CHAPTER 1

Working with Multi-Stressed Families

Recognizing the Importance of Relational Stance

Most people who have worked in community agencies are probably familiar with situations such as those described in the following three stories.[1]

> A particular client, Linda, is notorious among the staff of a local mental health clinic. Mere mention of her name elicits a collective groan. She is a single parent of three children, none of whom know their different fathers. Linda came from an abusive, alcoholic family and grew up in multiple foster homes. She has an extensive drug history, wildly fluctuating mood swings, and an explosive temper. She routinely calls in crisis, and members of the crisis team refer to her as a "frequent flyer." Numerous clinic staff members are alarmed about her parenting and view her as a "help-rejecting, hostile borderline in denial." After a recent incident in which Linda ended up screaming obscenities at her son's therapist in the waiting room, the staff is debating whether to demand an apology for her behavior or ban her from the clinic.
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> Edgar is a 16-year-old, large, menacing-looking boy with suicidal ideation, impulse control problems, and sexually provocative behavior. He has had multiple hospitalizations, and his parents have been begging protective services for an out-of-home placement. The family has been assigned a young home-based worker who is intimidated by Edgar and yet is supposed to help his parents develop better parenting strategies. The worker is profoundly worried that something will happen to Edgar's younger sister and doesn't know

where to turn. Her supervisor is on maternity leave and the temporary program director has had difficulty finding time to meet with her in supervision. When the director does meet with her and asks what she is trying to accomplish with the family, she replies, "I have no idea. I'm trying not to think about this case too much."

Crystal never seems to catch a break. She has an estranged daughter and two sons with recurring health crises. Her life has been an endless progression of tragedy and trauma. She was sexually abused by her four older brothers, two of whom died in accidents as teens. Six months ago, her live-in boyfriend shot himself. She recently lost her job and is impoverished and socially isolated. She accepted the referral for family therapy with the same fatalistic resignation that has permeated her life. Her therapist discusses her in a case presentation meeting and notices a pervasive gloom as team members begin to dissociate. That night, the therapist tries talk to her husband about the difficulty of listening to so many painful stories in her work. He responds by shaking his head and saying, "God bless you, honey. I don't know how you do it." Strangely, she doesn't feel comforted.

RELATIONAL DIFFICULTIES IN THERAPY

The preceding stories highlight some of the relational difficulties that can develop between clients and helpers and the effects that these difficulties can have on clinicians' work with multi-stressed families. Let's examine these difficulties.

Loss of Connection

Clinical situations like those just described can be emotional roller coasters. Our reactions to them can run the gamut from judgment to fear to despair to resignation. The ways in which we make sense of and handle these reactions shape our interactions with clients and may threaten our clinical connection. The mutual frustration that grows out of conflictual situations, such as that generated by Linda's interactions with the mental health clinic, can fracture relationships and lead to further adversarial interactions that polarize and escalate anger and blame. Difficult clinical situations can also provoke concern and fear, as evidenced in Edgar's situation, and make it difficult to develop open, appreciative relationships. Finally, the relentless trauma and sorrow in lives such as Crystal's can become too painful to bear. As we seek to protect ourselves from overwhelming despair, avoidance becomes an appealing coping strategy. Each of these situations presents a danger of losing our connection with

clients. This danger is exacerbated as funding cuts lead to fewer available resources for families at risk. As the pace of work increases, there is more stress and less time and space to acknowledge our challenging emotional responses to families and to reflect on how to engage them. We, the clinicians, and families become increasingly reactive to or avoidant of each other, and our helping efforts become stuck.

Loss of Competence

The overwhelming nature of problems confronting multi-stressed families and the inadequate patchwork of available services can also pull us into feelings of incompetence. We can feel scared, inadequate, and unable to safely express those feelings. In hearing stories such as Crystal's, we can be captured by tragedy and victimization and lose sight of client resourcefulness. As we work hard to help families make changes in their lives, we can reflect on the apparent lack of progress and begin to question our own competence. Improvements seem so minimal, especially when compared with those shown in videotapes of magical interventions by the "masters" of family therapy. We can blame ourselves, clients, or the system, but we become profoundly attuned to what is not working. In addition, we are constantly subjected to pressures to do more with fewer resources. Managed care wants a 30% increase in functioning in 40% less time, agency mandates shift without notice, and paperwork eats up more and more hours. Amid all this, we can end up wondering why we ever got into the field in the first place, lose sight of our own abilities, and have difficulty seeing competence in clients.

Loss of Direction

Folksinger Steve Goodman's song "The I Don't Know Where I'm Going but I'm Going Nowhere in a Hurry Blues" captures another feeling that can often accompany work with multi-stressed families. Often we don't even know where to start. We feel overwhelmed by the multitude of problems and our own emotional reactions. Every time we think we have a focus, a new crisis hits and we end up feeling as though we're starting from scratch. In response, we can become frustrated with clients and blame them for the crises, referring to them with such phrases as "crisis prone." Or we can drift into resignation, going through the motions of talking with clients and wondering when the session is going to end. In either case, any thought of actual change becomes a distant possibility.

Loss of Hope

The magnitude of problems confronting families can at times become overwhelming. As we listen to the relentless tragedy and trauma in Crystal's life, it is easy to become caught in despair and resignation. Reflection on the system's apparent inability to adequately respond to clients like Edgar and his family only exacerbates these feelings. We can be dismayed by the task of trying to help people in unbearable situations and wonder about our own audacity in taking on this work. We can lose hope that things can be different and begin to search for ways to protect ourselves from both the wrenching pain in clients' lives and our own sense of impotence. The loss of hope makes it extremely difficult to continue doing this work.

Loss of Balance

In an attempt to deal with these dangers of losing connection, competence, direction, and hope, and to provide better services to families, numerous calls have arisen for strengths-based, collaborative approaches. Although this book reflects such a shift, a loss of balance can accompany these efforts. We can enter families' lives romanticizing the strengths we credit them with and ignoring or minimizing the limitations, difficulties, and pain that also exist in their lives. In the process, we may avoid difficult but important conversations with families. This lack of balance may leave family members feeling that we don't understand the severity of the difficulties in their lives, or it may direct us away from taking real risk factors into account. If we focus only on family strengths, we risk missing situations in which children are being abused, women are being battered, or individuals are doing substantial harm to themselves.

Isn't this a cheerful beginning? Aren't you glad you picked up this book? I wanted to start here to acknowledge that this work has many potential dangers. It is hard work and ripe for cynicism, despair, and resignation. Yet working with families such as these can also be challenging, stimulating, and rewarding. This book describes a way of thinking about and working with families that have not been well served by mental health, social service, and medical systems. It attempts to do so in a way that acknowledges the difficulties that can accompany this work and yet emphasizes the potential reward and personal gain for therapists working with them. Having considered some potential dangers of working with multi-stressed families, let's begin to examine a way of approaching clients that can help us avoid these dangers and stay connected to our hopes and values. The following story introduces the foundation of this approach.

A LESSON IN HUBRIS

A number of years ago, I took a job in a large agency to help staff members providing home-based therapy develop their family therapy skills. I was greeted enthusiastically by workers who welcomed my expertise in family therapy, and I entered with a certain degree of hubris. I had a lot of family therapy experience and believed the staff would benefit from it. Although many of the front-line staff members were experienced home-based workers, they were not "technically proficient" therapists. They had neither an articulated conceptual framework nor a set of techniques from which to draw. And yet they were very successful with families who had not responded to previous services. This was puzzling. It challenged much of what I had learned as a family therapist. These people knew little about family therapy and yet were doing great work with families. How was I to make sense of this?

