possibility is discussed in more detail in Chapter 2, and Appendix B contains a series of questions (clustered under assessment headings) that can be asked of clients to engage them in this type of assessment process. In this way, the institutional requirement of completing assessments can support preferred clinical practices and have empowering effects on clients. Next, we examine administrative paperwork.

### **RETHINKING ADMINISTRATIVE PAPERWORK**

Over the last few years, there has been a proliferation of forms in many agencies. We can distinguish between administrative forms (e.g., forms such as patient information forms, agreements to accept services, limits of confidentiality forms, explanations of clients' rights and responsibilities, release of information forms, audiotape or videotape release forms) and clinical forms (e.g., assessment forms, therapy contracts, progress

notes, quarterly updates, and termination summaries). Many of the administrative forms exist to register clients, maintain compliance with licensing standards, or initiate reimbursement mechanisms. These forms are often viewed as annoying but necessary evils. However, if we refer to the repeated assertion that everything we do with clients has the potential to invite the enactment of particular life stories and influence the therapeutic relationship, we are well served by attending to clients' experience of completing forms. The process of filling out initial forms can be seen as an engagement ritual. Do we want clients' initial contact with an agency to be channeled through a set of forms? How can we structure the process of completing forms so that it acknowledges, supports, and amplifies people's participation and influence in their lives? How can we develop forms and organize the process in ways that help to humanize initial contact and encourage respectful connection?

One way to attend to the process of completing forms lies in how we explain particular forms. For example, the process of completing release of information forms is often approached very matter-of-factly. We can come to assume that conversations with other professionals about clients are a right, rather than a privilege granted by clients, and can approach the requisite signing of a release form as a bureaucratic inconvenience. However, clients may experience the form as notice of our intention to engage in professional gossip and can feel objectified and disempowered or have any number of reactions. As one example of contextualizing administrative forms, consider the following introduction to a release of information form:

I have found that I'm able to be most helpful to individuals, couples, and families when I can coordinate my efforts with other services they may be receiving or have received from other helpers. To do that, I'm requesting your permission to talk to other professionals in order to get their ideas about how I can be more helpful to you. I will be glad to share with you the ideas I receive, if you would like.

This introduction contextualizes the request to contact other helpers and opens more space for a conversation about the purpose of such communication and the conditions that clients may wish to attach to their permission. One way to encourage a different response to paperwork is to build such contextualizing introductions directly into our forms. Doing so institutionalizes the practice. However, when using more traditional forms, we can verbally contextualize them. The important point is to attend to clients' experience of filling out forms and attempt to organize that process in ways that highlight rather than constrain clients' influence and participation in their lives.

### RETHINKING QUALITY ASSURANCE

A midlevel manager comes into an executive team meeting and sighs as she thinks about all the work that has gone into responding to documentation requirements for an upcoming audit. She looks to the team and says, “You know, I’ve been thinking, if our clinicians related to clients the way we’ve been relating to our clinicians, we’d fire them.” A close colleague responds, “You’re probably right, but if we don’t pass this audit, they won’t have jobs anyways.”

If quality care rests on a foundation of relationships characterized by respect, connection, curiosity, and hope, how do we develop organizational cultures that institutionalize these qualities, both in how clinicians are encouraged to relate to clients and in how supervisors and administrators are encouraged to relate to clinicians? The following ideas represent some initial thoughts designed to stimulate thinking “outside the box” rather than to provide definitive answers. One organizing criterion for evaluating agency policies and procedures is to subject them to the following questions:

- How does this policy or procedure encourage clinicians and supervisors, respectively, to attempt to better understand the phenomenological realities of families’ lives and workers’ work?
- How does this policy or procedure promote attention to client and worker resourcefulness?
- How does this policy or procedure support and enhance clients’ and workers’ influence and participation in the development of their lives and work?
- How do we ensure that we are continually including client and worker voices in organizational reflection on the effects of policies and procedures on them?

