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## Centering the voice of the client: On becoming a collaborative practitioner with low income individuals and families

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### Abstract

Despite current interest in collaborative practices, few investigations document the ways practitioners can facilitate collaboration during in-session interactions. This investigation explores verbatim psychotherapy transcripts to describe and illustrate therapist's communications that facilitate or hinder centering client's voice in work with socioeconomically disadvantaged populations. Four exemplar cases were selected from a large intervention trial aimed at improving Shared Decision Making (SDM) skills of psychotherapists working with low income clients. The exemplar cases were selected because they showed therapist's different degrees of success in facilitating SDM. Therapist's verbalizations were grouped into five distinct communicative practices that centered or de-centered the voice of clients. Communication practices were examined through the lens of collaborative approaches in family therapy. The analysis suggests that cross-fertilization between SDM and family-oriented collaborative and critical approaches shows promise to illuminate and enhance the challenging road from clinician-led to client-led interactions. This paper also stresses the importance of incorporating relational intersectionality with individuals and families who may not feel entitled to express their expectations or raise questions when interacting with authority figures.

### Keywords

Shared Decision Making; Collaborative practices; Intersectionality; Low income populations

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The conviction that clinical practices should be collaborative and center clients' voices—rather than based on the clinician as the expert and prescriptive director of treatment—is a central concern of postmodern social constructionist, narrative, dialogical and critical theory approaches in family therapy (Andersen, 2007; Anderson, 1997, 2012, 2016; D'Arrigo-Patrick, Hoff, Knudson-Martin, & Tuttle, 2017; Dickerson, 2010; 2014; Falicov, 2014a; Freedman & Combs, 1996; Madsen, 2009; McDowell et al., 2019; Pare & Lerner, 2004; Pare, 2012; Seikkula & Trimble, 2005; White & Epston, 1990). Thus, family therapy thinking is particularly rich in its commitment to promoting and expanding theory and practice in the service of centering client voice.

Collaborative approaches have also increasingly informed other health and mental health care fields, including patient centered care in medicine (Saha, Beach, & Cooper, 2008), in psychiatry (Drake, Deegan, & Rapp, 2010; Nott et al., 2018; Slade, 2017) and in social work (Sousa & Rodrigues, 2012; Lavie-Ajayi & Nakash, 2017). Person-centered democratic practice, as opposed to clinician-led paternalistic approaches has been shown to reduce health disparities and increase patient satisfaction with and outcomes of treatment (Robinson, Callister, Berry, & Dearing, 2008; Saha, Beach, & Cooper, 2008),

Studies also document difficulties in building a collaborative relationship arising from common reliance on traditional prescriptive expert models between clients and practitioners (Guilfoyle, 2018). Many health care practitioners, and to some degree mental health clinicians, assume leadership in treatment goals, demonstrate fewer client-centered behaviors such as question asking and assert greater verbal dominance with socially disadvantaged, racial and ethnic minorities than with white middle class clients (Cooper et al., 2012; Nakash, Dargouth, Oddo, Gao, & Alegría, 2009; Peek et al., 2009; Tai-Seale, McGuire, & Zhang, 2007).

An examination of what facilitates and what hampers client led interactions “in the moment” is always relevant from a clinical and an ethical frame, but may be even more needed in situations where intersectionality increases the unequal relational power inherent in the client and therapist subject positioning and interaction (Guilfoyle, 2018). Clients from socioeconomically disadvantaged groups may be more inhibited or intimidated to advance their needs for the session or question the statements of the clinician. We believe that new developments in collaborative endeavors in health and mental health care fields, such as the construct of Shared Decision Making (SDM) offer valuable tools and cross fertilization with collaborative and critical thinking in family therapy.

## Shared Decision Making in Mental Health Care

Shared decision making (SDM) in behavioral health care has been defined as an approach where patients interacting with providers are supported to arrive at informed preferences and decisions. The philosophical principles of SDM are client's self-determination and relational autonomy. Self-determination theory rests on our intrinsic tendencies to protect our well-being. Relational autonomy describes the view that our views and decisions are not individually constructed as they always arise in interaction with others (Shay & Lafata, 2014).

In recent years, SDM has increasingly been regarded as having significant potential application for implementing collaborative dialogues between clinician and client knowledge (Elwyn et al., 2012; Lippa, Feufel, Robinson, & Shalin, 2016) under conditions of unequal power (Joseph-Williams, Elwyn, & Edwards, 2014). There is also a body of research that documents positive effects of shared decision-making on client satisfaction, treatment adherence and health status (Joosten et al., 2008). In spite of this interest, there have been very few randomized clinical trials testing the effectiveness of SDM in psychotherapy with ethnic/racial minorities and/or socioeconomically disadvantaged clients. Clinical observations and descriptions of SDM in mental health settings are scarce. One recent study concluded that clinicians can significantly improve SDM with these populations in psychotherapy, as rated by blinded coders (Alegría et al., 2018). This large quantitative study provided the clinical sessions selected for the analysis of communicative practices reported here.

In this paper, we present an intensive analysis of four cases to show how communicative practices derived from postmodern collaborative and critical discourses in family therapy may illuminate the constructs of SDM when working with socioeconomically disadvantaged clients. In turn, collaborative constructs and practices in family therapy may be enriched by greater exposure to the field of SDM and its person-centered concepts and practices.