As I talked to both staff members and families, I was struck by consistent themes. The staff members, by and large, didn't see the families with which they worked as "resistant" or "pathological." Rather than view family members as some strange or dysfunctional "others," they described them as "regular folks." Some might describe these staff members as inexperienced or naive, but they preferred to think of themselves as "experienced optimists." The family members, in describing their experience of receiving services, repeatedly said things like "The workers were so respectful; I know we gave them a hard time, but they just kept coming back," "They were the first professionals who really listened to me," "They treated my kid like a normal kid, not a mental case," and "I liked talking to them because no matter how hopeless I felt, they always believed I could do better."

ATTITUDE AS THE FOUNDATION OF CLINICAL WORK

As I pondered the apparent paradox of staff without formal training doing effective work with families once considered unreachable, I became convinced that the foundation of clinical effectiveness lies in the basic stance we hold in regard to clients and the way we position ourselves in relation to them. I think this is particularly true with families we designate as "difficult." Our most important clinical quality is the attitude, stance, or emotional posture we take in relation to clients. That stance is the foundation for all subsequent clinical work. Although this assertion is a simple and perhaps commonsensical one, I believe it has profound implications and represents a significant change from how most of the mental health system currently operates.

Throughout the history of psychotherapy, numerous authors from a wide range of theoretical perspectives have highlighted the importance of the therapeutic relationship (e.g., Aponte, 1992; Duncan, Miller, & Sparks, 2004; Nichols, 1995; Rogers, 1957, 1961; Sullivan, 1953; and Yalom, 2002, to name a few). In conversations with families about their experience of helpful services, the consistently emerging themes have revolved around how families felt they were treated by helpers. Clients have repeatedly emphasized the importance of interactions characterized by respect, connection, curiosity, and hope. For the past 40 years, this point has been consistently echoed by the common factors literature in psychotherapy outcome studies. This extensive collection of literature has examined differential contributions to psychotherapy outcome and concluded that 40% of therapy outcome is attributable to client factors (those things clients are doing in their lives outside of therapy), 30% is attributable to common factors (relationship factors such as empathy, respect, warmth, and genuineness), 15% is attributable to the provision of hope and the expectation of change (which I contend could be another relationship factor), and 15% is attributable to technique (what clinicians do in therapy) (Asay & Lambert, 1999; Dore & Alexander, 1996; Hubble, Duncan, & Miller, 1999; Lambert, 1992; Lambert & Bergin, 1994; Patterson, 1984).

The research findings encourage some powerful realignments in how we approach clinical practice. If client factors are the single most powerful contributor to psychotherapy outcome, it behooves us to find ways to draw upon and enhance client resourcefulness. If relationship factors and the construction of hope are considered together, the relational stance we hold with clients becomes particularly important. Research on the power of the alliance reflects more than 1,000 findings (Duncan et al., 2004). A positive alliance is one of the best predictors of outcome (Horvath & Symonds, 1991). Families are more likely to put a therapist's suggestions into practice when family members perceive the therapist as understanding them and caring about them (Kuehl, Newfield, & Joanning, 1990). In fact, clients' perceptions of therapists' attitudes better predict successful therapy outcome than do therapists' perceptions (Bachelor, 1991; Free, Green, Grace, Chernus, & Whitman, 1985). The hope that therapists bring to therapeutic interactions also contributes to change. Successful therapists hold greater hope for clients (Frank, 1982), and efforts to heighten client hope may be as genuinely therapeutic as specific techniques (Connor-Greene, 1993; Lambert, 1992).

Increasingly, the field of mental health is recognizing the importance of the stance or attitude with which clinicians approach families. One example of this is Blow and Sprenkle's (2001) call for more attention to

common factors in marriage and family therapy training. However, the development of therapist attitudes still receives minimal attention in professional education and training, and the current organizational context of mental health and social services along with an increasing focus on evidence-based practice can pull for an instrumental focus on interventions and technique. This instrumental focus (according to literature just cited) accounts for a minimal portion of outcome and can lead to a situation in which clients experience helpers as experts *acting on* them rather than allies *working with* them. That stance may provoke a response from clients who resent the experience of being "acted upon." That response may be interpreted by professionals as "resistance" or "noncompliance," leading helpers to either pathologize or try to counter that response. The resulting behavioral sequence between clients and clinicians contributes to therapeutic "stuckness." In an era of cost containment and the search for more efficient techniques, the field may be losing sight of the simple fact that respect, connection, curiosity, and hope are cost-effective.

Throughout this book, the phrase "relational stance" is used to refer to the ways in which we approach clients. This phrase has also been described as a philosophical stance (Anderson, 1997), an emotional posture (Griffith & Griffith, 1992, 1994), a conceptual posture (Tomm, 1995), and a position (Elliot, 1998; Winslade, Crocket, & Monk, 1997). Each of these descriptions emphasizes a "way of being in relationship with our fellow human beings, including how we think about, talk with, act with, and respond to them" (Anderson, 1997, p. 94). Whereas this way of being has been in the background of collaborative approaches to therapy (an umbrella term referring to narrative, solution-focused, and collaborative language systems therapies), I want to move it to the foreground in order to evaluate our ways of *thinking* and *acting* in terms of their potential to support this way of being with clients.

This emphasis on the importance of our relational stance does not diminish the importance of therapeutic techniques. Our conceptual models (how we think) and clinical practices (how we act) position us in particular relationships with families and profoundly influence families' experiences of themselves in that interaction. With this in mind, we can evaluate our conceptual models and clinical practices by examining the kinds of therapeutic relationships they encourage and the effects of those relationships on clients' experience of self in their interactions with us as helpers. The relational stance we hold reflects a choice, and there are various options. We can let the pull of problems and difficult situations, as well as the conceptual models and clinical practices we happen to utilize, position us with clients. We can also consciously choose how we would prefer to position ourselves with clients and draw from conceptual models and clinical practices that help to keep us anchored in that

relational stance. The ways in which we think and act help us to embody the spirit or stance that is the foundation of our work.

BECOMING AN APPRECIATIVE ALLY

My preferred relational stance with families can be described as one of an "appreciative ally" (Madsen, 1999a). This description refers to a stance in which we position ourselves in alliance with clients and in which clients experience us as "in their corner" or "on their side." Drawing on more politicized language, this stance could be described as *standing in solidarity with clients* as they resist the influence of the problems in their lives. Appreciation is an integral part of this stance. We can begin with a focus on what is working in clients' lives and seek to support and elaborate on that. We can continually search for elements of *competence*, *connection*, and *hope* in our work with families. Those elements help us better anchor ourselves in this type of relationship. This stance has both pragmatic and aesthetic benefits. The work with families is more efficient and effective when anchored in this relational stance, and it better reflects how many of us generally prefer to be with people in the world.

A relational stance of an appreciative ally is characterized by a spirit of respect, connection, curiosity, and hope. Although we could think of these as inherent personality characteristics, I find it more useful to view them as ways of being in the world that we actively attempt to bring forward in our interactions with clients. This conceptualization draws from social constructionist approaches to psychology that view the "self" as something we construct in social interaction with others rather than an inherent essence. This shifts the focus from "who" we are with clients to "how" we are with clients. I prefer this focus because it opens more possibilities for us in how we position ourselves with clients. If the qualities of this relational stance are personal characteristics, we are in a position of either having them or not (e.g., she is empathic, he is judgmental) and then we're stuck with that situation. If we consider our relational stance to be a way in which we deliberately choose to position ourselves with clients, it opens up space for us to create very different relationships with clients. We can begin with an appreciation for the honor of being invited into people's lives, attempt to enter into their experience, and acknowledge and validate their pain and joy in the world. We can take the time to get to know clients as best we can and actively look for ways to connect with them. We can emphasize our similarities with clients and view them as regular human beings struggling with problems in some of the

same ways we all do. We can look beyond the problems in people's lives and develop ways of thinking about them that sparks our interest in getting to know them more. And we can hold onto an unshakeable faith that people can do better in their lives and that they have the resources to address the difficulties in their lives. At times, our most profound work can be aimed at keeping hope alive in the darkest of times. This is not naive romanticism, but rather experienced optimism.

