HUMANISTIC ONTOLOY: CLINICIAN VULNERABILITY, HUMILITY, AND ADVOCACY

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Abstract

As the field of psychotherapy expands its reaches beyond its original boundaries to now include systemic family therapy and partake in consequential multidisciplinary endeavors, so have the needs to justifying its relevance to non-Western populations given the vast array of diversity in experiences of culture, tradition, and identity. Consequently, as developing ontological stances and theories attempt to understand the nature of human beings and find ways to occasion change in their problem-organized systems, the essence of individuals' meaning making and self-actualization can be easily overlooked. Leading to an experience of incongruent conditioning of experiences in contrast to their sense of self-identity and self-agency. The humanistic approach to therapy which helped shift the narrative from the traditional directive of the therapist-knows-best to a client-centered point of view – valuing clients' humanness and potentials– favored the rise of collaborative language systems as a social constructivism paradigm of change purposing the contextual-self through narrative and descriptive language. The position described in this paper details the integration of that approach with the self-of-the-therapist to inform therapeutic alliance and outcomes.

Humanistic ontology: clinician vulnerability, humility, and advocacy

"Death will never come soon enough. Nothing I do will ever be enough!" said Sonia Kendrick times and times again as I would help her in her shop, at vegetable patches around town, or distributing freshly harvested produces in her makeshift van. It seemed it had steadily become a mantra she would recite to convince herself that the struggle was either worth bearing, to push through the aftermaths of her Afghan deployments, or to scream for help that never seemed to come. Only she knows how often she has flirted with death until the ultimate evening of March 20, 2018 ("Mrs. Sonia Stover", 2018). The Women Veteran Leader "Champion of Change" as she came to be bestowed upon by the White House in 2014 (Feed Iowa First, n.d.) had taken her own life after many years of fighting herself, and the cultural norms she felt disregarded her lived experience.

As a neophyte student in marriage and family therapy, many aspects of the field of systemic psychotherapy were, and still are, foreign to me. It seems nothing I learn will ever be enough to prepare me for the realities of the therapeutic process. Almost two years into the program, I have more questions than I started with, almost all centering around clinical humility, vulnerability, and curiosity, rather than mastery – how the self-of-the-therapist and vulnerability, or lack thereof, inform the systemic therapeutic process; how the cultural self has forever become transformed by the field of systemic psychotherapy; and how my position as a mental health advocate could act as a blind spot – as it pertains not only to individual clients, and the clinician as a collaborator and co-creator, but also to the larger communal well-being. Stories like that of Sonia, and personal struggles with mental health certainly continue to fuel these

questions and inform my aspirations in the mental health field; or at least efforts in identifying a silver lining. In trying to seek understanding regarding the connection between life experiences and the ontological position underpinning my approach to psychotherapy, I turned to the advocacy endeavors of Alice Miller, (2002) who stated:

> It is true that psychotherapy is still a privilege of a minority, and its achievements are often questioned. But having witnessed in case after case the forces that are set free when the results of a cruel upbringing are counteracted; having seen how these forces would otherwise have to be mobilized on all fronts to destroy vital spontaneity in oneself and in others because this quality has been regarded as bad and threatening from an early age, I want to communicate to society something of what I have learned in the therapeutic process. Society has the right to know, to the extent that this is at all possible, what actually takes place in the analytic setting; for what comes to light there is not only the private affair of a few ill or disturbed people; it concerns us all. (Pp. 7-8)

The well too common experiences of sheered acknowledgement of the nature of human beings, conditioned to suffering and misery should serve to inform a biopsychosocial imperative necessary to access readily available, yet untapped basic human resources. Sociocultural efforts to frame mental health in a unilateral light continue to serve to undermine the pluralistic and spectral nature of the human experience. As Sonia Kendrick put it best : “they tried to burry us; they didn’t realize we were seeds” (Feed Iowa First, n.d.). I often wonder if she found peace as she took her last breath; at the idea that her death would become the ultimate burial of “seeds” that would grow to give purpose to her vision of a “fresh revolution” (Feed Iowa First, n.d.). I

have certainly witnessed the hopeful prospect of her selflessness transform the life of many families and the community. But many would ask, at what cost? And justifiably so.

As a victim and survivor of cultural traumas, and of intimate partner violence due to mental illness; and having experienced childhood and developmental traumas, coping with the post-traumatic sequels took many forms including but not limited to distaste, disconnect, distrust, and despair that blindsided my ability to connect to my humane self and afford others unconditional compassion. It is an experience that is extremely hard to bear, to say the least. Yet, like Sonia, my yearning to make a difference in the world never quivered: it mattered to create new meanings to effectively integrate personal post-trauma life experiences and growth opportunities to serve greater causes. Similar to practicing as a systemic psychotherapist by integrating external therapeutic factors, the prospect of hope, and the self-of-the-therapist. According to the Mount Mercy university Marriage and Family Therapy (MFT) program handbook, the stated baseline of clinical competency as a psychotherapist clinician seems to be that we become capable of integrating therapeutic approaches that are theory-driven and illustrating application of major models of marriage and family therapy to assessment, intervention, and therapeutic outcomes; therefor affording us the opportunity to demonstrate our personal progress of the integrated approach to therapy (Webster, 2020). Nonetheless, as a reflection of my inquisitions on the effective integration of systemic psychotherapy, Nichols and Davis (2016) say of the “foundations of family therapy” to be comparable to an acknowledgement of clinicians’ limitations, countertransference, and the ability to transcend clinical competency, which is exemplified in the summary of this case scenario:

> Holly's memories resembled her mother's memories very little, and her stepfather's not at all. In the gaps between their truths, there was little room for reason and no desire to pursue it… I think that's when I became a family therapist. To say that I didn't know much about families, much less about how to help them, would be an understatement. But family therapy isn't just a new set of techniques; it's a whole new approach to understanding human behavior — as fundamentally shaped by its social context. (2016, p. 3)

Evidently, if there is more to mental health and systemic and family therapy than ICD-9-CM / ICD-10-CM codes, subtypes, and specifiers, (American Psychiatric Association (APA), 2013, p. xiii); since "a complete description of the underlying pathological processes is not possible for most mental disorders" (APA, 2013, p. xli), what other tools are available for budding clinicians faced with narratives that query beyond standardized criteria and generalized symptoms?

Let us review these few scenarios: what of an abusive partner who always says sorry after beating their intimate partner just to hit them again; what of a mother who works three jobs to provide for her kids but is never able to keep up with financial needs or childcare; what of a grandmother who his "mother" to an infant with neonatal withdrawal issues; what of generations of families living in food deserts, conditioned by intergenerational poverty traumas; what of Sonia Kendrick driven to join the army to escape what she described as an alienation of her self-identity; what of the veterans who come home traumatized and struggling to regain "functionality" in a society that lacks the basic tools to support them; what of systemic/institutionalized racism; what of the structurally unbalanced socio-cultural and socio-

economic realities across not only the United States but also the globe; what of the many stateless populations and refuges whose lives are directly impacted by wars of interests; what of a system that sees not your individuality and would rather fit you in "convenient" categories; what of the young child who woke up today feeling trapped in a foreign body and constrained by heteronormative and gender normative constructs; what of sexual assault victims having to prove their victimhood; what of the COVID-19 pandemic and its romanticization, and the roles all these factors play in contributing to a sense of self dysregulation that causes individuals, and families to further isolate while seeking answers to problems that are intrinsically systemic.

Certainly, these questions and their guiding frameworks are as diverse and unique as the experiences they portray. It is therefore important to understand how answering these questions through understanding the human condition inform my role as a systemic psychotherapist. And from there, try correlating the implications of my ontological position to my epistemic approach to theory of therapy, its practice and application.

Orienting Views

In a field that is predominantly informed by industrialized Western and Euro-American sociocultural values, the concept of systems perspective provides a crucial and pioneering map for understanding mental health. Becvar and Becvar (2018) referred to the development of systemic theory as a curiosity endeavor of people "scientists seeking to understand, predict, and control their worlds" whereas "different explanations produce different interpretations and feelings which interact with different kinds of responses" (p. 1). As such, an event could have

many meanings and interpretations which are informed by "our personal frame of reference and thus tend to validate the theory" (Becvar & Becvar, 2018, p. 1). Admittedly, arriving to a positive and life altering therapeutic outcome would be immensely enhanced by clinicians' ability to effectively integrate modalities with external factors, and a genuine appreciation of cultural differences and experiences (Thomas, 2006, pp. 202-209). Because people are a combination of multi-ethnocultural experiences shaped by varying biogeographical, psychosocial, and axiological inclinations, no one individual has a unified culturally coherent identity or experience (Marcella, 1996, pp. 441-442). Waterman (2013) further expands on the individual's experience by correlating it to existential consciousness, stating that "There is no essential individual human nature that determines what destiny each individual is to fulfill. The individual is, and the individual must decide what he or she will become" (p. 126). Because Waterman believed that people should not be controlled by external authorities or rely on others to tell them what to do, the individual experience becomes a vital part of larger wholes that seek to uphold the idea that "more than the sum of their parts, systems are the parts plus the way they function together" (Nichols and Davis, 2016, p. 257). Consequently, for systemic psychotherapists, "deciding when to delve into individual experience or fucus on interactional patterns presents a host of hard choices" (Nichols and Davis, 2016, p. 258).