## Collaborative Approaches in Family Therapy

The notion of collaboration between clients and therapists has become a common ground of clinical practice in many family-oriented approaches ranging from postmodern (Anderson, 2012; Anderson & Goolishian, 1988) to multisystemic therapies (Tuerk, Mc Cart and Henggeler, 2012). Although these approaches vary in the philosophical basis for collaboration and in significant aspects of intervention, they all stress the importance of collaboration for the therapeutic relationship. A comprehensive and comparative analysis of the various approaches to collaboration in psychotherapy cannot be undertaken here. For the purposes of this paper, we will concentrate on collaboration as defined in collaborative and critical approaches in family therapy. In these, the role of the clinician shifts from an expert who diagnoses and intervenes to one who participates with the client in a positive change process (D'Arrigo-Patrick, Hoff, Knudson-Martin, & Tuttle, 2017).

Collaborative practices stress a dialogical conversation centered on recognition and respect of the clients' views and resources in ways that encourage greater participation and less hierarchical, more equitable interactions with the practitioner (Anderson, 1997; Anderson & Gehart, 2012; Pare, 2012). Anderson and Goolishian (1988) and Anderson (2016) based their ideas on language as being a generative vehicle for knowledge construction and present therapy as "collaborative language systems," in which the professional becomes the expert at creating a "dialogical space" and the client is the expert on their own life, inviting the client to develop treatment goals and processes with the professional as facilitator or partner.

Critical approaches (McDowell, Knudson-Martin, & Bermudez, 2019; D'Arrigo-Patrick, Hoff, Knudson-Martin, & Tuttle, 2017; Parker, 2015) consider power as a central issue that pervades the therapeutic relationship (Guilfoyle, 2003, 2018), urging reflexivity about

power differentials in the clinician-client relationship, especially with clients who, due to the intersectionality of race, class, education, ethnicity, immigration status and/or positional hierarchy, may experience discrimination and unequal treatment (Tervalon & Murray-Garcia, 1998). Critical theory also considers the impact of sociopolitical stressors in the family's distress (Falicov, 2014a; Lavie-Ajayi & Nakash, 2017; McDowell, Knudson-Martin, & Bermudez, 2019).

The challenge for clinicians is how to achieve the partnership stressed in collaborative theory under the conditions of unequal power pointed out by critical theory (Falicov, 2014a, 2014b; 2016; Seikkula & Trimble, 2005; Guilfoyle, 2003, 2018). Few investigations have reported how this is carried out in clinical practice, and what factors facilitate or discourage it. Hierarchical differences in the practitioner/client positions and differences in socioeconomic and educational status create power challenges that may dominate rather than center the voice of clients. Shared decision making (SDM) concepts and tools hold promise to open avenues for joint exploration while acknowledging inevitable power differentials.

We analyzed verbatim psychotherapy transcripts of four exemplar cases to illustrate, compare, and contrast the communications of therapists trained in SDM or not that appeared to facilitate or hinder collaborative dialogue when working with socioeconomically disadvantaged clients.

## The Four Clinical Cases

The four exemplars of clinical sessions selected for this analysis were part of a large quantitative randomized control trial consisting of 312 clinical sessions with a diverse sample of therapists, clients and coaches. A total of 312 clients and 74 therapists at 13 community and hospital-based outpatient mental health clinics in Massachusetts participated in the trial. The purpose of the trial was to investigate the effectiveness of clinician and client psycho-educational interventions to improve SDM in psychotherapy sessions (Alegria et al., 2018). The results of the client intervention are reported in another publication (Alegria et al., 2018). The clinician intervention targeted three areas of client-centered communication and therapeutic alliance to improve SDM. These were: 1) augmenting perspective taking, or the ability to step outside of their own experience and accurately identify the emotions and perceptions of their client (Galinsky, Magee, Inesi, & Gruenfeld, 2006; Nakash, Saguy, & Levav, 2012); 2) avoiding erroneous dispositional inferences, whereby the provider attributes negative behaviors of patients of a different race/ethnicity to innate character traits rather than to situational factors (Alegria et al., 2008; Nakash & Alegria, 2013); and 3) increasing receptivity to patient participation and collaboration in decision making regarding care preferences (Nakash et al., 2009).

Clinicians attended 12 workshop hours on SDM and received individualized feedback by clinical coaches on up to 6 audio-recordings of their clinical sessions. For a full description of the trial and its findings, see previous publications (Alegria et al., 2018).

The authors of the current paper, who analyzed the four cases, are two immigrant Latina women (from Puerto Rico and South America) and an immigrant Israeli woman who

are all clinical psychologists and scholars in mental health disparities research. All three authors have lived in the Northeast or West coast for over 15 years. The first author, who led the analysis, is an expert in family therapy. Throughout the analysis, authors reflected on potential sources of bias during team meetings. To examine successful and unsuccessful collaborative practices, we selected cases where four different therapists with four different clients obtained high, moderate or low scores, ranging from 17.7–61.7 on a validated SDM scale of 0–100 (OPTION; Elwyn et al., 2005). We listened to 10 sessions in each category of scores, a total of 30 sessions. The four clients selected represented varied demographic characteristics and illustrated the verbal interaction. Two were men and two were women, ages 18, 40, 51, and 60 years old. All self-identified as low-income, unemployed and economically disadvantaged; two reported completing 12<sup>th</sup> grade education, one had less than 12<sup>th</sup> grade and one more than 12<sup>th</sup> grade education; two were Latinx, and two were non-Latinx White. All clinicians were females who were either psychologists or social workers; ages ranging 27–56 years old. The clinician/client dyads were language concordant. Three non-Latinx white clinicians had received SDM training and coaching for the session featured here; the fourth clinician, a Latina, was in the control group, which did not receive SDM training or coaching. This case was included because the communicative practices illustrated a low degree of collaboration. The four clients had different presenting problems (i.e. depression; addiction, psychosomatic symptoms), communicative styles (e.g., verbose, uncommunicative), and length of relationship with the therapist (ranging 7 months to 7 years). Each of these variables could be expected to present different collaboration challenges.