In posing these questions, I am not suggesting that managers abandon their organizational responsibilities to hold workers accountable for job-related performance, but rather recommending a reconsideration of how that is done. The ways in which managers fulfill an organizational responsibility to hold workers accountable shape the organizational cultures in which they both function. How do we develop institutional practices that are deliberately crafted to build organizational cultures grounded in a spirit of possibilities, collaboration, and accountability, rather than fall into organizational cultures that have developed as a by-product of responding to institutional demands? As a beginning step to becoming more conscious about the cultures we create in everyday inter-

actions, let's examine alternatives for approaching outcome measures, utilization review and quality assurance procedures, and mechanisms to elicit consumer input.

### **Outcome Measures**

With an ever-present push for documenting effectiveness, the field is continually searching for valid and reliable measures through which to assess treatment outcomes. A practical "show me the results" orientation increasingly permeates our culture. This trend ranges from the growth of standardized testing at all grade levels in education to the rise of evidence-based practice in mental health and social services. In this era, programs that can demonstrate improved outcomes receive increased legitimacy among funders. It is crucial that we develop ways to ensure that our efforts are helpful to clients and constitute a wise investment for funders. At the same time, *what* we attempt to measure and *how* we attempt to measure it have effects on clients, workers, and therapeutic relationships. I'd like to raise several concerns about developing trends in outcome measurement and offer some questions that can constructively guide our efforts to bring outcome measurement in line with the values and principles that organize this book.

The attempt to identify the essential factors of treatment protocols that contribute to positive outcomes for particular conditions, and then consistently apply them across situations to help clients, has a strong appeal in theory. However, there are translation difficulties when this approach is brought to real-world therapeutic interactions. Client experience is complex and nuanced and doesn't fit neatly into predetermined categories. The attempt to isolate specific actions that contribute to change ignores the importance of the therapeutic relationship as a jointly developed process. And it is difficult to separate a particular clinical practice from the person practicing it and the social field in which it occurs. As highlighted in Chapter 1, 40 years of psychotherapy outcome studies have consistently emphasized the importance of client and relationship factors and suggested that particular therapeutic actions contribute a minimal amount to outcome.

In addition, Pulleyblank Coffey et al. (2001) have identified a disturbing trend in community mental health toward an increasing emphasis on preestablished, replicable procedures over thoughtful and flexible clinical principles. They believe this trend results in simplified clinical thinking and eroded clinical imagination. At a time when services are becoming increasingly standardized and bureaucratized, the attempt to match specific therapeutic procedures to particular conditions encourages the development of approaches that can be easily encoded in a

manual and replicated, and further contributes to an assembly-line ethos. It can lead to an atmosphere in which clients increasingly experience clinicians as *acting on* them rather than *working with* them. This instrumental focus is disempowering to clients. It may also encourage the development of “stuck treatment.” Clients who resent the experience of being “acted upon” may respond in ways that professionals interpret as “noncompliance” or “resistance.” Professionals, under increasing pressure to “show results,” may respond by pathologizing or countering client responses. The resulting behavioral sequence can lead to therapeutic stuckness (a rather ironic outcome of efforts originally designed to promote clinical effectiveness and cost-efficiency). As emphasized repeatedly, every interaction with clients is a clinical intervention. As such, what life stories do we want to be inviting in our attempts to ensure that we are being effective within a limited budget?

Let me be very clear here. I am not suggesting that we discard concerns about clinical effectiveness or cost-efficiency, nor am I suggesting that we simply throw money at problems without evaluating the results of our investments. It is important that we ensure that our efforts are helpful to clients and constitute a wise investment for funders. The challenge is how to do that in ways that support a collaborative spirit. The following questions offer some guidelines in approaching this challenge:

- How do we ensure that client voices are included in outcome measurement efforts to ensure continued accountability to the people we serve?
- How do we develop nuanced measures that recognize that a particular clinical practice cannot be separated from the clinician practicing it and that therapeutic relationships are jointly developed?
- How do we develop measures that recognize the uniqueness of human beings and encourage tailoring our efforts to particular clients rather than specific conditions?
- How do we take into account the importance of client factors and relationship factors as the two biggest contributors to psychotherapy outcome as we attempt to develop outcome measures, and not focus only on isolated techniques (even though they may be easier to measure)?
- Finally, how do we think carefully about our intentions, purposes, and values in this work to ensure that we are *measuring what is valuable* rather than simply *valuing what is measurable*?