Tapping into that sense of uniqueness, coupled with the ability to access readily available community-oriented resources, growth opportunities, and advocacy tools as means of therapeutic viability, Rojano (2004) sought to utilize limitations, the human condition, and humanism as a systemic approach to psychotherapy. An approach seeing "families in poor communities not only

as resilient but also as change agents, not only as clients but as citizens" (Rojano, 2004, p. 59), informed by a mutual sense of engagement and vulnerability between therapist and clients. Rojano's argument is centered around Carl Rogers' premise that given favorable socioenvironmental conditions, clients can change and grow constructively (Patterson, 1977); leading to a humanistic ontology valuing not only clients' inner resourcefulness to promote growth and recovery, but also an attitude of advocacy for and curiosity of client's expertise oriented towards "the desire to understand the psychological functioning of specific individuals within their mental, physical, social, community, and broader environmental context" (Waterman, 2013, p. 128). The role of the therapist's epistemic commitment is therefore to serve as a curiosity outlet, whereas their assumptions of what constitute human nature, the nature of socioenvironmental realms and interpersonal experiences reflect not only an understanding of clients' psychological distress as well as their own, but also an awareness of the individual's ability to create meanings consistent with their own belief systems (Bacvar & Bacvar, 1993, p. 145). The allegiance to such philosophy can therefore become rooted in personal experiences. Toska, Neimeyer, Taylor, Buyukgoze-Kavas, and Rice (2010) argue that "a therapist would be drawn to the theories whose underlying story about the human condition closely matches to his own'" (pp. 66-67), suggesting that the therapist is more likely to congruently implement models of therapy that enhance the therapeutic process and maximize outcomes by effectively engaging with and personalizing interventions to clients' needs. Reflecting a search for meaningful and long-lasting systemic change, humanistic ontology as justification to epistemic approach to therapy therefore followed Bateson's (2000) study of feedback mechanisms/loops in self-

regulating systems, which postulates that cybernetics description is always considered to be negative. He states that:

> we consider what alternative possibilities could conceivably have occurred and then ask why many of the alternatives were not followed, so that the particular event was one of those few which could, in fact, occur… the course of events is said to be subject to restraints, and it is assumed that, apart from such restraints, the pathways of change would be governed only by equality of probability. (Bateson, 2000, pp. 405-406)

As changes in the system trigger self-correcting behaviors to pre-established functioning levels, leaving the system to fend for itself could lead to ineffective functioning without "check and balance" interventions of a reinforcing input (positive feedback) capable of shifting communication patterns and perspectives to help the system evaluate and change its rules (Nichols and Davis, 2016, pp. 51- 54). Because there is always a chance that if left to their own demise the systems will get out of hand, as demonstrated by vicious cycles like self-fulfilling prophecies and bandwagon effects (Nichols and Davis, 2016, p. 53), the philosophical underpinnings of humanistic ontology encourage an integrative approach aimed at promoting:

> A third order type of change in which the individual gets out of the system, gets empowered, and forms or joins other healthier and more functional systems - while simultaneously facilitating the implementation of first and second order changes within the primary system and the surrounding local community. (Rojano, 2004, p. 66)

Informing such systemic dynamics with the epistemic insight of humanistic ontology requires the careful exploration of the paradigms that I believe shape them.

With the understanding that a clinician's ontological positioning is crucially relevant to their theories of choice and practice style, one thing that is undisputable to psychotherapy is that the understanding of the nature of human beings and their suffering is centerpiece to an effective therapeutic working alliance and outcome. There are certainly diverse opinions on how to get to that understanding, given the many schools of thoughts guiding clinicians' trainings and developing worldviews. Whereas psychoanalysis describes human nature as inherently destructive, contrary to classical behaviorism postulating that human nature is neutral and moldable (Patterson, 1977). And while rationalist cognitivism assumes that "there is a single, stable, external reality, and thoughts are held superior to senses when determining the accuracy of knowledge" leading to more "persuasive, analytical, and technically instructive" therapeutic interventions and outcomes (Lee, Neimeyer, and Rice, 2013, pp. 325-326); the epistemic underpinnings of humanistic ontology suggest that human beings are socially constructive entities because of their inability to escape the essence of their existence thus the need to attempt to continuously give meaning to life. Waterman (2013) says of the implications of such that:

> The oft-quoted dictum "existence precedes essence"… means that we as human organisms, through consciousness, must define ourselves through our actions. Although limited by the biological constraints of what is possible for human beings to do (a generic human nature), it is up to each of us, as individuals, to decide what it is that we will do with our existence. (pp. 126-127)

Carl Rogers in his speculations of the absence of "Scientific Knowledge" hinted to the notion that knowledge is an experienced accumulation of individual perceptions and interpretations of phenomena. With that premise, Carl Rogers paved the way for the birth of a humanistic approach to psychology aimed at exploring the experiences of the individual and its human nature as informed by a client-centered point of view of liberally cooperative and constructive people (Patterson, 1977). The incongruence between the individual experience and stated social standpoints becomes one of the primary bases for the behavioral, emotional, and psychological responses of the organism to what is perceived as a threat to its self-actualization. This incongruence is well represented by the story of Sonia Kendrick, thus her attempts to seed herself and create new meanings, which parallels Carl Rogers' argument that the individual can self-actualize "as a seed grows and becomes its potentials" if the "capacity to guide, regulate, and control himself, providing only that certain definable conditions exist" is respected and allowed to become conscious (Patterson, 1977, p. 4). The ability to access a state of maximal psychological growth is therefore correlated to effectively maintaining healthy interpersonal relationships and staying a functioning person. The aim is not to become an unachievable ideal prototype of the self by changing problematic patterns of interaction, but rather to access new perspectives or constructs. As a clinical tool, Nichols and Davis (2016) say of the personal construct theory, developed by George Kelly in 1955, that clients and therapists create their own constructs of socioenvironmental realities through reframing, explaining that:

> In a world where all truth is relative, the perspective of the therapist has no more claim to objectivity than that of the clients. Thus, constructivism undermined the status of the

> therapist as an impartial authority with privileged knowledge of cause and cure. It's probably well to remember that even our most cherished metaphors of family life — system, enmeshment, dirty games, triangles, and so on — are just that: metaphors. They don't exist in some objective reality; they are constructions, some more useful than others. (p. 56)

Seeking meaning beyond the individual mind, social constructivism presents incongruences as "meaningful perturbances in client's network of meaning, both at individual and societal levels" (Toska, Neimeyer, Taylor, Buyukgoze-Kavas, and Rice, 2010, p. 68). Nichols and Davis (2016, p. 57) further expand on social constructivism as informing the interpretation of intersubjective and contextual experiences, which are influenced by cultural and linguistic paradigms.

Theory of Therapy

In an attempt to make light of the role of the human species on the planet, Quinn (1995) masterfully crafted a philosophical narrative of covert cultural biases informed by dominant assumptions about socioenvironmental structures. In "*Ishmael*," he highlights the importance of meaning making through intersubjective narration, which is brought centerstage in chapter six. The narrator engages in a dialogical conversation with Ishmael who identifies problems-organized systems based on the narrator's interpretations of reality and lived experiences and engages him in guru-like attempts to elucidate where he believes the problems stem from. As the Socratic dialogue unfolds between the two characters, redescription and retelling of realities transcend the narrator's interpretations, as it becomes apparent that a "jellyfish" and even a

"rock" can also have meaningful descriptions and interpretations of the same reality. Anderson (1995) reiterates that inference regarding descriptive language, stating that "each problem description and imagined solution, is one of many possibilities" (p. 33).