## **An Intensive Analysis of In-Session Verbal Exchanges of Four Clinical Cases**

Complete audiotaped sessions were transcribed and a flow chart of the session progression for each case by content unit, timing and duration was developed (the chart is available upon request). The percentage of time that therapist and client talked in each session could reflect a balanced or unbalanced exchange, duration, or “space” of talk. For example, while in Case 1 (high SDM score) the client dominated the space of talk (58.3%), in Case 2 (moderate SDM score) the therapist dominated the talk in the session (67.4% of space talk). We include verbatim sections of transcripts with line numbers for several purposes: it allows us to see when an interaction took place and for how long, and to refer to specific content when discussing each conversational sequence. The focus of this analysis was on the clinician’s communication practices with the client. Nevertheless, we also include selected transcribed excerpts of coaching sessions to illustrate self-reflections by clinicians who had received SDM training. We believe the coach’s statements have modeling value for clinicians and supervisors as they highlight “how” things are told and responded to in a dialogical process between therapist and client rather than the “what” or the content told.

The first author listened to and repeatedly read the audio recordings and transcripts for content and process. We conducted an intensive analysis of these four cases. By employing a constant comparative method across the four cases, the first author developed a preliminary set of categories based both on the literature of SDM and the literature on collaborative

and critical approaches in family therapy. This helped identify and label exchanges throughout the length of each session. The other two authors reviewed the transcripts adding their observations and refining the preliminary categories of communication practices. In addition, parameters such as “turn taking,” “topic initiation,” (Beckman & Frankel, 1984; Sacks, Schegloff, & Jefferson, 1978) “uncertainty markers” that modulate suggestions and “balanced amount of talk” were helpful general guides in arriving at the description and comparisons of communication exchanges. Three-way consultations among the three authors helped to clarify further the final categories or themes presented here. Since we wanted to analyze the communication styles used by clinicians trained in SDM, we also made connections with concepts taught in the SDM training.

## Communicative Practices that Center or De-Center Client’s Voice

Our intensive analysis of 4 clinical cases revealed several clinician’s communicative practices that either facilitate or hinder collaboration as linked to SDM scores. We grouped these practices into five topics: 1) shared agenda setting and/or reviewing client’s concerns from previous sessions; 2) balanced or unbalanced amount of talk time; 3) tentativeness and relativity and/or certainty and absoluteness; 4) collaborative meaning making and/or diagnostic labeling; and 5) co-constructing and/or prescribing behavioral tasks. In the paragraphs below we elaborate on each of these topics.

### (1) Shared Agenda Setting and/or Reviewing Client’s Concerns from Previous Sessions

Shared agenda setting is central to SDM training (Frankel, Salyers, Bonfils, Oles, & Matthias, 2013) to insure including the client’s priorities for the session. In many cases clinicians who were trained in SDM initiate interaction by synthesizing previous sessions, a practice that demonstrates knowledge of client’s concerns and enhances alliance building.

Case 1 (high SDM) involves an 18-year old Latino male, ‘Rafael.’ He is struggling to become autonomous from his family and sees college as his best alternative for separating. In this session, he describes his frustration about not getting a scholarship and the behaviors he engages in because of this new stress added to his many family and work stresses. The therapist focuses on Rafael’s agenda by asking: “*What do you want to talk about tonight? I know that the last time there was a lot going on for you...*” (lines 32–33). This invites the client to express goals for this session and to give an update while implying the therapist is empathic with the client’s stresses. Rafael expresses feeling “very angry” for not getting a college scholarship:

34 Rafael: “Last week was fucking crazy for me. I did not know I had so

35 much anger built, it just didn’t go away.

36 The entire week I was just angry. I was just pissed.

41 Every time I think about it, I just get even more angry.

42 I did not get shit... one of ...fucking dumbest kids probably got one (scholarship)



94...I should have been humping her on her ass (his teacher),

95 She knew I am pretty much dead broke, angry even more...

111 A fucking 3.60 and I did not get shit.

127 I was supposed to be happy but it is just bitchy, angry, fucking...

The therapist empathically paraphrases the reasons for the client's anger. Rafael then shares that he only feels better when he smokes marijuana, but this has become a problem that fills him with "disgust".

345 Rafael...The only thing that keeps me happy is fucking pot...

346 It just disgusts me...at the end of the night I just look at myself

350 and I am what the fuck am I doing?

The conversation with the therapist evolves into addressing the anger and the addiction. Nevertheless, in the coaching session, the coach recommends that the therapist make it even more explicit that the anger and the addiction are the agenda topics chosen by the client.