These are difficult and thought-provoking questions. As a beginning step in addressing them, I highlight two approaches to outcome measurement

that support a collaborative spirit, encourage client participation, and promote accountability to those we serve.

A qualitative approach to outcome measurement could draw on collaborative inquiry, as outlined in Chapter 5. At the beginning of joint work, we could ask members of a family, “How will we know that what we’re doing here is helpful?” At the end of services, we could go back and evaluate progress in light of those early comments (while also inquiring about ways in which the family’s initial impressions may have changed over time). The consolidation interview outlined in Chapter 9 offers a series of concrete questions to guide this process. In this approach, outcome measures are collaboratively developed with families, become immediately relevant to families, and directly support our clinical work as a co-research process. We could also examine themes that emerge across interviews to develop a grounded theory about contributions to positive outcome.

An empirically based quantitative approach is exemplified in the efforts of Barry Duncan, Scott Miller, and Jacqueline Sparks (Duncan & Sparks, 2005; Duncan et al. 2003; Miller, Duncan, Brown, Sparks, & Claud, 2003) to move from evidence-based practice to what they call practice-based evidence. Practice-based evidence refers to a process of eliciting client perspectives about outcome (how clients are doing in their lives) and process (how therapy is going) in a way that provides immediate and ongoing feedback for clinicians.

They have developed two simple, user-friendly scales that take about a minute each to complete and are completed at each session. The Outcome Rating Scale (ORS) offers a simple way for clients to evaluate how they’re doing in their lives in terms of personal, interpersonal, social, and overall well-being. The Session Rating Scale (SRS) offers a simple way for clients to evaluate how therapy is going in terms of factors known to be related to effective therapy (the degree to which clients felt heard, understood, and respected, the degree to which therapy focused on what clients deemed important, the degree to which clients felt the therapist’s approach was a good fit for them, and the degree to which the session felt right for clients). Through completing these scales, clients are invited to become active participants in the measurement process. The scales provide ongoing immediate feedback, as well as openings for therapeutic conversations about how things are going. This immediate feedback enhances clinical effectiveness and reduces the number of no-shows and cancellations. Duncan and Sparks (2005) document an elaborate outcome management system that integrates the use of these scales in a comprehensive fashion.<sup>4</sup>

Most research approaches strongly encourage the development of multiple measures, and a combination of qualitative and quantitative

approaches have the potential to help us develop a rich appreciation for the information we are trying to obtain. These two examples are offered both as possible vehicles and as mechanisms to invite further reflection on the challenge of responding to the push for documenting effectiveness in a way that enhances clinical work, is consistent with family-centered values and principles, and organizationally conveys the importance of client participation and professional accountability in services.

### **Utilization Review and Quality Assurance Mechanisms**

Public sector agencies are under intense scrutiny by both funders and the public. Part of that scrutiny is reflected in agency utilization review/quality assurance (UR/QA) teams that meet to review clinical records or charts. These reviews typically focus on whether paperwork is completed and meets certain regulatory requirements. Those regulatory requirements are traditionally based on a medical model and promote selective attention to certain aspects of records and inattention to others. UR/QA processes are a regulatory requirement that can also be used to support the ideas presented throughout this book. For example, in addition to the required questions on a UR/QA form, we could include the following questions:

- Are individual, family, and broader contextual issues adequately considered?
- Does this record promote sufficient attention to client resourcefulness?
- Does this record convey a tone of respect for the client or family?

Admittedly, the inclusion of these questions adds more work. However, excluding them runs the risk of ceding quality assurance to disconnected bureaucratic requirements rather than keeping it anchored in the foundation of respect, connection, curiosity, and hope that has consistently been shown to enhance therapeutic effectiveness.