With that in mind, I have come to convince myself that of all the feedbacks I have so far been receiving, the one giving greater meaning to my approach is the description of my therapeutic disposition to just being a human being. In my view, such a perspective describes an attempt at a neutral therapeutic engagement that is "seeded" in clinicians' sense of vulnerability and humility, which are informed by their ability to be cognizant of the implications of the basic nature of suffering and misery as part of the human condition; as well as of the impact of clinicians' epistemic allegiance on psychotherapeutic alliance and outcomes as described by Toska, Neimeyer, Taylor, Buyukgoze-Kavas, and Rice (2010). It is a paradigm of the contextual-self purposing physiological and mental experiences through narratives and descriptive languages comprised in "aspects of stories/storytelling, as they relate to life, to the definition of stories, to therapy in general, and to family therapy in particular" (Becvar & Becvar, 1993, p. 145). Given the constructivist argument that the meanings we give to our experiences are directly correlated to contextual factors such as cultural values and interpersonal relationships; William Carlos Williams is quoted as averring that due to the implications of our interpretations of those experiences and the application of their meanings:

> We have to pay the closest attention to what we say. What patients say tells us what to think about what hurts them; and what we say tells us what is happening to us – what we are thinking, and what may be wrong with us. Their story, yours, mine – it is what we all

> carry with us on this trip we take, and we owe it to each other to respect our stories and learn from them. (Coles, 1989, Pp. 30)

Theory of change. The necessary preconditions to occasion change and work towards reestablishing congruence between the individual sense of self, experiences, and interpretations of those experiences are therefore embedded within the integration of the description (or meaning making) of constructs about the nature of the self in relation to those lived experiences, their interpretations, and their contextual ramifications. The American psychologist and spiritual teacher Richards Alpert alias Baba Ram Dass concluded one of his summer of 1988 lectures "Promises and Pitfalls of the Spiritual Path" by quoting the Buddhist lama Kalu Rinpoche as saying: "We live in illusion and the appearance of things. There is a reality. We are that reality. When you understand this, you see that you are nothing, and being nothing, you are everything. That is all." This notion of nothingness and everythingness being one in the same is echoed by Carl Rogers' reflection on construct as a process of subjective interpretation finding meaning in the integrative experience and interpretation of our own reality through that of others and vice versa, whereas we are capable of shading off rigidity by creating:

> a decrease in conditions of worth, with an increase in unconditional positive regard from others in an empathic atmosphere. Positive self-regard increases, with congruence between the self and experience. The individual is more congruent, less defensive, and more open to his experiences, showing more positive regards for others. (Patterson, 1977, p. 9)

This integrative nature of the subjective and collective experience, as describing one reality embedded in the interrelation of our conscious and unconscious processes (as exemplified by the action and reaction feedback loop of cybernetic systems), finds meaning in the postmodernist interpretative perspective of language and conversation as core components of change towards psychological adjustment and self-actualization (Anderson, 1993, p. 324). Anderson (1993) premised that collaborative language systems approach to therapy, emerging as one of those interpretative perspectives, utilizes these core concepts of language and conversation as guiding principles in helping clients deconstruct and story their own sense of liberty and freedom. A process that can be facilitated through a democratic and dialogical therapeutic environment as highlighted by Carl Rogers when stating that "the facilitation of significant learning rests upon certain attitudinal qualities which exist in the personal relationship between the facilitator and the learners" (Patterson, 1977, p. 16).

Problem development. Because the meanings we assign to socioenvironmental events and their contexts can shape who we are as individuals and how we relate to others, they can also lead to feelings of incongruence that arises between the self and the experience, and therefore cause psychological maladaptation. Carl Rogers says of such occurrence that:

> In a situation where a significant experience demonstrates the presence of a large or significant incongruence between self and experience, the process of defense is unable to operate successfully. Anxiety is then experienced, to a degree depending on the extent of the self-structure which is threatened. The experience becomes accurately symbolized in awareness, and a state of disorganization results. The organism behaves at times in ways

> consistent with the experiences which have been distorted or denied and at times in ways consistent with the concept of the self, with its distorted or denied experiences. (Patterson, 1977, p. 9)

As conflicts arise within the individual's understanding of the nature of self, their interpretation of lived experiences, and the meanings being assigned to them, the functional self organizes their experiences in terms of denial and distortion of their awareness of reality, their ideal self, and their sense of self-actualization. Subsequently, problems are assessed as the developing self presents as undifferentiated, and the development of the need for positive self-regard and conditions of worth becomes reliant on feedback loops stimulated by societal and dominant narratives that perpetuate defensiveness of the self and deterioration of interpersonal relationships (Patterson, 1977). The problem-organizing system is determined by interacting participants identifying "an event or person someone else is concerned or alarmed about and wants to change" (Anderson, 1995, p. 33), presenting as linguistic descriptions of "events or positions, which are often interpretated in conflicting ways" (Anderson,1995, p. 33) so that some behaviors create dissonance between interacting participants, and lead to a state of stress/anxiety and inconsistency with the self.

Interventions. The framework of collaborative language systems is that there is not just one problem with the system which is "one kind of meaning-generating system, one kind of linguistic conversational system" (Anderson, 1995, p. 33), nor are there specific learned tools to resolve it because "each client, each problem, each therapy session, and each course of therapy is seen as unique. The approach does not rely on preconceived knowledge such as commonalities

of problems or on across–the–board skills or techniques" (Anderson, 1993, p. 325). Rather, there is an array of problems, including the therapist's own interpretation of the perceived problems and course of therapy, and the therapist's philosophical stance being rooted in humanist hermeneutics focused on a client-centered process. The following guidelines therefore serve to encourage therapist's curiosity and promote client's expertise.

A / Conversational questions: "Not knowing" and the intersubjective process. The clinician's ability to create a democratic partnership through genuine curiosity and conversations that reflect the client's language and expertise is primordial in collaborative systems language. It is a conversational process that values and promotes the client/system's sense of agency through a deconstructive and transformative process aiming to gradually utilize client's everyday language to negotiate individually appropriate goals. According to Anderson (1993), it is a process of "wihtness" whereas partnership is formed through the therapist just being with the client. Anderson writes that:

> "The process of therapy is a therapeutic conversation, a dialogue, a "talking with." The conversation entails an "in there together" process, in which the therapist and the client engage each other, through dialogue, in co-exploring the issues at hand – the problem – and in co-developing "newness" that is, altered or novel meanings, realities, and narratives." (pp. 324-325)

It is this ability to access newness through conversations that facilitates the deconstructive process. It is therefore important for the therapist to present themselves as non-experts and utilize

the client's language when asking questions that allow for a democratic and dialogical conversation seeking to genuinely help both therapist and client understand the client's stated problem and allow for a continued dyadic learning experience.

B/ Accessing new meaning through a reflecting process. To access new meaning through linguistic interpretation, the therapist collaboratively work from a "not knowing" standpoint whereas conversational questions and processes, rather than conditional questions–driven by professional agendas seeking to assess what the client knows about what the therapist thinks they know (Anderson, 1997) – are formulated in the form of "appropriately unusual" comments (inviting curiosity and offering new perspectives), puzzling questions/processes (joining client in meaning-making), and writing processes (slowing down to access inner, alternative, or significant people's voices (Penn & Frankfurt, 1994)). Such processes are meant to provoke and invite the client's curiosity of different perspectives within the familiarity of the language being used by the client, and therefore create a sense of mutual exploration and affirmation of client's agency (Anderson, 1997). Anderson (1995) says of that agency to be informed by the client's sense of self-identity and it being "likened to having a voice and being free to use that voice or not. It is also the telling of a new history that is more tolerable, coherent, and continuous with present intention" (pp. 30-31).

C/ Being collaboratively public. In an attempt to avoid that the therapeutic process becomes polarized and monological, being public speaks to the therapist ability to tentatively and tactfully grow through the collaborative process while making the client's perspectives central. The therapist appeals to the client's regard by honestly sharing their thoughts with the client

when engaging in (a) professional communications regarding client's ongoing treatment with third parties (St. George and Wulf, 1998); and when (b) offering significant differences in values and goals. In the latter, the therapist makes known their values on discussed subjects without requiring a course of action from the client: becoming engaged it the conversation as a co-creator because they are no longer an expert "who structures the therapeutic interview; that structure is determined by both the client and the therapist. This does not mean that "anything goes," that the therapist throws all her or his knowledge and preconceptions out the window. It does, however, suggest that the therapist's knowledge, experience, and values are no truer than the client's – nor more final" (Anderson, 1993, p. 343). Additionally, the client is allowed to navigate reflections with teams composed of the client's identified support system. It is a process of suggestive guidelines including focusing on each individual/team/family inner dialogue and using reflecting team and reflections from team members only with client's permission, "as if" they were part of the problem-organized system (Anderson, 1997).