Holding a stance of an appreciative ally does not mean that we uncritically accept everything clients do or that we ignore our own strongly held values and positions. It is important to acknowledge negative emotional reactions to clients whose actions we find intolerable. Implicitly invalidating those reactions can be shaming of us as clinicians. At the same time, in working with clients who shock, offend, infuriate, or sadden me, I have repeatedly found that significant work begins only after I have been able to find something (however small) that I can appreciate and respect about them. That kernel of appreciation and respect is the foundation for an alliance and subsequent work. Valuing a stance of an appreciative ally also does not limit us in taking a stand on important issues. There are times when we may decide to confront clients about the effects of their actions on others and times when we may decide to act in ways that will be experienced by clients as "not being on their side" (e.g., arranging involuntary hospitalization for someone who is considering suicide or filing a child abuse report on a parent). The important issue in taking a stand in situations like this is not whether we do so, but how we do so. A useful approach is offered by Sallyann Roth (1999, 2006a), who raises four questions that can guide difficult conversations:

- Am I speaking my truth with integrity?
- Does my speaking move the relationship forward?
- Is it more, rather than less, likely to be heard by the other?
- Do I like what I've said and how I've said it?

I think these are useful guidelines that can help professionals to have difficult conversations with clients from a relational stance of an appreciative ally.

This focus on process is both an aesthetic and pragmatic decision. As Alan Jenkins (1996, p. 122), who works primarily with abusive men, put it this way:

> I remain convinced that I cannot assist a man to give up patterns of abusive behavior by abusing him in return. I cannot assist a person to respect

> others' personal boundaries by violating his own. Respectful therapy involves a process of knocking on doors and waiting to be invited in, rather than breaking them down, barging in, and then expecting to be welcomed with open arms.

It's important to acknowledge that holding a stance of an appreciative ally with clients is often easier said than done. The clinical situations described in this book are complex and difficult. The stresses that families face can be overwhelming, and their behavior can be outrageous. And the ways in which we are encouraged by many conceptual models to make sense of and respond to problematic client behavior often exacerbate the problem.

In an attempt to provide some direction for the development of a relational stance of an appreciative ally, the rest of this chapter examines four commitments that underlie it: striving for cultural curiosity and honoring family expertise, believing in the possibility of change and building on family and community resourcefulness, working in partnership and fitting services to families rather than families to services, and engaging in empowering processes and making our work more accountable to clients. These commitments are framed as active verbs to highlight the point that we are attempting to intentionally conduct ourselves in particular ways in therapeutic relationships.

STRIVING FOR CULTURAL CURIOSITY AND HONORING FAMILY EXPERTISE

Our understanding of challenging clinical interactions can be constructively viewed through a metaphor of a cross-cultural negotiation. I'll illustrate this metaphor with a story. A number of years ago, when I was training family practice and pediatric residents in a large public hospital, I heard a story of a woman who came to the hospital to have a baby. The delivery went without complications until the physician who delivered the baby congratulated the mother, exclaiming, "You have a beautiful baby boy. In fact, he is one of the most beautiful babies I've ever seen." Rather than joining the physician in his appreciation of her son, the mother became apprehensive and retorted, "No, it's an ugly baby." The physician was perplexed and sought to reassure the mother that her new son was perfectly healthy, quite normal, and very beautiful. However, the more he attempted to reassure her, the more upset she grew. She became agitated and began crying, "Get out of here. Leave me alone. He is an ugly baby; ugly, ugly baby." The physician wondered about the

mother's emotional state. He thought she might have an attachment problem and became concerned for the baby's well-being. He decided to separate them in order to give the mother time to calm down. However, the attempted separation backfired and resulted in the mother desperately clinging to the baby and trying to hide him under the bedsheets. At this point, the physician retreated to consider his options. He thought the woman might be psychotic and potentially abusive. He considered a psychiatric consultation and wondered about contacting protective services. He was puzzled and alarmed.

This is a perplexing situation until one puts it into a particular context. The mother was a Southeast Asian woman who believed in the existence of dabs, or evil spirits, that can steal away the souls of beautiful babies. Within this prevailing cultural belief, she believed it was important to camouflage the beauty of her baby. From this perspective, the mother's actions become protective and caring, whereas the physician's proclamations of the baby's beauty potentially put the baby at risk. This story highlights an unfortunate cultural mismatch.

A cross-cultural metaphor can be useful when applied to the therapeutic process. We can view both families and helpers as distinct cultures with particular beliefs and preferred styles of interacting, embedded in a wide range of taken-for-granted assumptions. Therapy can be seen as a cross-cultural negotiation in which the two cultures interact in a mutually influencing relationship (Harkaway & Madsen, 1989; Madsen, 1992). In this negotiation, the beliefs and interactions of a client or family may be more understandable through their perspective than ours. In the previous example, the mother's emotional outburst makes sense in her cultural context. She is not a "crazy" person but a concerned and protective mother who is pursuing her only option in the face of the physician's apparent disregard for her baby's welfare. Similarly, the physician's actions make more sense within his cultural context. In this situation, the difficulties that developed did not stem from a crazy mother or a neglectful physician but grew out of a cross-cultural exchange that went awry. It is important to note that this cross-cultural exchange does not occur on a level playing field. In this exchange, the physician and his culture take a dominant position and are much more visible in the interaction. The mother and her culture occupy a more marginalized position and can be easily overlooked or rendered invisible. As Jean Baker Miller (1976) has pointed out, people in a subordinate position usually know significantly more about people in a dominant position because they have to.

Although a cross-cultural metaphor has been most commonly applied at a macro-level to refer to broader ethnic or sociological

differences, it is also useful with any family we encounter. To encourage our consideration of each family as a distinct culture, we can refer to individual clients or families as "micro-cultures." In thinking about particular families as micro-cultures, it is important to enter into their lives with an attitude of curiosity, seeking to learn about them while developing a keen sensitivity to the influence of broader macro-cultures. The concept of micro-cultures can be particularly applicable with families who seem most like us. Because they seem like us, we can fall into the mistake of thinking we know who they are, that we (metaphorically) speak the same language, and that their taken-for-granted assumptions are the same as ours. It is important to remind ourselves that we need to figure how the world looks from their perspective. Viewing each family as a foreign micro-culture encourages an attitude of cultural curiosity in which we actively try to elicit a family's particular meaning rather than assume we already know it or that it is the same as ours.

To fully understand the complexity of each family, it is useful to approach it as a unique culture and to learn as much as possible about that culture. Some of this learning can be accomplished by asking family members to teach us about them. It can be useful to think about entering each family as an anthropologist looking to *elicit* client meaning rather than looking to *assign* professional meaning. Such an endeavor can be supported by entering with a stance of "not knowing" (Anderson, 1995, 1997, 2005; Anderson & Goolishian, 1988, 1992). I have come to refer to this as an attitude of cultural curiosity. Just as anthropologists (or, more accurately, ethnographers) immerse themselves in a foreign culture in order to learn about it, therapy from an anthropological stance can begin with immersing ourselves in a family's phenomenological reality in order to fully understand its members' experience. Within family therapy, a cultural metaphor has been proposed as an alternative to the prevailing systems metaphor, with the idea that families may be more usefully viewed as cultures than systems (Pare, 1995, 1996).