Case 2 (moderate SDM) involves 'Sandra', a 40-year old White female, whose children have been put in foster care due to her drug abuse and her erratic neglectful behavior towards them. She is in therapy with the aim of recovering her children. Sandra's therapist also shows interest in her agenda for the session: "Before we kind of jump into *whatever it is you want to discuss today* (lines 10–11), I wanted to know how the meeting went the other day?" (line 12). By asking about the meeting (parenting classes), the therapist postpones agenda-setting. This would be acceptable were it not for the fact that the therapist proceeds with inquiries that reveal the therapist's already established diagnosis and professional opinions, insinuating her expert role in the life of the client. The therapist never returns to ask Sandra what is on her mind for this session. In the coaching session about SDM, the therapist shows that trained clinicians can be self-reflexive about missed opportunities for centering the client's agenda for the session.

**Coach** ...It seemed like you were really proactive and conscious about setting an agenda.

**Therapist** Yeah. I have [been] doing that more since the training... but *I think what I end up doing is. Ok I need to get this, this and this done and I may not always be like: "What's your agenda?"*

**Coach** Yeah, I agree. There is more space for you to invite their concerns, be explicit about what they want to talk about.

**Therapist** Ask specifically what they want to talk about?

**Coach** Yeah, how I do this is asking *"Have you got anything on your mind that you want to make sure we cover?"*



In Case 3 (low SDM), which involves ‘Rob’, a 60-year old White male in long-term therapy with a diagnosis of anxiety and depression. Rob has been undergoing a difficult protracted divorce. The therapist starts by asking the client how he is doing. Rob reminds her of a commitment he made to schedule medical appointments. The therapist offers recommendations for more effective results on this pursuit. Later on (line 195), the therapist encourages agenda setting: “*What else would be helpful for us to focus on today?*” The client says he would first like to hear the clinician’s (“expert”) opinion about his diagnoses because of other professionals’ assessments. The therapist gives opinions about appropriate diagnostic labels but does not inquire whether Rob wants to make this the agenda of the session or about Rob’s own opinions or reactions about the various labels. She seems unaware of the power implications of labels and diagnoses and the relational dynamics that ensues from this unequal social location. Instead, the therapist initiates a new sequence and topic, by asking for an update on the client’s ongoing divorce process, de-centering or deflecting the client’s presenting concern.

Case 4 (low SDM), involves ‘Marta,’ a 51-year old Latina, who suffers from multiple somatic issues, including menopausal hormonal imbalances, as well as many family stresses and obligations of caretaking of others. The therapist converses with the client about the temperature of the room, getting ready for Christmas and various traditional foods the client cooks, rather than inquiring about what Marta would like to talk about, which may lead to centering on the needs for which Marta is seeking relief.

15 Therapist: How have you been?

16 Marta: I am very well. Trying to survive my worries.

17 Therapist: Are you ready for Christmas?

18 Marta: Trying.

19 Therapist: What do you need to do?

20 Marta: It’s hard to do everything in advance.

21 Therapist: It’s next week, right? Where do you all get together?

Although in line 16 the client states that she is “trying to survive my worries” and in line 20 she expresses tensions about doing “everything in advance”, the therapist asks about holiday preparations instead of inviting her to talk about those worries and pressures, thus missing an opportunity for agenda setting.

Setting the agenda early about what matters to the individual or the family centers the clients as the experts on their life today, brings interest in the present, and a hands-on attitude as the meta-message for the session. An emphasis on past problems may ensure thematic continuity, but when extended, may dampen the possibility of new information, as the conversation may convey that the clinician knows best what they should talk about. Thus, these transcript descriptions show that the practice of *shared agenda setting* appears

to be consistent with a progression of effectiveness of skills in bringing out the voice of the client.

## (2) Balanced or Unbalanced Amount of Talk Time

The person who initiates topics usually shapes the direction and content of the conversation, often unwittingly conveying ownership over the verbal space. Balanced exchange of talk time is presumably more likely to reflect shared dialogue, as couple and family clinicians often observe and seek to balance by engaging multiple voices. However, turn taking and topic initiation by each person (Sacks et al., 1978) did not sufficiently clarify how the interlocutors in the therapist-client dyad collaborated in conversation as either one could take turns, initiate topics, and be answered by the other.

Verbal dominance appeared to be a more suggestive indicator of speech entitlements and possible power differences, although as far as we know only substantiated in primary care visits (Tai-Seale et al., 2007) and not in psychotherapy, but worth future exploration. When talk is dominated by one person, the dialogical space appears unbalanced, possibly hindering collaborative exchanges. In Case 2, (moderate SDM) the therapist speaks more than twice as much (67.4%) as the client (32.6%). She offers extensive prescriptions, does not invite turn taking through asking client's opinions, or leave space for responses, and therefore exerts verbal dominance. Instead of generating new meanings through dialogue, the clinician presents meanings from her powerful position as expert. The client's voice is heard only in monosyllables like 'yeah,' 'maybe,' or 'no', bordering on monologue rather than dialogue (Guilfoyle, 2003; Seikkula, 2002).

Sometimes, it is the client who is verbally dominant. In Case 3 (low SDM, the client speaks much more (80.4 %) than the therapist ( 9.6%). In the coaching session, the therapist describes the interactional challenge and the frustration she experiences with this verbally dominant client.

**Therapist (talking to Coach)** .... this is really what I think gets in the way (of agenda setting) ...he goes on tangents. He could talk the entire session. Very hard to redirect him. Very hard to interrupt him.