Change as grounding of self-identity and self-agency. Because there is no predefined model or map of health guiding what change looks like, the therapeutic process of collaborative language systems is a mutual engagement towards progressive transformation, whereas the client's experienced shift is informed by an increase in awareness and competency of the "organism to develop all its capacities in ways which serve to maintain or enhance the organism" (Patterson, 1977, p.4); and by the therapist worldviews evolving to appreciate the client's perspectives as additional and alternative ways of creating meaning and hope (Anderson, 1997). Anderson says of change to be a process of creation and meaning making within the self, and

intersubjective relationships in constructed socioenvironmental contexts, where one's self-identity is "subject to shifting definitions as the social interaction shifts" (Anderson, 1995, p. 31). Subsequently, the progressive shift from "perceptions of characteristics of the 'I' or 'me' and the perceptions of the relationships of the 'I' or 'me' to others and the various aspects of life, together with values attached to these perceptions" (Patterson, 1977, p. 5) toward "the self-concept which the individual would most like to possess" (Patterson, 1977, p. 5) determines the client's ability to access competency and demonstrate thoughtful decision-making abilities. This allows the client to access a sense of liberty and freedom congruent with their experience of and interaction with the problem-dissolving process and their self-agency, described as the "ability to act, feel, and think in a way that is liberating, that opens up new possibilities or simply allows us to see that new possibilities exist" (Anderson, 1995, p. 31).

Application

The following case examples provide insights into attempts to create conversational partnerships, facilitate dialogical processes, validate clients' expertise, and set collaborative goals during the collaborative process of promoting change.

Individual Collaborative Therapy: Sergeev Vladmirovic

During intake call, client stated experiencing (bad) depressive episodes and persistent stress, and seeking individual therapy to manage strong communication issues and depression. Client's assessment determined that client's experience with developmental traumas, culture shock and conflict, and family dynamic were major factors in client's depressive episodes, anxiety, and

stress. Client's symptoms fitted criteria for generalized anxiety, and adjustment disorders with mixed disturbance of emotions and conduct but opted to not have diagnosis on file.

Sergeev Vladmirovic clip 1. Goal and interventions: Developing working therapeutic alliance through Conversational Partnership and use of Conversational Questions.

The conversation in this clip starts with a brief summary from the intake session, and student therapist acknowledging client's effort at engaging in the therapeutic process and being vulnerable.

Conversation transcript:

> Student therapist (T): And I know last time when we spoke (and I really appreciate you going those places with me, right) I know it is not easy. I know like there is the idea that this is therapy, so "I am supposed to be here and just say stuff", right… "and everything is okay." And I know it is not always that way, right? So, I really appreciate that you did not have to go there but I really thank you for going there with me… hmmm, if it is okay with you, I just want to ask you, like, what do you, like, what was the day like today? What things about today did you like and what are you looking forward to this weekend?
>
> Sergeev Vladmirovic (S): hmmm, I guess today I was very happy, I got to leave work early... hmmm.
>
> T: okay

S: It was a really long week for me…

T: yeah?

S: hmmm, I got… you know, my co-workers got pizza to and… you know, I got to hang out with them a little bit.

T: Exciting

S: I am going up to Madison today, after this pretty much, for the weekend, hmmm…

T: Okay

S: I am going to see my girlfriend, hopefully you know that goes well. To see my friends and yeah, I am just excited to just kind of go relax a little bit.

T: Yeah, and I know last time (I mean first of all it is something exciting to look forward to, like just being out of [sight] here going there, distress a lit bit after the long week) hmmm, and last week you spoke a little bit about like the tension between you and your girlfriend, and I know that you tried to make a correlation between, you know, seasonal occurrences of depression and how that impacts your relationship with her. Hmmm, but I just want to like, ask you what are you looking forward to when you guys meet?

S: I honestly am just looking forward to spending time with her. I, hmmm, (I don't know) I honestly… what I am really excited about is like go grab breakfast with her on Saturday. I am a big fan or going around a taking walks.

T: Okay

S: And I loved Madison, I like, I kind of walk by the capital city, that's why

T: Yeah, well, what do you like about Madison?

S: I think it's a… it's a really pretty city. I, hmmm, I really like, you know, I really love living in this one area of the city.

T: okay

S: I kind of live where the capital is, but I really like that entire area. And big coffee drinker so…

Both exchange laughter…

S: I mean there is like ten different coffee shops on the way so kind of grab me something, walking around. On my way back grabbing like some tea or something. Because I should not have that much coffee. That's it!

> T: Yeah… and you said, like… the city is beautiful, what is that like? I know you said, on the one hand I am a big walker… I am assuming you love nature. Is that why…

Student therapist reviewed state of partnership with client and provided unconditional positive regards through validation of client's willingness to be vulnerable and stay engaged. Student therapist utilized conversational questions from within ongoing conversation to explore client's language usage through their description of events and life. Student therapist built rapport with client and client problem-organized system by using client's preferred language and description of events. Student therapist actively listened to client's description of meaning making and life without problem.

Sergeev Vladmirovic clip 2. Goal and interventions: Offering opportunity for reflection by making "Appropriately Unusual" Comments.

Conversation transcript:

> Sergeev (S): Like feeling worse and worse. So, I… sometimes… I am not sure if that is contributing to it or not. But I guess I…
>
> Student Therapist (T): But still, it is worth looking at.
>
> S: Yeah, yeah [inaudible] that it could be at least part of the issue
>
> T: hmmm… and like of course, the other aspect of what I was saying is the possibility that you just associated different things to those

experiences. And even if those don't happen and you still either smell something, see something, experience something (the changes revolving around all of that)… the fact that you are already wired for it might trigger you without you knowing.

S: hmmm… yeah…

T: it is a (good) possibility worth looking at

S: yeah… yeah that … I guess definitely worth thinking about, hmmm… 'cause I guess I kind of… I know she is gonna come and visit my brother in the fall and… but that… even kind of thinking about it… I kind of… it makes me a little anxious. And I know she is not going to be around my parents but her being here just makes me anxious about that. But at the same time, look, I have been talking a lot of that, you know… I figured I should try to reconnect with my family in Russia and kind of try to put everything to rest. At least for myself, and kind of talk to everyone again. Get pretty much a normalized relationship with everyone. And talking with her, I don't really feel like that unless I think about her coming.

T: Yeah… you kind of answered questions that I had, questions that I wanted to go over, and I am glad that you bring that up. And actually, I am glad you brough it up before I stated asking about it, because what I am

about to do is challenge you on something. On the fact that your… definition of normal is different from her definition of normal…

S: yeah…

T: Because… to her what is going on right now is pretty normal in many ways, right? You have allowed yourself to have a wider view of the world, or different, not to say wide, but different view of the world… which kind of challenges what it is that you see in that, right?

(Sergeev nodes)…

Compared to them seeing the same cycle and not seeing your perspective, and yes…sure your perspective of them, which you say you want to normalize (I am going to use another term if that is okay with you) but sure your perspective of them…

Student therapist acknowledged client's attempts to explore new perspectives of sociocultural dynamic, and family of origin's negative stress cycle. Student therapist reflected on client's description of negative stress cycle as one of many alternatives. Student therapist validated client's description of experience with culture of origin and family dynamic. Student therapist attempted to invite client's curiosity and offer new perspectives by challenging client's belief about culture of origin and family dynamics as the source of client's anxiety. Student therapist sought to increase awareness of relationship between client's description of events as experienced by client and others by utilizing appropriately unusual comments.

Sergeev Vladmirovic clip 3. Goal and interventions: Inviting curiosity by utilizing Mutual Puzzling Process.

Conversation transcript:

> Student therapist (T): But then again… healing needs to happen because like I said… I am guessing (and let me know if I am wrong) you do have a lot of unsettling feelings about everything that has happened… and how gramma coming here has contributed to that, and how it is likely that you have associated gramma's coming or the idea of gramma coming, to other things (even if she does not come). Even times when she's come, and you know that this is the time when everything goes haywire … and just… your body getting ready to react to that, right? So, becoming anxious… do I want to fly (run away)? Do I want to freeze (not say anything and take it in)? Or do I want to fight? (Which I don't think you are a fighter in that sense, I hear that your brother is, he does not flight, he fights).
>
> Sergeev Vladmirovic (S): yeah… yeah…
>
> T: And everyone is different in the way they respond to it, but I will probably flight too, I will not freeze and just… but it seems like there has been times when you have been there, and you've taken it in and… you should not have had to experience that. And I know it is part of family dynamic (we have like two more minutes) [student therapist provides

update on time. I know it is part of like family dynamic and especially your family dynamic and I do not know a lot about you guys specifically but you seem to be a strong knit family and I think your gramma's (let me reformulate that) I think it would be worth understanding what it means for gramma to come here. Hmmm… and to do that it probably is going to take compassion, right… You have been triggered… you have been triggered and you continue to be triggered even though gramma is not here, and I am sorry that is the experience that you are feeling, and I can see how that can almost permeate into your own relationship, right… 'cause we have talked about how often you've said that you need your own space, right? 'Cause you are still trying to process everything that has happened to you… what is normal… what is not normal, right… and trying to create your own normalcy… hmmm… but I think it is probably worth understanding what it means for gramma to be here, what it means for your father, for his mom to be here. Because the support that he needs as a person, he might not be getting that from your mother either, right?