Clifford Geertz (1973), a prominent cultural anthropologist, differentiates between thin and thick description in considering an anthropologist's task. Thin description refers to those portrayals of other cultures that are arrived at through categories derived by the anthropologist (e.g., the aforementioned physician viewing the Southeast Asian mother's response to his declaration of her baby's beauty as evidence of dysfunction). Thick description is arrived at through interpretations that are anchored in the other culture's own categories of understanding (e.g., searching for the cultural belief within which the mother's actions make sense). Clinically, thin descriptions attempt to fit clients to professional categories, whereas thick descriptions attempt to understand people within their own experience. Geertz is critical of thin description. He

regards any descriptions of an action that "attempt to cast what it says in terms other than its own as a travesty—as the anthropologist's severest term of moral abuse, ethnocentric" (Geertz, 1973, p. 24).

Ethnocentrism is the emotional attitude that one's culture is superior to others. At times, we in the therapeutic community can fall into *therapeucentrism,* referring to the tendency to privilege our categories of understanding clients' lives above others. We can mistake our categories for objective facts rather than interpretive frameworks that we developed to support our work. We can become oblivious to clients' perspectives, either assuming they are the same as ours or simply placing more stock in our own values and beliefs. Therapeucentrism inadvertently suppresses the reality of different perspectives. In the process, valuable information is lost and we risk cross-cultural negotiations that are experienced by others as dishonoring them.

An example of therapeucentrism is reflected in the story of Linda, the client described at the beginning of this chapter. Linda was viewed by the clinic staff as a "help-rejecting, hostile borderline in denial" (a potentially very thin description). She had many questions about what was happening in her son's individual therapy and was quite insistent on getting them answered. Her son's therapist viewed her demands to be more involved in that therapy as evidence of enmeshment and poor boundaries. He responded by working harder to keep her out of the therapy in order to protect the confidentiality of that relationship. If we draw on a cross-cultural metaphor and seek to understand the context in which Linda's actions might make sense, we discover that Linda had a long history of physical and sexual abuse in various foster homes, as well as emotional abuse by previous helpers. Within that context, her demand to know what a stranger whom she doesn't trust is doing all alone with her son in a locked room makes perfect sense. Her fury at the therapist when he tells her he can't tell her what is going on and implies that she should not be asking that question takes on a whole different light in this context.

When we enter into clients' lives without an attempt to develop a rich understanding of the texture of their lives, we risk being experienced by them as arrogant, patronizing, or oblivious. Clients may respond to us by acquiescing (e.g., Linda could simply comply with the therapist's demand that she not question his rules and thus feel abused by authority yet again), rebelling (e.g., Linda could refuse to comply with a rule of confidentiality that she fears puts her son at risk), or a mixture of both (Linda could loudly protest and also experience herself as disempowered and pathetic). Each response has powerful effects on the story she will tell about herself and her interactions with helpers. Viewing Linda's actions within the context of her experiences, values,

and beliefs helps us develop a more compassionate view of her actions and interact with her in more constructive ways. Although an anthropological approach can be useful, it is often difficult to remain curious when we observe events that challenge our own values and beliefs. The following questions may provide some help in this process:

- In what context might this behavior make sense?
- What might be a positive intent behind the behavior I find frustrating?
- How can I come to respect and appreciate that positive intent even if I don't condone the behavior?
- What do I not know about the members of this family that might change my opinion of them?
- What could I learn from this family?

If we view each family as a distinct micro-culture and regard clients as the experts on their experience, our role moves beyond intervening with families to bring about particular outcomes. We can become curious inquirers dedicated to bringing forth family abilities, skills, and know-how.[2] Rather than imparting professional knowledge, we can jointly develop new ideas that draw on both local client knowledge and our professional experiences and understandings. In this process, we move into *learning with* clients (Hoffman, 1992). As we invite clients to teach us about their competence, connection, and hope, they begin to experience themselves in important new ways. The art and skill of this process lies in how we organize our questions to elicit information. In the process, new ideas emerge and clients experience themselves in a different, richer fashion.

BELIEVING IN THE POSSIBILITY OF CHANGE AND BUILDING ON FAMILY AND COMMUNITY RESOURCEFULNESS

As we enter family cultures, what we look for profoundly shapes what we see and how we experience that culture. What we see shapes how we act, and how we act reinforces what we see. We can enter families with a focus on deficit and dysfunction, and it will affect our interactions with them and the possibilities that emerge. We can also enter with a focus on possibilities and resourcefulness. We are always faced with a fundamental choice that guides all subsequent action. That choice involves whether we are attending primarily to *what is and could* be or to *what isn't and should* be.[3]

Historically, the field of mental health has been strongly influenced by a deficit model. A deficit model assumes certain knowable norms for

family organization and interaction. Whatever deviates from those norms is assumed to be defective. Services then focus on fixing that which is in need of repair, inadvertently reinforcing a focus on dysfunction. This process puts helpers in a position of identifying what is missing or broken in families and attempting to address that. In contrast, a resource model of family functioning assumes the following:

> A family is continually generating its own norms in an interacting context of history, culture, ethnicity, social class, politics, interpersonal relationships and individual quirks. The therapist searches for strengths, and attempts to remain respectfully curious and open to difference. Diversity is welcomed. Therapy is seen as that which facilitates the family's creative capacity to solve problems, to effect healing, to generate development and to gain new knowledge, first with the therapist and then without the therapist. (Imber-Black, 1986, p. 149)

Increasingly, the field of family therapy has embraced a belief in possibilities and a commitment to building on family resourcefulness. All families have the capacity to grow, learn, and change and often have significant untapped abilities, skills, and knowledge that can be useful in their lives. A resource model does not ignore difficulties, but prefers to focus on expanding competence.

A deficit model and a resource model can be thought of as stories or narratives held by practitioners that organize what is seen. Our stories about families shape our view of them and promote selective attention to some factors and selective inattention to others. What we see and attend to shapes how we act with others. Professional stories about Linda, the woman described earlier, provide an example of this. Clinic staff viewed Linda as a "help-rejecting, hostile borderline in denial." That story promoted attention to her "borderline" nature, her interpersonal difficulties, and her incompetence as a parent. It became a self-fulfilling prophecy and influenced the staff's interactions with her. Linda was expected to be out of control and yet was also asked to publicly apologize for her behavior. Her interactions with staff members in turn confirmed their story about her (as well as her story about them), leading to a situation that was extremely frustrating for everyone involved.

Linda was later referred to another clinic for family therapy and had a different experience. Two therapists working together met with various members of Linda's family. Having heard about Linda's previous experience with professional helpers, they made a deliberate choice to approach her quite differently. They viewed Linda as a trauma survivor whose whole childhood had been a fight to stay alive. They saw her as overwhelmed at times by shame and humiliation and viewed her substance use as a way to cope with that shame. They were impressed with

her commitment to quit drugs for her children and risk confronting shame. Knowing that Linda was fiercely protective of her children and had a long history of bad experiences with professionals, they structured an initial meeting as an opportunity for Linda to interview them to see whether she would be willing to entrust her family's "intimate life" to their care. Subsequently, they drew on Linda as a consultant for ongoing work with her children. Linda's relationship with these therapists had its ups and downs. She was volatile and often challenged them. They appreciated Linda's strong feelings and saw her as someone who gave them opportunities to practice sitting with clients experiencing intense affect. Linda's trust grew slowly but surely, and as she came to believe that the therapists' faith in her was real, she became less reactive and more resourceful. These therapists actively tried to develop a different story about Linda, and the resulting interactions held much more promise. To summarize here, what we look for shapes what we see. What we see shapes how we act with others. And how we act with others shapes what is possible to occur.