In addition to broadening the scope of UR/QA, we can shift the way in which the process is organized. I used to chair a UR/QA team in a mental health clinic. In that context, we were bound by licensing regulations and the combined tyranny of too many records and too little time. Despite our attempts to humanize the process, a common anticipatory response on many clinicians' part was a fear of "flunking UR." If clinicians' interactions with families invite the enactment of particular stories about their lives, administrators' interactions with clinicians can also invite the enactment of particular stories about their work. Based on this assumption, a number of questions can be raised about our adminis-

trative practices. What would be the consequences of acknowledging and honoring what is present in clinicians' work as well as searching for what is missing in the documentation of that work? How can UR/QA teams be developed as appreciative audiences for clinicians' work while also meeting regulatory requirements? And how can administrators, supervisors, and clinicians find ways to openly discuss and share their dilemmas in embracing a family-centered philosophy while responding to licensing regulations that often operate from a very different set of assumptions? These questions support a spirit of possibilities, collaboration, and accountability. Weaving that spirit into the organizational culture may be the most important contributor to quality care. The ways in which organizations treat their employees will be directly reflected in how workers treat clients. If organizations want workers to work from a stance of an appreciative ally, they need to develop a culture that will support that stance. This can be a difficult endeavor for administrators, who also operate under significant organizational pressures. As an ex-administrator who often was pulled into reacting to staff in ways that didn't reflect my values, I realize this all too well. Again, I am not suggesting that managers abdicate organizational responsibilities, but that they reflect on how to approach those responsibilities in ways that are consonant with the values to which they aspire.

### **Eliciting Client Input**

One of the best ways to ensure quality is to elicit feedback from the clients we serve. They are the best judges of the effects of our efforts, and the process of seeking their feedback has therapeutic effects. Eliciting client input to improve services has beneficial effects both clinically and programmatically. We can seek client input in a variety of ways. At a very immediate level, we can continually check with clients to see how our work is going. For example, at the end of sessions, I routinely check with people to see what from the meeting they want to remember and carry away with them, and what will help them to do that. This provides a transition to then periodically ask some of the following questions:

- “I want to make sure that what we're doing is working for you. How is this going for you? Are we moving in a direction that works for you?”
- “Are we talking about the right things? Are there things we should be talking about that we're not?”
- “What direction do you hope we'll move in over the next month?”
- “Are there factors outside our meetings that are affecting our work together?”

“How will you know when therapy is coming to an end? What will have changed that will tell you that ending makes sense?”

“Is there anything you need to know from me in order to make this conversation easier?”

At a broader level, many programs that receive public funding are required to conduct consumer satisfaction surveys. Such surveys provide a powerful way to elicit consumer feedback about our efforts to help them and yield a potential gold mine of valuable information to ensure quality of care. In consumer satisfaction surveys, we can ask scaling questions such as:

“To what extent did you feel that we made an effort to understand the uniqueness of your life and family? How did we do that? How could we do that more?”

“To what extent did you feel your abilities, skills, and wisdom were acknowledged and honored by us? How did we do that? How could we do that more?”

“To what extent did you feel treated with respect and as an important partner in our work with you? How did we do that? How could we do that more?”

“To what extent were you encouraged to be an active participant in our work with you? To what extent did we ask for your feedback throughout the process? How did we do that? How could we do that more?”

Questions such as these convey a message about agency priorities and subtly organize our interactions with families. These questions also invite clients to reflect on their lives and can have beneficial clinical effects. In this way, they both support our clinical work and contribute to an appreciative organizational culture.

We can also put more effort into the development of consumer advisory boards and develop ways to help them hold agencies truly accountable. We can make human rights committees more than a regulatory requirement and give clients a role in the governance of agencies. Finally, we can involve parents in developing proposals for funding (paying them as we would any important consultant) and, at a state level, in developing requests for proposals from agencies. Examples of such efforts include those by Peter Fraenkel (2006) in the collaborative development of programs for homeless families attempting to move from welfare to work, along with similar efforts by Marcia Sheinberg, Peter Fraenkel, and Fiona True in developing programs for sexually abused children and

their families (Fraenkel, Sheinberg, & True, 1996; Sheinberg, True, & Fraenkel, 1994; Sheinberg & Fraenkel, 2001).

### ADDRESSING THE LARGER CONTEXT OF ORGANIZATIONAL FRENZY

Even when clinicians are thoroughly grounded in their commitment to a collaborative approach and have organizational structures that support them in that commitment, there is still the problem of extreme workloads and dwindling resources. For example, consider the following two stories:

A clinician comes into a family therapy seminar in a community agency and breaks into tears. "I can't stand it," she says catching her breath, "I'm so frustrated and angry that I keep trying to do a job that just can't be done. I'm cutting corners left and right in order to get done all that I'm responsible for, and I'm scared to death that I'm going to be caught and held responsible for what I'm not doing." She concludes by apologizing for breaking down.