S: hmmm (in agreement)

T: And he… I mean it could be in his nature, and whatever he is doing…

Student therapist normalized client's feeling about family dynamics and events that have helped maintain client's anxiety and depression. Student therapist empathically validated client's

description of events and triggers. Student therapist used mutual puzzling process to help client normalize their feeling of triggering events while inviting them to examine the possible benefits of becoming curious about alternative meaning making of those events. Student therapist collaborated with client to help redefine contextual meanings of events. Student therapist attempted to invite client's curiosity about other family members' experiences and description of same events. Student therapist used metacommunication to assess client's response and reflection of therapist's comments.

Couple Collaborative Therapy: Samuel Lee Shawn and Celestine Joan Smith

Samuel initially sought individual therapy for depression, self-esteem, and anger management issues. Client transitioned to couple therapy to address ongoing marital and communication issues. The couple assessment determined clients to be emotionally undifferentiated leading to anger and reactivity issues, withdrawal, and a pursuer-distancer dynamic. The couple and family are dealing with financial problems that also contribute to stress and negative patterns in the family system. Samuel is a war veteran diagnosed with Major depressive disorder, recurrent, moderate; and Generalized anxiety disorder, and is still engaged in individual therapy.

Samuel Lee Shawn and Celestine Joan Smith clip 1. Goal and Interventions: Building the therapeutic partnership through conversational questions (curiosity and "withness").

Conversation transcript:

Celestine Joan Smith (C): He has itchy legs.

Student therapist (T): aww…

Samuel Lee Shawn (S): (scratches with vigor and sights)

All exchange laughter and jokes.

T: What would you guys like to talk about? What's going on in your life?

S: We are both rather depressed that America so vehemently chose to keep Donald Trump in the mix.

T: I am not sure I follow you…

C: Neither one of us think that the election should have been anywhere near as close as it is…

T: hmmm…

C: It should have been a landslide

T: hmmm… but Samuel says he feels depressed

S: oh, I am depressed anyway… I am just discussed with my country that so many people in my country are choosing…

C: The wrong choice

T: Yeah…

S: The cheater in chief

T: Valid point there Celestine … [turning towards Samuel] You said they are choosing the [cheater in chief]?

S: Cheeto! He is orange like a Cheeto!

T: Oh! Cheeto in chief! Okay I have never heard that one before.

C: One of the …. One of the many, huh…

S: Monikers that he has… liar in chief…

T: So, hmm, you are talking about the current president, correct?

C: Yes!

S: Yes! Disgustingly!

T: Oh disgustingly!… okay, so… you…

C: We are not fans of his…

T: You are not fans of his… And you feel like it should have been a landslide? [exchanges laughter]

C: There should have been… pretty much everyone should have been like we've had four years of him, and we need to get him the heck out of here…

T: yeah? Is that like, hmmm, hopeful thinking or like, is it from… political studies or whatever? [exchanges laughter]

C: No, I mean, it's… it's from a moral standpoint, I mean there are so many…

S: Suppose because she supported that…

T: suppose …

S: Suppose ‘cause… he is against immigration, he is against… loving your fellow humans, which is what Christianity is supposed to be about, and that is why I am not a Christian anymore because Christians support that ********** [explicit language]

T: Okay…

C: hmmm…

T: Okay, that is a strong statement…

C: there…

T: Hmmm, I really acknowledge your feelings. Sorry it makes you feel that way.

C: There… there has just been so many things that… if it were anyone else, the amount…

Student therapist sought to explore and understand clients’ description of lived experiences and meaning making. Student therapist validated clients’ feelings and description of events as experienced by clients. Student therapist facilitated a dialogical process to normalize client’s

language and promote their sense of expertise and provide unconditional positive regards. Student therapist demonstrated curiosity by using conversational questions to explore client's emotions about ongoing events and their impact on clients' description of problems.

Samuel Lee Shawn and Celestine Joan Smith clip 2. Goal and Interventions: Exploring agency and collaborative goals setting through Mutual Puzzling Process.

Conversation transcript:

> Samuel Lee Shawn (S): The anger issues are mostly in check… but I have come to realize that my self-esteem is somewhere beneath the sewer and my self-worth is about ten meters below that, and that is I believe a large part of the reason why I sometimes think I would like to get off this ride.
>
> Student therapist (T): So, what I just heard you said is that you recognize that you deal with certain things with anger. You call it anger issues but when things happen you react to them with anger, is that right?
>
> S: I do so a lot less now than I used to
>
> T: Yeah, but that has been the case…
>
> S: It has been the case in the past
>
> T: And medication helps with that…
>
> S: Yes!

T: When you are not on medication you find yourself again dealing with those things with anger?

S: I lose my **** [explicit word] a lot faster

T: Okay. The way you formulate this is really interesting, and I am really, like, drawn to you.

S: Okay…

T: Hi, Celestine !

Celestine Joan Smith (C): Hi!

T: He just said that he wants to manage his anger in a way, and that medication helps. As a couple… I know last time we started talking about what you guys would like out of therapy. Nate formulated it this way: he said, "*fix* me!"

C: Yeah!

T: Or "*fix* us!" Hmmm… and we were having an argument about that. Without trying to fix you or without trying to resolve any issues (even if that is possible) why do you want to be here?

C: Hmmm… I think that the biggest issue is that our communication sucks. Hmmm…

S: It sucks!

C: We perpetually miscommunicate and …

S: On the … on the way here, I asked is that 35th or 32nd ? Then she said 32nd, so I started to turn, she goes "What! This is 35th, you don't come here!" Because she though I asked do we drive across town on 32nd or 35th ? And she answered 32nd. But we are coming up on 35th street.

T: Can you hold on one second! Could you hold on one second! Did he just cut you off or is that okay?

C: Yeah, I guess he did! I did not even think about it, but yeah, I guess!

S: We do both do that sometimes.

T: [to Celestine] How do you feel about that?

C: In this case, I did not even think about it. I did not notice it until you said something.

T: But you did not get to express what you wanted…

Student therapist engaged client Samuel in verbalization of agency as informed by client description of anger management issues, description of self-esteem and self-worth issues. Student therapist led client's exploration of self-agency by inviting client's curiosity about self-defeating life patterns and beliefs. Student therapist encouraged client's exploration of new meaning regarding goal setting by utilizing metacommunication and mutual puzzling process.

Student therapist made appropriately unusual comments regarding communication dynamics to invite spouse curiosity and offer new perspective about couple's patterns and description of interaction. Student therapist highlighted couple's negative interactional patterns to increase sense of agency and clients' meaning making of problem-organized system, including couple's description of communication issues.

Clinical Assessment, Case Conceptualization, and Treatment Plan

Clinical Assessment

Client ID # (do not use name): 19459	Ethnicity(ies): Caucasian	Primary Language: ☑ Eng ☐ Span ☐ Other: _____
List all participants/significant others: Put a [★] for Identified Patient; [√] for sig. others who **WILL** attend;[×] for sig. others who will **NOT** attend.		
Adult: Age: Profession/Employer [*] AM†**: Samuel Lee Shawn** [✓] AF**: Celestine Joan Smith** [ ] AF/M #2**: _____**	**Child: Age: School/Grade** [ ] CM**: Ervin Shawn** [ ] CF**: _____** [ ] CF/M #2**: _____**	
Presenting Problem		

☑ Depression/hopelessness ☐ Couple concern
☑ Anxiety/worry ☐ Parent/child conflict
☑ Anger issues ☐ Partner violence/abuse
☐ Loss/grief ☐ Divorce adjustment
☐ Suicidal thoughts/attempts
Hyperactivity
☐ Sexual abuse/rape ☑ Sexuality/intimacy concerns
☐ Alcohol/drug use ☐ Major life changes
☑ Eating problems/disorders
Isolation/withdrawal
☐ Job problems/unemployeds
☐ Other: _____

Complete for children
☐ School failure/decline performance
☐ Truancy/runaway
☐ Fighting w/peers
☐ Remarriage adjustment ☐ Wetting/soiling clothing
☐ Child abuse/neglect
☐ Legal issues/probation ☐ Other:_____

† *Abbreviations:* AF: Adult Female; AM: Adult Male; CF#: Child Female with age, e.g., CF12; CM#: Child Male with age; Dx: Diagnosis; IP: Identified Patient; Hx: History; GAF: Global Assessment of Functioning; GARF: Global Assessment of Relational Functioning; NA: Not Applicable.