The coach proposes that agenda setting can help therapist and client agree on goals for the session so that the therapist can gently return the client to these goals when his speech becomes tangential: *"I think we're getting away from our goals of our session today. Did you want to change the goals?"*

Training in SDM stresses language-oriented interventions that amplify the voice of the client such as using open-ended questions that require client explanations. The use of inclusive language ("we" rather than "I"), as suggested by the coach in Case 3 (*"we could try this" or "let's think together about this"*), emphasizes that the client's voice is crucial in exploring solutions. Centering the client's voice does not mean the practitioner cannot offer ideas informed by clinical experience (De Haene, Rober, Adriaenssens, & Verschueren, 2012). However, expert knowledge may be best offered in the language of tentativeness or possibilities, to promote greater equality between therapist and client.

### (3) Tentativeness and Relativity and/or Certainty and Absoluteness

Collaborative practices and critical theory in family therapy point to the usefulness of “discursive or verbal uncertainty markers” (Anderson, 1997; Anderson & Gehart, 2012; Guilfoyle, 2003; Hoffman, 2002). Some examples are: “*I don’t know if I am right about this, but it occurs to me ...*”; “*I am guessing that...*”; and, “*In my experience...but you correct me if I am wrong.*” These markers convey that the clinician’s statements can be questioned, debated, or rejected as they do not represent fixed authority. Statements that are provisional, tentative, and hypothetical can be reviewed or changed. The transcripts in this analysis reveal different degrees of tentativeness by the practitioners.

In Case 1, (high SDM) Rafael mentions how his only relief from anger is using marijuana, which makes him very upset. The clinician answers:

357 Therapist: So, *it sounds like it’s something that kind of helps* but in the end it

358 makes you feel worse. That’s *kind of funny* how things like that can work?

359 Rafael: Yeah. It’s like....

367 Therapist: You said your mood has been pretty low... What else...

368 because *maybe* marijuana works? But at the same time, it

369 doesn’t. What else has helped you to *kind of* get out of these

370 periods where you felt really angry or low? Do you remember

371 any other things that helped with those?

In lines 357–368 the clinician uses tentative language (see italics) while inviting the client to express what helps him and what does not, thus implicitly recognizing the client’s skills to find solutions or exert choices. In lines 369–371, she regards the solution as within the client’s repertoire, while the phrase *kind of* lessens the need for absolute success. The therapist’s tentative use of language continues:

390 Therapist: You said “I stopped exercising and that’s that.” *Is it that’s not*

392 going to happen again? Because I have seen you when you worked out

393 consistently and how good it can be for your mood and your sleep.

394 Rafael: Yeah

395 Therapist: Is that *something you want to think or talk about* ways to bring

396 that back *a little bit*?

Here the practitioner shares an observation of the benefits of exercise (lines 390–393) not as a general prescription, but as a personalized (line 393) communication while acknowledging the client’s self-management over decisions (line 395–396).

In Case 4 (low SDM) when Marta discusses how the rheumatologist treating her fibromyalgia always insists on exercise, the therapist responds in a different manner.

354 Therapist: How do you feel when he tells you to exercise?

355 Marta: How do you tell me to go exercise?

*(her tone seems to imply “And do I do it when you tell me?”)*

360 Therapist: But he insinuated you need exercise.

364 Marta: I’m going to try, but I’m busy.

365 Therapist: You’re *always busy* helping your parents or your nephew *you*

366 never take time for yourself.

368 Marta: It won’t happen

369 Therapist Yes, *it will. Be positive.*

The therapist tries to motivate the client with the language of certainty and absoluteness (line 365), commanding her to be positive (line 369), ignoring the client’s doubts and objections. Training in SDM encourages clinicians to connect with the *client’s perspective* to understand the client’s worldview, decision-making, and response to situational stressors (Alegría et al., 2008, Nakash & Alegría, 2013). In Case 4, the therapist does not take the client’s perspective into account. Nor does she explore how the intersectionality of ethnic socialization, age, gender and socioeconomic oppressions may be motivating this Latina client to attend to family needs before her own. Instead, the therapist asserts she should take less care of others, without exploring the influence of cultural and sociopolitical factors (lines 364–368). Interestingly, even though the clinician and the client share similarities in language, ethnicity and gender, differences in socioeconomic class, education and acculturation might explain the therapist insistence on a less family-centered lifestyle. Inquiring about the client’s views is necessary even when the client and the therapist are ethnically and/or racially concordant, as in this case (Falicov 2014a, 2016). Without this inquiry, the therapist misses opportunities to reflect on her relational intersectionality with the client and to explore the cultural, gender and class understandings of a problem. This would be a step to empower or support clients to find their own voice whether in cultural accommodation or resistance.

In Case 3 (low SDM), the coach points out to the therapist that she gave unilateral and absolute advice rather than relative or tentative, to Rob that he should trust only his divorce lawyer and not his wife. The therapist recognizes to the coach that Rob had not asked her for this advice but that she wanted to protect him from what she viewed as his self-destructive decisions, which had resulted in a past restraining order. The therapist’s familiarity with the client’s history over many years of treatment may have influenced her to assume a protective role intended to shield the client from his past errors. This perceived superior knowledge about “what is good for the client” conflicts with the values of SDM. Although client and

therapist are both white and they are close in age, their socioeconomic status and their subject positions as long term therapist and client may entitle the therapist to believe in her “expertise” about the client’s “fixed” personal attributes, without considering possible changes in context or attitudes between his previous and his current decisions regarding his divorcing wife. The coach suggests that the therapist could have used a language of relativity rather than certainty to discuss the pros and cons of the client’s contact with his wife and to make use of the “inclusive” language of SDM:

Coach: Maybe one way is to invite him along with you to take a look at his choice, and what are some of the pros and cons of it. I’m suggesting using inclusive language so that it’s not your way or my way but what worries does he have, and you also have, about the decision he is talking about....