A worker, contacted to assess training needs for his program, despairingly replies, "Unfortunately, the idea of getting any training right now feels self-abusive. If I focus on what my work *could* look like, I won't be able to tolerate what it *has* to look like right now. There is no room to apply new ideas, and learning about them just feels like a setup to me. I'm hanging on by a thread here."

Clearly, when a person's experience of work is similar to these stories, it becomes difficult to hold onto respect, connection, curiosity, and hope with clients. The workers in these two stories are experienced, competent helpers who are passionately dedicated to their work. Their stories, although distressing, are not unusual. In the process of providing training and consultation for community agencies and public sector workers, I encounter stories like these every day. The common themes are overwhelming frustration, severe emotional strain, exhaustion, and demoralization. These elements have often been collectively described as "burnout" and attributed to the difficult nature of the work and seen as an effect of prolonged exposure to clients' suffering and misery. However, in a phenomenological study of child protective workers (one of the most likely groups to be candidates for burnout), Joyce White (1996) found that although all of the participants described their jobs as extremely difficult, frustrating, and overwhelming, they did not attribute

their distress to clients, but rather to organizational problems such as high caseloads, inadequate resources, too much paperwork, and wasted time in transportation. One worker put it this way:

I think that, although my clients often wear me down, I am somehow inspired by them. . . . I have no idea how they manage to live their lives. . . . [S]ome of my clients . . . have to manage with so little. So little money, so little support, that I'm stunned, really, at their strength and their creativity. I think that in this era of cutbacks it's probably gotten a lot worse for them. . . . I find my clients funny, lovable, different, amusing. Sometimes I've had clients that I consider brilliant . . . I very rarely actually get depressed by my clients themselves. (in White, 1996, p. 133)

Their relationships with clients and colleagues actually buffered these workers from the disconnection and alienation that developed out of organizational difficulties. Many clinicians would agree that dealing with the organization of the work is much more difficult than direct client contact. Clinicians describe having too much to do with not enough time and too few resources, being overwhelmed with paperwork, and feeling exasperated with bureaucratic dilemmas and continually shifting mandates. As evidenced above, the relationships developed with clients have the potential to buffer workers against these organizational stresses. In this way, therapeutic relationships grounded in respect, connection, curiosity, and hope both anchor quality care and provide an effective bulwark against contextual forces that inadvertently undermine quality care. Legitimizing professional discourses of possibility, collaboration, and accountability, and building in institutional supports (alternative clinical discussion formats, revisions in clinical and administrative paperwork, different quality assurance mechanisms) can go a long way to alleviating the effects of organizational frenzy. At the same time, it is important to acknowledge and confront funding priorities that make the implementation of this work a near impossible task. It is important that supervisors and administrators acknowledge and bear witness to the heroic efforts of frontline workers and take forceful stands against the all-too-common demeaning of public sector workers. It is important to keep an acknowledgment of the dilemmas caused by underfunding on the table and part of an ongoing conversation in community agencies. It is important that workers, supervisors, and administrators all take steps to engage in self-care and collective care. And it is vital that we all raise questions about current funding priorities at local, state, and federal levels and advocate for funding that would truly allow us to build a system of care characterized by respect, connection, curiosity, and hope.

**NOTES**

1. Ellen Pulleyblank Coffey and colleagues (Pulleyblank Coffey, 2004; Pulleyblank Coffey, Olson, & Sessions, 2001) have written two powerful articles documenting these trends in community mental health and offering additional ideas in addressing them.
2. Although the use of the term “discourse” can seem foreign and unwieldy, it best captures this interrelated combination of values, assumptions, practices, and institutional structures.
3. These questions are designed to be asked of the therapist. If a family were at this meeting, the same format could be used, with one person posing the questions to family members and the clinician.
4. For readers interested in learning more about these measures and their use, please consult *www.talkingcure.com*.