(continued)

Mental Status for IP		
Interpersonal issues	☐ NA	☑ Conflict ☑ Enmeshment ☐ Isolation/avoidance ☑ Emotional disengagement ☐ Poor social skills ☑ Couple problems ☐ Prob w/friends ☑ Prob at work ☐ Overly shy ☐ Egocentricity ☐ Diff establish/maintain relationship ☐ Other: _____
Mood	☐ NA	☑ Depressed/sad ☑ Hopeless ☐ Fearful ☑ Anxious ☑ Angry ☑ Irritable ☐ Manic ☐ Other: _____
Affect	☐ NA	☐ Constricted ☐ Blunt ☐ Flat ☐ Labile ☑ Dramatic ☐ Other: _____
Sleep	☑ NA	☐ Hypersomnia ☐ Insomnia ☐ Disrupted ☐ Nightmares ☐ Other: _____

Eating	☐ NA	☑ Increase ☐ Decrease ☐ Anorectic restriction ☐ Binging ☐ Purging ☑ Body image ☐ Other: _____
Anxiety symptoms	☐ NA	☐ Chronic worry ☐ Panic attacks ☑ Dissociation ☐ Phobias ☐ Obsessions ☑ Compulsions ☐ Other: _____
Trauma symptoms	☐ NA	☐ Acute ☐ Chronic ☐ Hypervigilance ☑ Dreams/nightmares ☑ Dissociation ☐ Emotional numbness ☐ Other: _____
Psychotic symptoms	☑ NA	☐ Hallucinations ☐ Delusions ☐ Paranoia ☐ Loose associations ☐ Other: _____
Motor activity/ speech	☐ NA	☑ Low energy ☐ Restless/hyperactive ☐ Agitated ☐ Inattentive ☑ Impulsive ☐ Pressured speech ☐ Slow speech ☐ Other: _____
Thought	☐ NA	☐ Poor concentration/attention ☑ Denial ☑ Self-blame ☑ Other-blame ☑ Ruminative ☐ Tangential ☐ Illogical ☐ Concrete ☐ Poor insight ☐ Impaired decision making ☐ Disoriented ☐ Slow processing ☐ Other: _____
Socio-Legal	☑ NA	☐ Disregards rules ☐ Defiant ☐ Stealing ☐ Lying ☐ Tantrums ☐ Arrest/incarceration ☐ Initiates fights ☐ Other: _____
Other symptoms	☐ NA	
Diagnosis for IP		
Contextual Factors considered in making Dx: ☑ Age ☑ Gender ☑ Family dynamics ☑ Culture ☑ Language ☑ Religion ☑ Economic ☐ Immigration ☐ Sexual orientation ☑ Trauma ☑ Dual dx/comorbid ☐ Addiction ☐ Cognitive ability		

Mental Status for IP

Interpersonal issues	□ NA	□ Conflict □ Enmeshment □ Isolation/avoidance □ Emotional disengagement □ Poor social skills □ Couple problems □ Prob w/friends □ Prob at work □ Overly shy □ Egocentricity □ Diff establish/maintain relationship □ Other: _____
Mood	□ NA	□ Depressed/sad □ Hopeless □ Fearful □ Anxious □ Angry □ Irritable □ Manic □ Other: _____

Axis I
Primary: **Major Depressive Disorder**
Secondary: **Generalized Anxiety Disorder**_____
Axis II: _____
Axis III: _____
Axis IV:
□ Problems with primary support group
□ Problems related to social environment/school
□ Educational problems
□ Occupational problems
□ Housing problems
☑ Economic problems
☑ Problems with accessing health care services
□ Problems related to interactions with the legal system
□ Other psychosocial problems
Axis V: GAF___GARF _____

List DSM symptoms for Axis I Dx (include frequency and duration for each). Client meets 6 of 13 criteria for Axis I Primary Dx.
1. **Depressed mood** _____
2. **Diminished pleasure**_____
3. **Hopelessness** _____
4. **Excessive worry**_____
5. **Easily fatigued** _____
6. **Irritability**_____

Venlafexine
Trazadone
Pantoprazole
Risperadone Propranolol

Have medical causes been ruled out?
☑ Yes □ No □ In process
Has patient been referred for psychiatric/medical eval? □ Yes ☑ No
Has patient agreed with referral?
□ Yes ☑ No □ NA
List psychometric instruments or consults used for assessment:
☑ None or _____

Medications (psychiatric & medical) Dose /Start Date
□ None prescribed
1. **Venlafexine**____/_____mg; _____
2. **Trazadone**_____/_____mg; _____
3. **Pantoprazone**__/_____mg; _____
4. **Risperadone Propranodol**_____/ _____mg; _

Client response to diagnosis:
☑ Agree □ Somewhat agree □ Disagree

	□ Not informed for following reason:

Medical Necessity *(Check all that apply):* □ Significant impairment □ Probability of significant impairment
□ Probably developmental arrest
Areas of impairment: □ Daily activities □ Social relationships □ Health □ Work/school
□ Living arrangement □ Other: _____

Risk Assessment

Suicidality	**Homicidality**
☑ No indication	☑ No indication
☑ Denies	☑ Denies
□ Active ideation	□ Active ideation
□ Passive ideation	□ Passive ideation
□ Intent without plan	□ Intent without means
□ Intent with means	□ Intent with means
□ Ideation past yr	□ Ideation past yr
□ Attempt past yr	□ Violence past yr
□ Family/peer hx of completed suicide	□ Hx assault/temper
	□ Cruelty to animals

Hx Substance Abuse	**Sexual & Physical Abuse and Other Risk Factors**
Alcohol:	□ Current child w abuse hx:
☑ No indication	□ Sexual □ Physical □ Emotional □ Neglect
☑ Denies	□ Adult w childhood abuse:
□ Past	□ Sexual □ Physical □ Emotional □ Neglect
□ Current	□ Adult w abuse/assault in adulthood:
Freq/Amt: _____	□ Sexual □ Physical □ Current
Drugs:	□ History of perpetrating abuse:
☑ No indication	
☑ Denies	

□ Past □ Current Drugs: _____ Freq/Amt: _____ □ Current alc/sub abuse by family/ significant other	□ Sexual □ Physical □ Elder/dependent adult abuse/neglect □ Anorexia/bulimia/other eating disorder □ Cutting or other self-harm: □ Current □ Past Method: _____ □ Criminal/legal hx: _____ □ None reported

Indicators of Safety: ☑ At least one outside person who provides strong support ☑ Able to cite specific reasons to live, not harm self/other □ Hopeful □ Has future goals □ Willing to dispose of dangerous items
□ Willing to reduce contact with people who make situation worse □ Willing to implement safety plan, safety interventions ☑ Developing set of alternatives to self/other harm □ Sustained period of safety:
□ Other: _____

Safety Plan includes: □ Verbal no harm contract □ Written no harm contract □ Emergency contact card
□ Emergency therapist/agency number □ Medication management □ Specific plan for contacting friends/support persons during crisis □ Specific plan of where to go during crisis □ Specific self-calming tasks to reduce risk before reach crisis level (e.g., journaling, exercising, etc.) □ Specific daily/weekly activities to reduce stressors □ Other:_____

Legal/Ethical Action Taken: □ NA Explain: _____

Case Management

Date 1st visit: **10/21/2020**_____ Last visit: **4/7/2021**_____ **Session Freq:** □ Once week □ Every other week □ Other: _____ **Expected Length of Treatment: 12 months** _____	**Modalities:** ☑ Individual adult □ Individual child ☑ Couple □ Family □ Group:	**Is client involved in mental health or other medical treatment elsewhere?** ☑ No □ Yes: _____ **If Child/Adolescent:** Is family involved? □ Yes □ No

Patient Referrals and Professional Contacts
Has contact been made with social worker?
□ Yes ☑ No: explain:_____ □ NA
Has client been referred for physical assessment?
□ Yes ☑ No evidence for need
Has client been referred for psychiatric assessment?
□ Yes; cl agree □ Yes, cl disagree ☑ Not rec.

Has contact been made with treating physicians or other professionals?
□ Yes ☑ No □ NA
Has client been referred for social/legal services?
□ Job/training □ Welfare/food/housing □ Victim services
□ Legal aid □ Medical □ Other:
_____ □ NA Anticipated forensic/legal processes related to treatment:
☑ No □ Yes _____
Has client been referred for group or other support services?
□ Yes ☑ No □ NA
Client social support network includes:
☑ Supportive family ☑ Supportive partner □ Friends □ Religious/spiritual organization ☑ Supportive work/social group □ Other:
_____
Anticipated effects treatment will have on others in support system (parents, children, siblings, significant others, etc.):

Treatment will help client develop a healthy relationship with family members through effectively managing anger and developing a sense of agency.

Is there anything else client will need to be successful?

Client could benefit from coaching skills to deal with sense of worth and esteem. Client has mentioned wanting to lose weight but has been having difficulty staying motivated and engaging in self-care.

Client Sense of Hope: Little 1---------**3** ---------- 10 High

Expected Outcome and Prognosis
□ Return to normal functioning
☑ Expect improvement, anticipate less than normal functioning
□ Maintain current status/prevent deterioration

Evaluation of Assessment/Client Perspective
How was assessment method adapted to client needs?