Although beyond the scope of this investigation, we note that the coach also uses tentative language and asks questions that open a space for reflection for the therapist, thus making therapy and coaching communications isomorphic.

#### **(4) Collaborative Meaning Making and/or Diagnostic Labeling**

Meaning making about the definition, causes, and solutions of a problem is a central concern in the communications between clients and clinicians. In SDM training, clinicians are asked to balance “the voice of medicine,” which is a product of formal training and clinical knowledge, with “the voice of the life world,” a product of the client’s attitudes toward themselves and the world (Mishler, 1984). The challenge is how to bring these discourses into balanced collaboration. The four cases in this investigation represent various degrees of practitioner’s reliance on expert knowledge blended with the client’s life world. When Sandra, the client in Case 2 (moderate SDM) mentions missing her children, who have been taken away from her by child protection services, the therapist is supportive. But rather than inquiring further into the meanings that the sadness has for Sandra (the voice of “her life world”), the clinician emphasizes that the client’s anxiety originates from avoidance of feelings. This is an attribution of meaning based on a psychiatric diagnosis (“the voice of medicine”) is presented as uncontestable fact.

221 Sandra: I just miss my kids so bad.

222 Therapist: I don’t blame you. That’s kind of the double edge that you are

223 busy (with classes) so you can put that (anxiety) away and can

224 learn. The downside is that the emotions get pushed back...

225 they don’t go away. Just being pushed in the closet and the

226 doors shut. It’s like you have one closet where you stuff all the

227 random stuff you don’t know where to put and eventually you

228 open the door and everything falls out.

229 Sandra: That's what I am afraid of one of these days I'm gonna ...

230 Therapist: It may happen.

231 Sandra: Lose it...

232 Therapist: It may happen. You stuff and you stuff and then the lid pops off

233 and makes the volcano erupt.

234 Sandra: Yeah.

The practitioner advances her expertise further by seeing the client being busy (line 223–224) as contributing to her avoidance of feelings and predicts a relapse (lines 228–234): “the eruption of the volcano” (line 233). The client agrees that she fears this outcome (line 229), validating the clinician’s predictions with a flat-toned “Yeah” (line 234). The therapist’s interpretation could be disempowering the client by implying that her attending a mandated class is a false accomplishment built on a fragile foundation of avoidance, rather than supporting her learning new parenting skills as potential for change and family reunification. The therapist mobilized her identity as expert by viewing the client’s activities with a fixed pathology frame.

“Formulations” are statements in which a speaker summarizes what the other speaker previously said, while at the same time introducing a change in content (Heritage & Watson, 1979). An example is the therapist in Case 2 who formulates a connection between the client’s emotional repression and adds that this could lead to decompensation or “losing it”. Antaki (2008) discusses how formulations are powerful constructions that often shut down dialogue. Diagnostic formulations constitute a means by which an individual or a family therapist can shape dialogue about symptoms using dominant discourses of knowing pathology (Antaki, 2008). Furthermore, rhetorical devices, such as “vivid description” may be deployed when a speaker wants to construct an account as factual (Edwards & Potter, 1992). In Case 2 (moderate SDM), the therapist may be unaware that the “vivid description” of volcanoes erupting may solidify the diagnosis of anxiety rather than create openings for the client’s lived experience.

After listening to the audiotape of this session, and without prompting by the coach, the therapist in Case 2 recognizes that she has not created enough space for the client’s voice.

**Therapist to Coach** I could have easily said, “Ok, it seems like after these meetings with your kids, it increases your loneliness, *what do you think you can do to help manage these reactions?*”

**Coach** Yes

**Therapist** *Instead of throwing like “do this, do this”* at her.

The clinician, trained in SDM, quickly realizes that she offered “professional” prescriptions tailored to a diagnosis of anxiety without allowing the client to mobilize her own resources

to cope. In a client experiencing the oppressive intersectionality of unemployment and poverty, alcohol and drug abuse, unstable living situation, and having her children taken away, Sandra's sense of control could be further thwarted when the clinician, asserts that, because she is not dealing with her internal emotions, her control becomes even more precarious. When the clinicians express certainty about their assessments of the clients' inner life, they may disempower clients, particularly those in an unequal socioeconomic level that might feel deprived of agency.

SDM training includes the construct of "*avoiding attribution errors*." These errors refer to the assumption that behaviors result from inherent traits (i.e. patient is lazy or resistant to change) or essentialist personal traits or "dispositions," as opposed to contextual stressors (i.e. patient missed the session because of lack of transportation). Attribution errors are more frequent when clinicians interact with racial/ethnic or socioeconomic minorities (Hewstone, Rubin, & Willis, 2002). In Case 2 (moderate SDM), the therapist attributes Sandra's problems to her internal instability or dysfunction, her "volcano waiting to erupt." Interestingly, it is the client who corrects or "repairs" this communication by changing the metaphor to "a tornado taking over my life," an evocative image of destructive external circumstances that could overpower her rather than her internal dysfunction. Dispositional attributions and diagnostic labels close off conversation and highlight the intersectional authority of the clinician, while situational attributions allow understanding of the client's circumstances, sometimes sociopolitical, creating a space for the client to reflect about their contextual problems and co-create solutions with the clinician.

