The effectiveness of collaborative therapy model: future of postmodern therapy

Sociology, Communication

Collaborative therapy model is a form of postmodern therapy that best complements my current view of what therapy should feel and look like. During my early years as a Child Welfare Specialist and Community Advocate, I felt as if I could conquer the world and solve every clients' problem, provide a path of happiness, and work miracles. However, now that my life has become my own I now feel that setting the stage and laying the groundwork is more appropriate and effective for clients as they move past obstacles to ensure a more comfortable way of living. Collaborative therapy's therapeutic relationship involves the philosophic stance, conversational partners of " withness," the art of not knowing, client and therapist expertise, ordinary language, inner and outer talk.

Model Description

Collaborative Therapy Model is a two-way dialogical process in which therapist and clients together explore and create a more useful understanding of the client and his or her problems, (Gehart, 2014). Anderson (1997) suggests that it is through conversations that we form and shape our life's experiences and events, and through them, we build and rebuild our realities, relationships, and identities. The role of a collaborative therapist is to keep the conversation moving with the client or between the family system throughout the session, (Gehart, 2014). Collaborative therapists co-explore and co-create new understandings by avoiding the usual scripted techniques and focus on the process of therapy and how the client's concerns are explored and exchanged. The objective is to listen for how clients interpret events in their lives and then ask questions and make comments to better understand how the story " comes together." These

questions naturally emerge from the conversation as the therapist strive to understand the client from within the client’s worldview, as the process continues the therapist’s curiosity invites the client to share a mutual or shared inquiry.

The process presents an opportunity for clients to see their situation differently and begin to make new interpretations and adjust how they view their problems and develop alternative ideas that include new options or strategies for living, (Gehart, 2014). The model, collaborative therapy was developed by Harlene Anderson and Harry Goolishian along with other colleagues at the University of Texas Medical Branch in Galveston. The concept of “ not knowing” was first introduced in 1988, which refers to how therapists think about what they think they know and the intent with which they introduce this knowing to the client. Therapists choose to “ know with” and together with clients as they engage in a process of better understanding the client’s life and problems. After noticing how family members have their own language, using words and phrases with unique meanings, Anderson and Goolishian began to conceptualize their work from a postmodern perspective by focusing on constructing the meaning in relationships. Other researchers such as, Tom Andersen and Jaakko Seikkula, joined Harlene Anderson and renovated the collaborative language systems by transforming the systemic practice using postmodern sensibilities that reduced the team-client hierarchy and switched the process from strategic to more dialogical. The use of inner and outer dialogues provided collaborative therapists with concepts used to facilitate therapeutic conversations without

the use of technique. Theoretical visionary, Lynn Hoffman worked with Peggy Penn and helped further developments of the model including the unique approaches to using writing in therapy, (Gehart, 2014).

Research Support

The most important research to support Collaborative Therapy is to successfully train and education therapists and practitioners how to become effective using a model with no steps or predictable guidelines. In 2012, five researchers published data from a study to provide information on collaborative care and develop skills that will help therapists and practitioners in a medical healthcare setting. The study comprised of thirty-three “ experts” who were given a survey of thirteen questions. These questions consisted of six open-ended questions to elicit skills needed for successful collaborative practice, six closed-ended questions to gather demographic information, and one final question requesting the identification of whom they would consider to be experts in the field and can provide additional valuable information. The last question also points back to the initial participant criteria exercised to determine “ expert” status. Data were analyzed by the primary researcher and a research assistant using the constant comparison qualitative data analysis method, and a preliminary codebook of themes or skills was inductively identified. Therapists working in medical healthcare facilities must acquire a skill set that prepares them for the fast pace, medical culture that requires a different language and a variety of medical protocols. The results of the survey presented 56 skills needed to train therapists and practitioners to be competent in the medical

healthcare setting. Simply stated by a surveyor respondent, “ Many MHPs (Mental Health Providers) enter into a medical setting speaking therapy and not understanding medical-ease. Developing a common language means abandoning the terms that we learned in graduate school for more user-friendly words that medical professionals understand,” (Bischoff, Springer, Reisbig, Lyons, & Likcani, 2012, p. 202).

Model Fit

The main strengths I have that will fit well are the abilities to listen and adapt to various unique situations. Collaborative therapists’ essential tools are conversations, relationships, and dialogical processes, (Anderson, 2007). Collaborative therapists must really listen to what the clients are saying. Unlike other models, listening should not be from a theoretical framework opinion because it will not be consider listening to fit this type of model. Careful listening is listening to clients from a curious stance without judgment or criticism. It is very important if not the most important instruction that will help to create the dialogical process, (Gehart, 2014). No two clients or family system are the same. It is important to be ready to speak to clients in a language that makes them feel comfortable and safe. In collaborative therapy a conversation is never singular and self-contained. It is an assortment of intertwining, over-lapping of present, past, and future conversations that people have with each other and with themselves. Each conversation is a collage of story fragments that may merge, fade, or alter into something different for everyone involved, (Anderson, 2001).

Collaborative therapy model has no formula or guidelines that can be explained to clients to ensure positive results. Many people are weary about therapy, I will have to find ways to improve how to showcase and push confidence in a model by continuing to emphasis on the client as being the expert. “ The expertise of the client does not deny or refute the expertise of the therapist. This expertise delivers attention to the client’s means of “ know-how” on his or her life and cautions us not to value, privilege and revere the therapist as a better knower than the client,” (Anderson, 2012, p. 138). Recovery Model and Collaborative Therapy Model The recovery model and collaborative therapy model both share the empowerment of clients being in control, open communication, client’s as the focus, the encouragement of clients using their strengths to prevail, and the use of multiple community resources, (Gehart, 2014). Self-direction, in which clients choose their own treatment and steps to recovery; individualized and person-centered, in which treatments paths are personalized to the clients’ experiences, strengths, and cultural background are important for collaborative therapist to use throughout the collaborative process to help clients sustain a quality of life, (Gehart, 2014). Model Application Case Summary Deja Fuller is a fifteen-year-old bi-racial female who has recently experienced a dramatic drop in her grades. Her parents, David and Erica, has also notice that she has become irritable and fatigued.

Deja constantly snaps at them and spends much of her time lying in bed. Last weekend, Erica, her mother found bottles of alcohol underneath Deja’s bed. When confronted Deja stated that she had no idea how the bottles got

there and became very upset. Deja screamed “ she wishes she could just die and wanted to be left alone.” School officials contacted Deja’s parents about her persistent absentees which they were unaware of. Erica states she tries to make Deja attend church and other community functions with the family, but she refuses to. David suggests that Deja seeks help because he feels her actions and constant rages will start to affect the other children. Family Background: David (Caucasian) and Erica (African American) have been married for 17 years. They have three children, Deja 17, Marco, 12, and Shia 8. David is an auto mechanic working mostly 12-hour shifts, and Erica is a registered nurse working 3 days a week PRN. Erica cut down her working hours after having Shia to be more available for the kids. The family lives in a four-bedroom home in a community which both parents grew up. First Session: In the first therapy session with Deja she states that she does not want to die, but she said that because she was angry with her mother for not seeing she was depressed and didn’t like going to school. Deja states that she has been avoiding school because she feels that she doesn’t fit in and that nobody at school likes her. She gave a detailed account of going to school each morning and then sneaking back home after her first class ended.

She stated that she got the alcohol from a group of students who would talk to her at school. This group of teenagers have been labeled as being participants of tardiness, nonattendance and petty crimes.