Assessment was adapted by taking into consideration client S.S. history with trauma and description of socioenvironmental al realities. Client negative self-talk was used to assess client's meaning making and problem-organizing system.

Age, culture, ability level, and other diversity issues adjusted for by:

Assessing client to be moderately functional and in fair health. Client political and religious worldviews serve to reinforce client's description of problem.

Systemic/family dynamics considered in following ways:

Client's family of origin dynamic impacted client's mental health, and client has a non-existent relationship with family members. Client previous marriage and past relationship issues impact client's current relationship dynamics.

Describe actual or potential areas of client-therapist agreement/disagreement related to the above assessment:

Client and student therapist agree on client's difficulty in managing anger, and client's disposition to easily getting frustrated and reactive. Client and student therapist agreed on working on managing anger issues to help client foster healthy communication.

Case Conceptualization

Therapist: Kpoti Accoh_____ Client/Case #:19459_____ Date: 10/21/2020

I. Introduction to Client and Significant Others *(Include age, ethnicity, occupation, grade, relevant identifiers, etc.). Put an * next to persons in session and/or IP for identified patient.*

AF† or_____: Samuel Lee Shawn_____

AM or_____: Celestine Joan Smith_____

CF or_____:_____

CM or_____: Ervin Shawn_____

II. Presenting Concern

Client's/Family's Descriptions of Problem(s):

AF or_____: Anger Management; self-esteem; Self-worth; Depression; Relationship issues_____

AM or_____: Communications issues; partner's anger issues; relationship issues_____

CF or_____:_____

CM or_____: _____

Broader System Problem Descriptions (description of problem from referring party, teachers, relatives, legal system, etc.):

_____*:* _____

_____*:* _____

III. Background Information

Recent Background (recent life changes, precipitating events, first symptoms, stressors, etc.):
Issues with employment satisfaction and financial stability; COVID-19 pandemic

Related Historical Background (family history, related issues, past abuse, trauma, previous counseling, medical/mental health history, etc.):

Family of origin dynamic; Veteran; Trauma; past relationships issues; anger issues

IV. Systemic Assessment
Client/Relational Strengths

Personal/in*dividua*l: **Sense of humor; role model for son; hobbies**_____

Relational/social: **Partner support; social network**_____

† *Abbreviations:* AF: Adult Female; AM: Adult Male; CF#: Child Female with age, e.g., CF15; CM#: Child Male with age; IP: Identified Patient; Hx: History; Ex: Explanation or Example; NA: Not Applicable

Spiritual: **non-practicing Christian**_____

Family Structure and Interaction Patterns

Couple Subsystem (to be assessed): ☑ Personal current ☑ Personal past ☑ Parents'

Couple Boundaries: □ Clear ☑ Enmeshed □ Disengaged □ Other: _____

Rules for closeness/distance: **Emotional enmeshment; Intimacy is asexual.**

Couple Problem Interaction Pattern (A ⇄ B):

Start of tension: **Samuel needs are not met. Uses sarcasm to address unmet needs. Partner becomes reactive.**

Conflict/symptom escalation: **Samuel gets triggered and becomes defensive and angry. Partner escalates conversation. Healthy communication stops. Samuel feels sorry and grieves loss of communication and start feeling sorry for self through doubting of worth and esteem**

Return to "normal"/homeostasis: **Partner comfort Samuel but does not meet Samuel's initial needs.**

Couple Complementary Patterns: ☑ Pursuer/distancer ☑ Over/under functioner ☑ Emotional/logical □ Good/bad parent □ Other: _____
Describe: _____

Satir's Communication Stances:

AF: □ Congruent □ Placator □ Blamer ☑ Superreasonable □ Irrelevant
AM: □ Congruent □ Placator ☑ Blamer □ Superreasonable □ Irrelevant

Describe dynamic: **intimacy issues; communication issues; problems with child rearing; shared hobbies; knit family**

Gottman's Divorce Indicators:

Criticism: ☑ AF ☑ AM Ex: **Does not compliment partner when she cooks**

Defensiveness: ☑ AF ☑ AM Ex: **Does not accept negative feedback**

Contempt: □ AF ☑ AM Ex: **Judgmental of others**

Stonewalling: □ AF ☑ AM Ex: **Will not compromise on problems/solutions**

Failed repair attempts: ☑ AF ☑ AM Ex: **Does not engage in process of healing**

Not accept influence: □ AF ☑ AM Ex: **Does not like to be chanllenged**

Harsh startup: □ AF ☑ AM Ex: **Complaint about communication issues and understanding student therapist accent**

Parental Subsystem: □ Family of procreation ☑ Family of origin

Membership in Family Subsystems: Parental: ☑ AF ☑ AM □ Other: _____
Is parental subsystem distinct from couple subsystem? □ Yes ☑ No □ NA (divorce)

Sibling subsystem: **None; only child**_____

Special interest: **Gaming**_____

(continued

IV. Systemic Assessment
Family Structure and Interaction Patterns
Family Life Cycle Stage:

□ Single adult ☑ Marriage ☑ Family with young children ☑ Family with adolescent children □ Launching children □ Later life Describe struggles with mastering developmental tasks in one of these stages:

Hierarchy Between Child/Parents:

AF: □ Effective □ Insufficient (permissive) □ Excessive (authoritarian) ☑ Inconsistent

AM: □ Effective □ Insufficient (permissive) □ Excessive (authoritarian) □ Inconsistent

Ex: **Mother relationship with son is centered around Boy scout organization**____

Emotional Boundaries with Children:

AF: □ Clear/balanced □ Enmeshed (reactive) ☑ Disengaged (disinterested)

□ Other:_____

AM: □ Clear/balanced ☑ Enmeshed (reactive) □ Disengaged (disinterested)

□ Other:_____ Ex:

Problem Interaction Pattern (A ⇄ B):

Start of tension: **Samuel needs are not met. Uses sarcasm to address unmet needs. Partner becomes reactive.**

Conflict/symptom escalation: **Samuel gets triggered and becomes defensive and angry. Partner escalates conversation. Healthy communication stops. Samuel feels sorry and grieves loss of communication and start feeling sorry for self through doubting of worth and esteem**

Return to "normal"/homeostasis: **Partner comfort Samuel but does not meet Samuel's initial needs.**

Triangles/Coalitions:

□ AF and C_____against AM: Ex: _____

☑ AM and C M against AF: Ex: **Using sarcasm to undermine partner**

□ Other: Ex: _____

Communication Stances:

AF or_____: □ Congruent □ Placator □ Blamer ☑ Superreasonable

□ Irrelevant

AM or_____: □ Congruent □ Placator ☑ Blamer □ Superreasonable □ Irrelevant

CF or_____: □ Congruent □ Placator □ Blamer □ Superreasonable

□ Irrelevant

CM or_____: □ Congruent ☑ Placator □ Blamer □ Superreasonable

□ Irrelevant

Hypothesis (Describe possible role or function of symptom in maintaining family

homeostasis): **Couple's relationship roles have shifted through the years, intimately as well as financially. Couple has not engaged in explicit conversations about what the shifts mean and how they might change the couple and family dynamic. Needs are suppressed and come out as frustrations which leads the couple's negative interaction cycle.**

Intergenerational Patterns

Substance/alcohol abuse: ☑ NA □ Hx: _____

Sexual/physical/emotional abuse: ☑ NA □ Hx: _____

Parent/child relations: □ NA ☑ Hx: _____

Physical/mental disorders: □ NA □ Hx: _____

Historical incidents of presenting problem: □ NA ☑ Hx: **History of abuse and neglect**_____

Family strengths: **Shared hobbies; adequate housing; at least one partner with a stable job; unconditional support for child; active with therapy in past; partners support for one another**_____

Previous Solutions and Unique Outcomes

Solutions that DIDN'T work: **Mindfulness practices; discussing primary and secondary emotions; targeted date for employment; identifying unique outcomes; differentiating persons from problems** _____

Solutions that DID work: **establishing a partnership with clients' system; addressing communication issues as secondary effect; reviewing and collaborating on state of clients relationship; meeting individuals apart from the problems; deconstructing clients' narrative**_____

Narratives, Dominant Discourses, and Diversity

Dominant Discourses informing definition of problem:

Cultural, ethnic, SES, etc.: **narrative of self-image and self-worth; narrative of social status; values around intimacy and family roles; family is moderate in**

cultural and social values, but state having strong Christian values, despite no longer practicing

Gender, sex orientation, etc.: **couple has conservative views but are explorative and curious about other values.**

Other social influences: **Couple has strong political opinions and are open about their ideologies.**

Identity Narratives that have developed around problem for AF, AM, and/or CM/F:

Samuel is struggling with socially and culturally assigned gender roles. Client does not believe that they are fulfilling their assigned roles. Client is self-conscious about self-worth and self-esteem and is struggling with body image and weight issues. Client believes that their partner is smarter than they are and make it a point to reiterate it often.