A constructive use of authoritative expertise in diagnosis can be observed in Case 1 (high SDM). When Rafael calls himself a "retard" because of his addiction, the clinician reminds him that smoking is the only thing that makes him feel good, and thus has meaning for him. The therapist incorporates this meaning and adds her expertise by referring to "healthy or unhealthy coping skills" (lines 389–390).

388 Therapist: There's lots of *things that people do that feel good* for a little

389 while and *then* don't and *have some negative*

390 *effects*. Sometimes we talk about it as *healthy coping* skills and

391 *unhealthy coping* skills.

The notion of coping, unlike a label of dysfunction, acknowledges that the client is dealing with difficult circumstances. The idea of healthy or unhealthy coping affirms the client's earlier statement that he is trying to cope with his own resources and strengths, even if sometimes the coping has negative effects (see Madsen, 2014).

## (5) Co-constructing and/or Prescribing Behavioral Tasks

Systems-oriented therapists often prescribe behavioral tasks to mobilize change and/or to assist with problem management. These direct assignments may or may not encourage the client's approval of the task (Brown-Standbridge, 1989; Omer, Golden, & Priebe, 2016). SDM and collaborative approaches attempt to center the client's voice on the construction,



the optimal context, the timing and likelihood of adherence to the task (Metz et al.2019). Often in SDM, like in solution-focused therapy (de Shazer, 1988; Berg & Dolan, 2001) and in motivational interviewing (Hettema, Steele, & Miller, 2005), the starting point is the client's own attempted conceptualization of the problem and attempted solutions (Omer, Golden, & Priebe, 2016).

In Case 1 (high SDM), the therapist explores what the client has already done (line 437, line 441) on his own to help himself with the behavior he finds disturbing:

437 Therapist: Have there ever been times where you decide “I don't want to

438 *smoke this much” and have been able to cut down on it?*

440 Rafael: Yeah. Like for one day and that's it.

441 Therapist: *So what happened* that one day?

Here the client has experimented with the task and therefore can discard it, revisit it, or determine the need for a new task, with the therapist as an engaged, curious, attentive (to even just a single successful day) and collaborative partner.

In contrast, the therapist in Case 2 (moderate SDM) prescribes tasks (in lines 247–253) that she tailored to the client's diagnostic label and asserts that these tasks would be of absolute value, without inquiring about the client's views of whether they have value for her.

245 Therapist: So how do we prepare for making the eruption less intense?

246 you are doing O.K. now because it is being pushed away, but

247 when you push away you don't deal with it, then it grows and

248 erupts...those are the moments where you

249 have urges to drink. I think something you can do one night a week,

250 two nights a week ... either write in a journal or go in the

251 shower and give yourself permission to cry.

252 set a timer, 15 minutes, 20 minutes and once the timer goes

253 off you stop it, so that you don't flood with intense emotions.

254 Sandra: Yeah.

The coach later points out that the therapist has not checked the likelihood that the client would follow through with tasks. The therapist acknowledges that she has not considered possible obstacles to task completion by stating, “I have taught this patient many coping skills like EFT, deep breathing, pressure point, so many things over the last few months and she does not do any of them.” Madsen (2009, 2014), in his collaborative helping

approach with multi-stressed low socioeconomic level families, correctly points out that it is especially valuable to co-construct rather than prescribe tasks and to promote talk about obstacles and facilitators of task completion. Boyd-Franklin (2000) speaks of the tendency of beginning family therapists wanting to “fix” or “solve” the problems of poor families when the goal should be to empower them to find their solutions rather than “helping” them.

A client’s failure to follow up on behavioral prescriptions may be interpreted by clinicians as “resistance” to change. Conversely, the emphasis on SDM and collaborative therapy centers on the client’s voice in the construction or agreement about the session tasks. Couple and family therapy requires a buy-in from all members through an exploration of how they view the meaning and viability of the tasks being suggested. Training in SDM may help therapists recognize how their unilateral professional prescriptions may unwittingly disempower clients and result in a lack of follow up. This does not mean doing away with tasks, but rather engaging all members in the construction of the tasks or at least in a discussion of whether the task is realistic, doable or of interest to try for those involved.

## Discussion

We conducted an intensive analysis of four exemplar cases to illustrate communication practices that clinicians can use to center client’s voices in moment to moment interactions. The five themes identified in this investigation with therapists trained in SDM are consistent with aspects of postmodern collaborative and critical practices in family therapy. Like these approaches, SDM attempts to decrease assumed paternalism and professional hierarchy, and endeavors to avoid imposing a diagnosis or a superior interpretation of the client’s experience in order to promote mutually-arrived ideas or solutions to problems. It establishes from the beginning that clients are in charge of stating and sharing their agenda for the session. SDM also recognizes individuals and families as experts in their lives, mobilizing attention to contextual stressors and avoiding diagnosing fixed traits that require intervention (Fraenkel, 2006; Anderson, 2016; Falicov, 2014a). We believe that SDM can fall in the construct of “activism through collaboration” advanced in family therapy clinical investigations (D’Arrigo-Patrick et al., 2017). Thus, SDM has implications for studying evidence that disparities in mental health care of low -income families could be reduced if clinicians consistently seek all family members’ perspectives in treatment (Seikkula, 2002; Seikkula & Trimble, 2005).