This juxtaposition of Linda's experiences with helpers is not a comparison of a "good" team and a "bad" team. I invite readers to view it as a story about the interpersonal effects of our conceptual frameworks. I am encouraging critical reflection on our conceptual models, not critiquing individuals influenced by those models. Moreover, in juxtaposing a narrative of pathology and a narrative of resourcefulness, it is important to avoid a polarization in which clients are seen as simply dysfunctional or resourceful. There were significant difficulties in Linda's life. However, the ways in which we make sense of those difficulties have powerful effects. A deficit model often situates client lives in a tragic story. There is a focus on what is missing and what has been lost. A tragic story can have significant appeal. There is a certain drama that accompanies it. However, it can also obscure possibilities for clients. A resource model often situates client lives in a heroic story that acknowledges the tragedies in their lives but also emphasizes their courage in confronting multiple stresses. A heroic story can pull for a appreciative connection with clients without losing sight of life's challenges.

A deficit model is a strong organizing assumption in our field and is supported by a number of factors. One of the most pressing is the immediate context of our work. Mark Karpel (1986) points out that clients typically go to therapists because they (or someone) feel something is wrong. They arrive unhappy in some way, and the purpose of therapy can easily be seen as trying to understand what is "wrong" and do something about it. Because we are being asked on a daily basis to "fix" something that is wrong, it makes sense that we have developed a language for this endeavor. By the time clients get to therapy, the problems

that bring them have often become entrenched and occupy significant space in their lives. In the words of Michael White and David Epston (1990), clients' lives have become "problem-saturated." Michael Durrant (1993) suggests that helpers' views of clients are often derived from inadequate or skewed data. We see people when things are not going well, and such a skewed sample easily leads us to see the world in terms of dysfunction, pathology, and deficit. A couple I saw put it this way: "You know, you really see us at our worst." We could view this statement as a minimization of their situation or as a sobering comment on the limited views we get of people in a clinical setting. Our immediate work context often promotes selective attention to problems and inattention to resourcefulness.

Our work is also shaped by professional assumptions that strongly support adherence to a deficit model. The field of mental health has a long tradition of attempting to identify, categorize, and describe pathology. This is reflected in the diagnostic categories available to us, the assessment questions required by licensing regulations, and the documentation requirements for continued funding. Our field is much more organized around what is wrong with people than what is right with them. Much of our adherence to a deficit model can be traced to the evolution of a medical model as the dominant metaphor for understanding problems in living. The medical model was developed to address physical maladies. It seeks to describe symptoms, group them into syndromes, and understand their etiology in order to develop cures. It has proved extremely useful in the treatment of acute and infectious diseases. For example, from 1900 to 1980, the development of antibiotics and improved immunological measures brought most infectious diseases under control (Burish & Bradley, 1983). However, this stunning success in addressing acute physical maladies has not translated well into addressing chronic physical illnesses (which have replaced infectious disease as the most prevalent form of sickness in the United States) and is even less applicable as a metaphor for problems in daily living.

The application of a medical model to social functioning has encouraged us to view human life through a lens of disease, with a strong focus on presumed pathology within the individual. In the process, the broader context of social interaction and meaning is obscured. The family as a social context is essentially ignored except as the locus and source of trauma (which can position counselors and families in an adversarial relationship). And the influence of broader social, economic, and cultural factors disappears almost entirely. As a result, what began as a major triumph in one arena (infectious and acute physical illnesses) has become quite limiting in the field of mental health. The problem here is not the medical model, but our continued unquestioned adherence to it.

Much of family therapy has also replicated this search for pathology. Attempts to view individual clients within a family context have often shifted from labeling the patient as the problem to labeling the family as the problem. Family therapy began with research on the etiology of schizophrenia, and the thrust of most early family formulations was to better understand and spell out the roots and persistence of pathology. Increasingly, there has been a gradual shift from identifying pathology to eliciting resourcefulness; however, there is still a historical trail littered with fault-finding concepts such as schizophrenogenic mothers, enmeshment, and function of the symptom. The legacy of those concepts continues to affect our thinking.

Finally, as a participant in a workshop I once led, put it: "Competence is quiet; it tends to be overlooked in the noise and clatter of problems." I like that quote. I have two children. When they are getting along well, it's easy for me to not notice (despite my best intentions to pay attention to those times and remark on them). However, when they are fighting, it's impossible to not notice. Is that true in your life? In your own clinical supervision, do you talk more about the aspects of your work that are going well or the problems you encounter? If you drive to work, are you more likely to notice when traffic flows smoothly or creeps at a snail's pace? Are you more likely to write a letter to your congressional representative when he or she does something you like or when he or she does something you dislike? We are all steeped in a culture that promotes attention to complaints and problems. Competence is quiet. The trick is to listen carefully for it.

Advantages of a Belief in Possibilities and Resourcefulness

When we begin with a focus on resourcefulness, we are less likely to provoke resistance. I assume that for most of us that it is easier to introduce ourselves to strangers by talking about what we do well than by leading with our deepest, most shameful secrets, and this holds true for clients as well. When exploring problems, building a foundation of competence provides a reminder that families are resourceful as well as struggling with difficulties. Eliciting resourcefulness evokes a sense of competence and pride that provides a stronger foundation from which to derive solutions to problems. Focusing only on problems can be demoralizing. Recognizing resourcefulness invites hope and opens possibilities.

A belief in possibilities and resourcefulness also provides an organizing focus for our work. Waters and Lawrence (1993) point out that many therapy models offer elaborate schemas for investigating what's wrong with a person but little for what's functional or effective. We are likely to study people's difficulties *ad absurdum* but altogether ignore

their assets. The development of a proactive vision offers a map for moving forward in life. When we begin therapy with an exploration of resourcefulness, we are better positioned to help clients draw on their resources to address problems.

In addition, a focus on client resourcefulness adds to the accumulated wisdom brought to clinical situations. Clifford Geertz (1973) draws a distinction between expert and local knowledge. Expert knowledge includes those bodies of professional knowledge that have been written, published, and given credence in our society. Local knowledge is that wisdom that grows out of people's daily lives and experiences. A focus on resourcefulness encourages us to elicit clients' local knowledge. In the example described earlier, the second team's consultations with Linda about their work with her son resulted in a number of creative ideas that they would never have developed on their own. In addition, as clients and workers share knowledge, new ideas are collectively developed. As the second therapy team and Linda discussed her family's situation, they synergistically generated new ideas for helping her son that far exceeded the usefulness of prior attempts by either party.

Finally, a belief in possibilities and resourcefulness has the potential to enrich our clinical work. If you think back to the two Lindas described previously, would you rather work with a help-rejecting, hostile borderline in denial or a trauma survivor who is intensely committed to her children and yet wary about whether she can trust helpers? When we focus on client resourcefulness, clients become more intriguing human beings. They become easier to respect and appreciate. We begin to realize that we may also learn something from them. It offers the potential for this work to become something that is quite remarkable.

I am not romanticizing clients' lives here. Let me reiterate that a belief in resourcefulness need not minimize the difficulties that exist in people's lives. It is important to avoid a dichotomous way of thinking in which clients are seen as either dysfunctional or simply resourceful. We need to acknowledge both the abilities of families and the difficulties they confront. However, beginning with a strong appreciation of family competence serves as an important foundation for helping them address the problems that enter their lives.