Celestine reasons most aspect of couple's life and rarely displays or discusses emotional items. Client is withdrawn from emotional and intimate aspect of couple's relationship.

Local or Preferred Discourses: **Samuel has not identified any preferred outcome, though would like to learn to manage anger and engage in communication without becoming triggered and reactive. Samuel would like to learn to transition into new roles in regards to couple dynamics and family system.**

Celestine would like couple's communication to improve but is dealing with own memory issues that causes frustrations and permeates into couple's relationship. Celestine believes that the relationship dynamic needs to shift toward mutual support without conditions or expectation of intimacy and traditional couple dynamic.

Other Influential Discourses: **Couple's sociocultural views impact family dynamic and relationship with support system**

VI. Client Perspectives

Areas of Agreement: Based on what the client(s) has(ve) said, what parts of the above assessmentdo they agree with or are likely to agree with? **The couple's dynamic needs renegotiated and couple need adjusting to new roles.**

Areas of Disagreement: What parts do they disagree with or are likely to disagree with? Why? **Communication issues is not the primary problem of the couple. Couple displaying a pursuer-distancer dynamic.**

How do you plan to respectfully work with areas of disagreement?

Be curious of couple's description of problem. Promote individuality and invite curiosity of multiple perspective. Uphold a non-expert stance by respecting couple's expertise.

Treatment Plan

Name: Samuel Lee Shawn **Date: 10/21/2020**

Case/Client: 19459 **Theory: Collaborative Therapy**

Initial phase of treatment

Goal # 1: Develop working therapeutic relationship: Student therapist will create a welcoming space for client's story to unfold naturally. Client had previously shown anxiety in regard to transition, so space needs to be maintained for progress toward a slow but steady therapeutic alliance and collaborative discourse.

Interventions:

a. Check-in on client by summarizing previous session and check on clients' engagement with discourse to ensure the maintenance of a democratic and dialogical process.

b. Student therapist will show interest in each partner's description of experience and constructed narrative by validating individual and couple's expertise.

c. Engage in the couples meaning-making, and discourse about their interpretation of reality and functioning.

d. Allow the couple to create a safe space within the therapeutic relationship that respects clients' individual, cultural, sexual, emotional, and social expressions.

Goal #2: Assess individual, systemic, and contextual dynamics and monitor quality of therapeutic partnership.

Interventions:

a. Identify the different narratives taking place and their authors through nuanced differences.

b. Empathically attune to and validate everyone's emotional expressions by checking on them at the start of each session.

c. Assess each partner's worldview of problem-organized system, and their interpretations of realities.

d. Explore individual's cognitive dissonance within the context of the couple's relationship, and within the cultural context.

e. Emotionally assess the couple system with RISSSC techniques every 4 sessions, to help the couple slow down and engage with their emotional processes rather than their defensiveness.

f. During each session, assess for clients or therapist monologues or break downs in dialogical exchange.

Working Phase of Treatment

Goal # 3: Increase couple's ability to engage in productive dialogue to handle problems in daily living to reduce conflict by increasing couple's awareness of negative interactions cycle and the emotions that fuel them.

Interventions:

a. Encourage clients to verbalize communication issues, negative effects, and individual's sense of emotional safety in sessions and after unresolved conflicts.
b. Track negative interaction cycle through explorations of individual's secondary and primary emotions.
c. Reframe context of couple's negative interaction cycle and attachment needs by exploring different perspectives.
d. Encourage verbalization of individual attachment issues and their impact on couple and family dynamics.

Goal #4: Increase the ability of family members to respond to each other in ways that create a sense of relational safety and bonding even in moments of conflict to reduce conflict, depressed mood, and /or anxiety by honoring multiple realities in the couple's relationship and sub-systems.

Interventions:

a. Utilize conversational and not knowing questions to expand meaning and possibilities.
b. Create an awareness of how each family member's response affects others by tracking empathic conjecture and interaction cycle as informed by individual meaning making.
c. Verbalize primary emotional needs through in-session enactments and reflecting team processes.

Closing Phase of Treatment

Goal # 5: Increase couple and family's ability to effectively respond to life stressors to reduce conflict and sense of hopelessness by affirming sense of personal agency and cohesiveness of shared relational narrative.

Interventions:

a. Consistently explore clients' construction of meaning and possibilities by tracking individual, couple, and family's positive and negative interaction cycle to anticipate setbacks.
b. Increase each person sense of self-identity and agency by inviting curiosity in exploring multiple perspectives. This will be done by using conversational questions, accessing writing and different literatures, and inviting mutual puzzling.

Client's Perspective

Has treatment plan been reviewed with client: ☑*Yes* ☐*No; If no, explain*_____

Describe Areas of Client Agreement ad Concerns: **Client started with individual therapy, then added couple therapy. Clients intentionally took a break from therapy because they felt they were in a good space but did not want to be discharged. Student therapist contacted client every three weeks to see where client was in the process** (Gehart, 2014, pp. 431-445).

Weaknesses and Strengths

Therapist Weaknesses

Of course, as a human being with three decades of experiences, I come to this field with many biases and influences. After a decade studying and living in the US, I am still experiencing cultural shock and struggling to balance the process of integration between not being enough or being too integrated. This struggle is always at the forefront every time I step into the therapy room. It is less about what the client might think of me, and more about my reaction (defensiveness) in anticipation of what I believe they might think of me. I have convinced myself that if I can demonstrate that I am intelligent enough, the clients will have a liking to me. So rather than being present with the clients, on many occasions, I find myself reasoning and intellectualizing the process and educating the client on marriage and family therapy. If I find myself in doubt and feeling disconnected, I will become too strategic in my intervention usages or "parent" my clients. And as that is taking place, it is easy for me to become stressed and confused about how to proceed. Then would emerge the feeling of language barrier, which in these instances present as the thickening of my accent which becomes more pronounced and persistent under stress. This has served to maintain the feeling of imposter. The self-doubt is

even more persistent when I think of my own struggles and reflect on how to effectively make space for others while myself experiencing life stresses. Having experienced many life stresses contributing to my joining the program, and many more happening while in the program, I was predisposed to project my experiences on clients and create the opportunity for counter-transference. Having sought therapy and come to term with my inescapable humanness, my experiences with stressful events, and my weaknesses have served as meaningful tools in reevaluating my self-worth.

Therapist Strengths

Certainly, I still experience doubt and a sense of being an imposter. Nonetheless, my choosing the collaborative language systems as theory of practice because of my willingness to acknowledge my humanity and limitations, speaks to the fact that it incorporates newer systemic realities and utilizes one of the most crucial characteristics shared by human beings: language and its usage for storytelling. Hailing from millennia of oral traditions that are still relevant in my cultures of origin, I do believe that my philosophical reflections on the nature of the human condition and the meaning we ascribe to life are defining factors in my becoming a therapist, and thus predisposing me to adopting a humanistic stance towards life in general, and people's storytelling specifically. I have not ten, nor five, nor even two things that would define me as a good therapist or fit to become a therapist, but what I have is the opportunity to recognize my humanness through others which fosters in me a sense of curiosity, resilience, humility, vulnerability, advocacy, and a desire to continue learning to grow to become a better person.

Conclusion

It is hard to speak to clinicians' epistemic position, and to the self-of-the-therapist in terms of competency, strengths, and weaknesses without addressing the philosophical and sociopolitical implications of their position. As we reflect on collaborative language systems as a constructionist ontology describing a process of constant revisitation and reinterpretation of our identities through the visors of socioenvironmental realities and interpersonal relationships, it is worth noting that the mere possibility of revisiting one's reality and incorporating new meanings to create a satisfactory sense of congruent self-structure does not in itself change others' descriptions of reality and the events that inform them. So naturally, taking such constructivist position creates a series of problematic questions seeking to address structural flaws and sociocultural consequences. As collaborative language therapists, our roles stem beyond therapeutic rooms and spill into every aspect of life. That is why upholding a philosophical stance that prioritizes humanism and requires the greatest sense of humility and reconsideration of therapeutic power should allow us to not only be mindful of our biases and privileges, but also allow us to be advocates for the emergence of the individual client as a competent and functional being with valid and transformative ideas, thoughts, and hopes beyond therapy rooms in order to create more just and healthier communities of heroic humans. Anderson (1995, p. 42) says of the ability to genuinely facilitate a mutually engaging dialogical process to be less "hierarchical, more egalitarian, more mutual, more respectful, more human – and usually briefer. This therapy, I find, does not work with or create dysfunctional categories or people. It discovers, or allows both the client and the therapist to discover… heroic feelings." This feeling speaks to the ability

to value one's worth through the recognition of our limitations and ability to engage with others through the validation of their unique experiences and interpretations of those experiences.

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