In couple and family therapy conversations involving more interlocutors than in individual work, increases the challenge of inclusive communication. Furthermore, the agendas of the individuals present may compete or differ with each other, but the trained family therapist may utilize the notion of arriving to a common agenda implicit in SDM as a clinical intervention that may be a first step towards therapeutic change.

Although the case studies of this paper are drawn from a trial with a large multicultural low socioeconomic population, we believe that SDM and the collaborative practices it illustrates is desirable and applicable to clients of all cultures and socioeconomic levels. Its practice centers the voices and personal interests of all those in distress. Subject positioning of

therapist and client is an inevitable aspect of the societal contract implicit in the relationship, so we must also take into consideration the type of relationship sought by the clients.

We must, therefore, also reflect that the cultural shift from an expert-led delivery of services towards one that integrates client-led practices is currently taking place within a Western, educated, industrialized context. Therefore, it is not in itself culturally neutral. In other cultures, or contexts, or depending on the individual case or life circumstance, maintaining the expert role with authoritative directness may be culturally congruent and even preferred by the client. Future investigations should consider client perceptions of their needs, preferences and definitions related to SDM and collaborative dialogue. Sensitive practitioners will assess these circumstances and negotiate decision-making processes (Feldman, Ploof, & Cohen, 1999).

This analysis did not include client feedback on how much they felt heard and if or how this made a difference to them. Further investigations of SDM and of collaborative therapy could triangulate the therapist and the client's views of what enhanced or detracted from collaboration. Such analyses could also observe the process of therapist-client collaborations over the length of treatment and address how length of treatment may influence the conversation of the session. For example, a therapist with long term-knowledge of the individual client or the family may unwittingly become more certain of what the client or family should do and thus become more directive. Alternatively, the client or family may expect this authoritative advice. It is important to clarify that collaborative dialogue need not silence professional voice in psychotherapy encounters. An exploration of the tension between directivity and dialogue in problem-focused techniques such as CBT, DBT, medication, or psycho-education may invite practitioners to consider new possibilities (De Haene et al., 2012) or multiple options (Alegría et al., 2018) that can mobilize change.

An important consideration is that the use of audiotapes limits data to verbal expressions. We acknowledge that dialogue also involves the non-verbal and inner dialogues (Andersen 2007; Guilfoyle, 2003), and that videotaped material might enhance the investigation. However, we also believe that the verbatim in-session communications reported in this article offer a "telling how to say it" which has didactic or imitative training value for individual and family therapists (Ratliff & Morris, 1995). Examining in detail how these verbal actions are implemented in vivo is useful for clinicians in training.

Finally, we chose to conduct in-depth analysis of 4 exemplar cases that provide concrete examples of in-session dialogue depicting the communication exchanges between clients and therapists showing different levels of SDM. Such exemplars can help guide skillful clinical practice. Yet, we acknowledge that the choice to refrain from systematically employing a standardized method of analysis (e.g., conversational analysis) may pose limitations to the investigation.

The notion that clinicians could benefit from sociopolitical self-reflection of how their practices are influenced by their professional identity fits with the construct of "cultural humility" (Tervalon & Murray-Garcia, 1998; Falicov, 2014a; 2016). This construct requires awareness of power differentials in relationships with clients, the cultural constructions of

the therapist and a recognition that families are the experts on their own cultural values, internal life, and treatment priorities (Falicov, 2014b, 2016).

Our findings and the reflection between the therapists and their coaches suggest that SDM training increases awareness of status or power differential. Nevertheless, the findings also suggest that SDM training may benefit from even further attention to the intersectionality and own social location for the therapist to gain self-reflection about their own privilege and Eurocentric frames (Falicov, 2014b). We agree with Guilfoyle (2003) that power is a common factor shared by all therapies and that because of their powerful speaking positions, collaborative and critical approaches require “special speaking arrangements” to remain in dialogue. We believe that training in SDM aids in the process of maintaining dialogically oriented “special speaking arrangements”. Nevertheless, none of the communications in these four clinical cases with disadvantaged minorities attempted explicit empowerment through consciousness raising or using sociopolitical education, a distinction made by Monk and Gerhart (2003) between therapist as sociopolitical activist or conversational partner; or what D’Arrigo et al.(2017) call “activism through countering”. SDM appears to fit more with an egalitarian-oriented “activism through collaborating” (D’Arrigo et al.2017).

This analysis suggests that collaborative-oriented and critically-informed family therapists could potentially incorporate SDM constructs and strategies in their repertoire, helping them to further put into practice those theoretical stances. Future analyses can explore whether the learnings from SDM training in mental health settings can enhance family therapy practice. Conversely, therapists could examine whether integration of family therapy collaborative and critical practices could facilitate optimal training outcomes in SDM.

## Conclusion

We hope this account will be useful to those interested in Shared Decision Making (SDM) as one form of engaging therapists in collaborative interactions with their clients. SDM offers a framework for person-centered conversations and potentially taking intersectionality into account. Family therapy conversations involve more interlocutors, increasing the challenge of inclusive communication. Nevertheless, we believe the five emerging categories presented in this analysis of clinical sessions and their embedded language usage can become useful tools for integration into family therapy training, supervision, and clinical practice. The illustrative verbal exchanges provided by the in vivo sessions open avenues for training by suggesting types of clinician communications that center the voice of the client and honor collaboration with socioeconomically disadvantaged groups.

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