WORKING IN PARTNERSHIP AND FITTING SERVICES TO FAMILIES

If we believe that families are the experts in their lives and often have more competence than we realize, our work together can become a collaborative process that draws on the abilities, skills, and knowledge of

both parties. Therapy proceeds much better when based on a collaborative partnership in which the nature of the relationship is jointly determined. Research studies have suggested that the degree of client collaboration and client participation may well be the best predictors of successful treatment outcome (Hartley, 1985; Orlinsky, Grawe, & Parks, 1994; Stiles, Shapiro, & Elliot, 1986).

If collaboration is jointly defined, cooperation becomes a two-way street and helpers as well as families can be noncooperative. As clinicians, with our culturally conferred status and professional privilege, we are typically in a position to determine the prevailing definition of therapeutic relationships. However, we benefit from attending to how clients experience these relationships. Partnership is an interactional process. Inasmuch as helpers hold a leadership position in the relationship, a collaborative partnership begins with our finding ways to cooperate with clients and make our work relevant to them, rather than simply expecting them to cooperate with us.

Collaboration also involves honoring the expertise of all involved parties. Clients are the best experts on their experience. When that expertise is acknowledged, they are better able to draw on it. Clinicians have expertise in creating contexts that help clients to envision possibilities and draw on their resourcefulness to address the problems that stand between them and preferred lives. In my own work, I find that I can be more helpful to families when I stay grounded in my area of expertise (supporting them in their life journey). I often become less useful when I stray into their areas of expertise (determining the direction of that journey).[4]

A collaborative partnership is enhanced when we come across as regular human beings rather than distant professionals with clients. In daily practice, this connection is supported by talking in a conversational way rather than conducting interviews, checking our use of jargon, and attempting to match clients' language. The process of connection is facilitated by emphasizing our similarities with clients while acknowledging and becoming curious about our differences. The connection we make with clients is influenced by our assumptions about our place in their lives. In community agencies clients are often assigned to workers, with little choice in the process. We can fall into assuming that because they are "our" clients, we have a right to enter their lives and ask personal questions. We need to be careful about such assumptions. A conceptual device that can help us stay grounded in collaborative partnership is to refer to clients in our heads as "the people we work for" and to see our presence in their lives as a privilege that needs to be earned.

In collaborative relationships, there are attempts to acknowledge and minimize the power differential between clients and therapists. As

therapists, even though we may not experience it at times, we are in a privileged position in our relationship with clients. Therapy typically occurs in our space, at a time we largely set, and in a structure we largely determine. We diagnose clients and keep the official record of our work in our charts. And we are paid for being in the relationship (albeit not much at times). Clients are culturally defined as being in need of help, are expected to disclose potentially embarrassing aspects of their life (even though they may choose not to), and are more likely to feel vulnerable in the interaction. Although attempts to flatten hierarchy in the relationship have beneficial effects, it is important to acknowledge that given the structural power differential in therapy, it is impossible to have a totally egalitarian relationship. It would be a mystification to pretend that the relationship is an equal one, and it runs the risk of obscuring the responsibilities that accompany our privileged position.

A metaphor that can support collaborative partnership is the idea of *working on family turf* (Madsen, 1999a). This metaphor can be considered both literally and metaphorically. The development of home-based therapy serves as a concrete example of the shift from professional turf to family turf. Home-based therapy emerged as an effective alternative for clients who have not been well served by more traditional programs services and falls within a broader approach to service delivery called "family-centered services." Family-centered programs typically include short-term intensive services that are delivered primarily in clients' homes, a focus on the whole family as the client, 24-hour availability so that services are delivered according to the family's schedule rather than the provider's schedule, a strong focus on integrating concrete services as well as traditionally defined "clinical" services in an attempt to respond to a broad range of family needs, and the active involvement of families in determining their own treatment plans (Berg, 1994; Berg & Kelly, 2000; Berry, 1992; Hartman, 1992; Kaplan & Girard, 1994; Kinney, Haapala, & Booth, 1991; Sandau-Beckler, Salcido, & Ronneau, 1993). Other examples of family-centered approaches to service delivery include wraparound services and family group conferencing. Wraparound services involve flexible, strength-based formal and informal services being wrapped around a family in the context of their own community, based on individualized plans in which families have a strong voice. (Swartz, 2004; VanDenBerg & Grealish, 1996). Family group conferencing consists of structured processes for family members (with significant advance preparation and available information and resources) to take the lead in devising plans to ensure a child's welfare and safety while professionals hold more of a supporting role (Hardin, Cole, Mickens, & Lancour, 1996; Mirsky, 2003a, 2003b, 2003c).

Family-centered services have resulted in a radical reorientation of services. Many home-based workers have been profoundly affected by the context of working in clients' homes rather than professional offices and have come to view both their work and relationships with clients in quite different ways. There is something profoundly different about doing therapy in clients' homes (family turf) rather than in our offices (professional turf). The *context* of home-based work structures the therapeutic relationship in a distinct way. For example, think about how it is different when the therapist shows up out of breath, late for an appointment after hitting bad traffic, and the family is wondering what the "real" meaning of the lateness might be. The power hierarchy is significantly flattened in home-based therapy. Whereas an office-based therapist might announce to the family that he or she is going behind the mirror to consult with the team, a home-based therapist is much more likely to encounter family "team members" (such as the chatty next-door neighbor or the teenager's boisterous friends) who drop by unannounced and join the session or bring it to a close.

The context of home-based therapy also makes it difficult to hold a disengaged expert stance. For example, consider the effect of any of the following situations on the therapeutic relationship:

> At the end of a session, you have to ask family members if you can use their bathroom, which unfortunately doesn't have a door.
>
> Immediately after a difficult session, you return to ask the family's assistance in jumping your car battery because you inadvertently left your lights on.
>
> Family members suggest that their 13-year-old boy walk you to the subway stop because they don't think you'd be safe walking there by yourself.

The context of home-based therapy exposes our own vulnerabilities and offers opportunities to come across as a regular human being (as well as highlighting family resourcefulness in responding to trying circumstances). For many of us as home-based therapists, collaboration is a daily practice rather than an abstract idea. Conversations occur over coffee around a kitchen table or in a living room surrounded by family photos. We are guests rather than experts and need to conduct ourselves differently.

Finally, in home-based therapy, the therapist is much closer to the family's lived experience. For example, a therapist is told, "You might not want to sit by that window. A bullet came through there last week." The

family goes on to describe how the police have been inadvertently bursting into the wrong apartments recently as part of a crackdown on drugs in the projects, and one of the family members jokingly says, "If they kick in our door tonight, do you think they'll believe you're our therapist?" As the therapist has difficulty holding his train of thought while staring at the door, he suddenly feels in his gut what the family experiences on a daily basis. He begins to wonder what they draw on to cope with their living situation. In this way, the context of home-based work offers helpers an intuitive grasp of client experience that is less accessible in other contexts and supports the development of an appreciation for our clients' wisdom and expertise. This immersion in family experience is a significant aspect of the power of home-based treatment. In my experience with family-centered services, families often express the sentiment, "You folks were the first helpers who really understood us."

These contextual elements that flatten hierarchies, humanize our interactions with clients, and invite us more directly into an appreciation of family experience all contribute to a collaborative partnership. The commitment to working in partnership is reflected in attempts to work on family turf by making ourselves relevant to families and fitting services to them. This can be reflected in the design of all services, ranging from user-friendly waiting rooms and intake procedures, to family involvement in clinical discussions, to being accountable to clients for how meetings are conducted. (Ideas for developing institutional structures that support collaborative partnership are discussed further in Chapter 10.)

Advantages of Collaborative Partnership

The advantages of collaborative partnership for clients can best be described by clients. The following exchange comes from an interview I did with two women from Parents Helping Parents (a self-help parent group) about their experiences in receiving mental health services. Here they talk about the importance of partnership between helpers and parents.

KAREN: I think what you're talking about is what I call breaking down the barriers and equalizing the relationship between professionals and parents. When you're sitting in a therapist's office and the therapist is sitting across from you in his or her professional attire and you're the person with the problems and you're feeling very ashamed about yourself in the first place, there's a definite hierarchy. It feels like this person sitting across from me has his or her life

all together and I'm a mess, even though rationally we know that's not true. But that's what it feels like, and to have somebody be able to meet you on an equal footing and connect as a human being—well, it just changes everything.

BILL: How does that change things? If helpers connect with you as human beings rather than as the experts, how does that change things?

KAREN: I think it decreases the feelings of shame and helplessness. To me, it gets rid of the feeling of I'll never be able to live up to where this person is or I'll never be able to get it as together because no matter what I do, I'm always going to be one step below.

NAOMI: I think what happens in that situation for me, when professionals are more human, is I'm more prone to being honest and to really be who I am. A lot of times, I carry around this image of myself. You know, how I'm supposed to behave, and what a good parent is, and I'm always doing, doing, doing. And the bottom line is I'm always feeling less than, like I'm not up to par. My image of professionals is that they're smart, they're put together, they're just all that I would like to be, and when I see that they're human and have their own struggles, I learn from that. I learn that I'm okay. I learn that we're all in this together. Nobody is perfect and so I'm more honest.

KAREN: I think there's a huge difference in focusing on what a person needs help with in a way that makes them feel less than others because they have problems, and in a way that makes them feel human because they have strengths and weaknesses, which we all do.

Clearly, conducting therapy on family turf, humanizing the relationship, and acting in partnership have powerful effects for these women. This way of working also holds potential risks and powerful opportunities for us as therapists. There is a certain amount of vulnerability when we step out from behind our professional roles. We run the risk of not knowing ahead of time how to respond to clients, of feeling that we are on the spot, and of having to acknowledge our own uncertainties. We also run the risk of more deeply connecting to clients' painful experiences, as well as experiencing our own feelings that are triggered in the process. These risks are also opportunities. The development of collaborative partnership has the potential to become a transformative process for us as well as for clients. We have opportunities to make powerful connections, to be profoundly moved, and to learn important lessons about ourselves, others, and life.

ENGAGING IN EMPOWERING PROCESSES AND MAKING OUR WORK MORE ACCOUNTABLE TO CLIENTS

As we seek to work in partnership with clients, our efforts may support them in building the lives they prefer and at times may inadvertently constrain them in those efforts. This section focuses on empowering and disempowering processes, highlighting some of the ways in which professional actions may inadvertently undermine clients and examining ways to make our work more accountable to the clients we serve. The phrase "empowering processes" is used to refer to ways of thinking and acting that acknowledge, support, and amplify people's participation and influence in developing the lives they prefer. "Disempowering processes" refers to ways of thinking and acting that may disqualify, constrain, or supplant people's participation and influence in their lives. The focus on empowering processes rather than empowerment is deliberate. It orients us to professional actions and their effects on clients.

As we interact with clients, our actions have certain effects on them. Our actions may have empowering effects, they may have inadvertently disempowering effects, and they may have mixed effects. For example, consider the different consequences for a mother's sense of competence with her son when a male therapist sets limits on her son's rowdy behavior in a family therapy session and when he helps *her* to set limits. In addition, the way in which he chooses to attempt to help her may have differential effects. The therapist may draw upon her past successes with her son and the wisdom she holds about him to help her develop more effective ways of dealing with him, or he may offer suggestions from a parenting training manual that, although effective, disqualify her knowledge and violate her preferred ways of being with her son. Every interaction with clients invites particular experiences of self and the enactment of particular stories. These interactions may have positive, negative, or mixed effects.

It is useful to draw a distinction between the *intent* behind our actions and the *effects* of those actions. Helpers generally attempt to act in empowering ways, but their actions may have inadvertent disempowering effects on clients. For example, a team holds a case conference and includes parents in an attempt to be family centered. In one of these meetings, the therapist begins a description of her work with the family by glancing at the mother and then saying to the team, "I began working with this case when DSS filed a C & P and the son was placed in an ASU to assess suicidality and whether he had an Axis II diagnosis." The therapist continues while everyone, except the mother, nods knowingly. What impact do you think this experience might have on this mother? How might it be for her to be referred to as "this case,"

followed by a string of unintelligible acronyms? If you were in her shoes, how would you feel about being in a room and hearing your life described in unfamiliar words to a group of strangers, believing that you were the only one who didn't have a clue about what was being said? The mother who related this incident to me described her reaction: "I thought we were coming to the meeting to *all* talk about my son's future, and when the therapist started, I realized that there was no place for me in the room. I felt really stupid and really pissed at my son for getting me into that situation." No one in the meeting had intended to negatively affect this mother. The way in which they spoke is fairly common practice in "case discussions." However, that manner of speaking had a devastating impact on this mother's participation and sense of influence in both the meeting and her life at that moment (and potentially on her son's well-being when she returned home).

I find it useful to draw a distinction between common clinical practices and the helpers engaged in them. The ways of speaking in the team meeting were not originated by the professionals who attended. Speaking in jargon is a common, taken-for-granted professional practice that can capture all professionals. I believe that helpers engaging in professional practices have positive intentions, and that sometimes those practices have inadvertently negative effects. The best judges of the effects of professional actions are those on the receiving end of them. It is important not to lose sight of the good intentions behind our actions. However, it is also important to be accountable for the effects of our actions on clients that occur despite our best intentions.

Our actions with clients are shaped by taken-for-granted assumptions about our role and what it means to be a "professional." There are a number of ways in which we, as therapists, are encouraged to view our job as acting on clients to change them or to repair damage. Many traditional clinical approaches are influenced by a medical model that positions professional helpers as "experts" who assess clients, develop treatment plans, and implement a series of interventions designed to bring clients more in line with "appropriate functioning." There is a privileging of professional knowledge and an invitation into professional certainty that is often reflected in attempts to assign professional meaning rather than elicit client meaning. This is reflected in the ways in which assessments are often conducted (who asks the questions and writes the assessment), and "cases" are often presented (with the subtle encouragement to deliver formulations with objectivity, professional distance, and confidence). It is important to reflect on the effects of these taken-for-granted practices and be aware of the ways in which they can have disempowering effects and supplant client functioning.

This inadvertent supplanting of client functioning is supported on many fronts. It is supported by the specialized expert knowledge we are

taught about development, functioning, and pathology. This has the potential to encourage clients to defer to our knowledge and lose sight of their own. It is supported by professional titles (e.g., "the Doctor will see you now") and by the semimystical aura of therapy (e.g., the idea that we know and can interpret what is *really* going on for people). Finally, it is supported by professional language that positions helpers and clients in particular relationships. For example, we have "service providers" and "service recipients," "case managers" and "cases." Language used in this way can construct clients as the objects of professional intervention rather than subjects in their own right with intentions, hopes, dreams, and agency.

Our inadvertent supplanting of client functioning may also be encouraged by our good intentions and the organizational pressures we face. Many of us come to mental health and social services out of a strong desire to help others. As we stand a little bit outside clients' lives and view their pain and distress, it may appear to us that there are some obvious solutions that would alleviate this distress. There is a strong pull to fix things. This "fix-it" mentality also receives significant support from the current push for evidence-based treatment approaches and the search for replicable procedures for specific conditions that will save time and money. Clinicians in community agencies are under incredible pressure to produce and document quantifiable changes in client functioning in a shorter and shorter amount of time. As therapy increasingly takes on an assembly-line ethos, we are encouraged into an instrumental orientation that transforms human beings into billable hours.

Our conceptualization of our role also influences how we think about and draw on clients' broader communities. All too often, we are aware of the professional resources available to clients but ignore the power of their natural networks. We make a point of coordinating our work with other helpers but neglect to learn about important neighbors, self-help groups, and faith and community organizations. We are only a temporary presence in clients' lives, whereas these community resources are embedded in the fabric of their lives. One concept that can help us remember our place in clients' lives is a distinction between *primary* relationships (consisting of an individual's relationships with family and household members, kin, friends, neighbors, associates and acquaintances, and community members) and *secondary* relationships (consisting of relationships with representatives of social institutions, which include mental health, social service, and health care workers) (Kliman & Trimble, 1983). It is important that we remain secondary and do not inadvertently undermine clients' primary relationships. Within a commitment to empowering processes, our job is to *support*, not *supplant* the knowledge and functioning of clients and their existing communities.

Making Our Work More Accountable to Clients

Our attempts to position ourselves as allies who actively support clients in building preferred lives can be guided by a series of questions to examine the effects of our actions on them:

- How might this client be experiencing our interaction right now?
- How might they be experiencing themselves in our interaction?
- Would they say our interaction is more or less likely to highlight their abilities, skills, and wisdom?
- Would they say our interaction is more or less likely to acknowledge, support, and amplify their participation and influence in life?

The questions provide a way for us to continually reflect on the effects of our actions on clients. They are rooted in an assumption that the best judges of the effects of our actions are the people most affected by them; that is, those human beings who come to be called "clients." We can minimize inadvertent disempowering processes by actively inviting clients' feedback about their experience of our actions and evaluating our work in terms of the degree to which our actions are experienced by clients as respectful, connecting, empowering, and hopeful. One way to do this is through accountability structures.

Accountability structures are attempts to amplify the voices of those who have less power in interactions and ensure that those with more power have opportunities to receive feedback about inadvertent negative effects of their actions as well as opportunities (and consequent responsibilities) to acknowledge and address those effects (Hall, 1996; Waldegrave, Tamasese, Tuhaka, & Campbell, 2003). Often, accountability is seen as a unidirectional flow in which those in hierarchically subordinate positions are accountable to those in positions of more power or responsibility (e.g., workers are accountable to supervisors). However, accountability in this context refers to partnership accountability in which parties are mutually accountable to each other, with a particular emphasis on amplifying voices less likely to be heard.

We can make our work accountable to clients by routinely inviting their feedback on the effects of our actions in ways that convey a commitment to take that feedback seriously and act on it. We can do this at the end of sessions by checking with clients how the work is going from their perspective and how we can together make it a more useful experience. We can also develop institutional structures to address this so that the maintenance of accountable practices becomes an institutional responsibility rather than an individual inclination. We can include

clients in clinical discussions and solicit their feedback about the process. When clients are unable to attend such meetings, we can include "client voices" in clinical discussions through having someone listen to the discussion as the client being presented, and then being interviewed about his or her experience of the discussion (Anderson, 1997; Madsen, 1996, 2004). Finally, we can develop clear structures and processes for involving clients in organizational decisions that affect our efforts to help them. Additional ways to make our work more accountable to clients are discussed throughout this book.

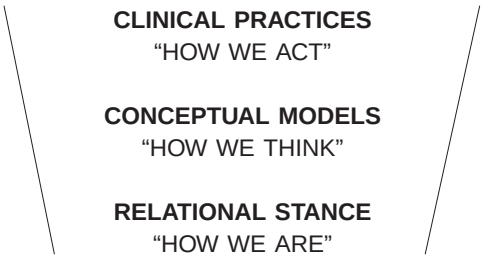
We can also make our work more accountable to the clients we serve by engaging in practices of "transparency." David Epston introduced this term to refer to the process of sharing our organizing thoughts and assumptions with clients (White, 1993). The process of clearly identifying the experiences, ideas, and intentions that guide our questions, thoughts, and suggestions helps clients become more aware of the rationale for our actions and participate on a more equal footing in therapeutic interactions. Examples of transparency in the course of therapy sessions include questions like "Would you be interested my thinking behind this question and why I'm asking it?" or "I'm thinking about pursuing this line of questioning—how would that be for you?" I've often thought of this process as conducting therapy with subtitles that show our thinking. This both brings clients into the process and helps us to get "on the same page" so that work can proceed in a collaborative fashion. As we check with clients at the end of sessions, we can also offer them opportunities to better understand (if they desire) the rationale behind particular questions or comments made during the session (Madigan, 1993; Nylund & Thomas, 1997). In this way, they can leave with a clear sense of the intentions and hopes behind our clinical practices rather than wondering what we "really meant" by a particular statement or question.

Accountability structures and therapist transparency are both means of demystifying our thinking and anchoring it in a specific context rather than contributing to the belief that professional thoughts arise out of some distant "truths" that are inaccessible to clients. These practices help develop a context in which clients are better able to decide for themselves how they might want to respond to our efforts and become more active participants in important aspects of their lives.

SUMMARY

This chapter has highlighted the importance of the relational stance we adopt with clients. That stance is the foundation for our clinical work. A

stance of an appreciative ally is characterized by the active cultivation of respect, connection, curiosity, and hope. Four commitments that support the development of an allied stance include striving for cultural curiosity and honoring family expertise, believing in possibilities and building on family and community resourcefulness, working in partnership and fitting services to families, and engaging in empowering processes and making our work accountable to clients. These commitments help us to maintain this type of relational stance. Our relational stance reflects "how we are" with clients. It underlies and informs our conceptual models or "how we think" about clients, as well as our clinical practices or "what we do" with clients. Our conceptual models and clinical practices help us embody a particular relational stance. Graphically, it can be illustrated in the following way:



The rest of this book explores ways of thinking about and working with multi-stressed families that help position therapists as appreciative allies.[5] The next three chapters outline conceptual models that are useful in thinking about families, problems, and therapy. The subsequent five chapters outline clinical practices that grow out of these conceptual models and support a relational stance of an appreciative ally. The final chapter examines possibilities for weaving a spirit of respect, connection, curiosity, and hope into the fabric of organizational cultures.

NOTES

1. The names of clients discussed in this book and the details of their lives have been changed in order to protect their confidentiality.
2. In this book, I refer to abilities, skills, and know-how (or knowledge or wisdom) frequently. In this context, I am using know-how to refer to concrete "hands-on" knowledge or wisdom about life that has been gained in the context of living life. This knowledge is often developed in a social context and shared among people.
3. It is important to emphasize the word "primarily" here. This is not a choice of attending to possibilities *or* problems, resourcefulness *or* difficulties,

safety *or* risk. Clearly, it is important to appreciate both. However, where we put our primary focus will influence what we see, how we act, and what possibilities emerge.

4. Child protective work is a notable exception to this distinction. In this context, workers have a goal of ensuring a situation is safe enough for children to remain in or return to their home. In that case, their expertise and responsibility also involves making judgments to ensure children's safety. Nonetheless, collaborative partnerships can significantly enhance protective work. A great resource for further pursuing this possibility is Turnell and Edwards's (1999) *Signs of Safety: A Solution and Safety Oriented Approach to Child Protection Casework*.
5. I do not in any way want to imply that the conceptual models and clinical practices described in this book are the only ones that invite the enactment of the relational stance I'm proposing. They are simply ones that I have found particularly useful.

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