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Shifting From Treatment Plans to Action Plans: Solidifying the Therapeutic Alliance

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This article summarizes the evolution of my theoretical orientation and treatment intervention style over the past thirty-something years. It discusses the pathways taken, influences felt, and experiences that have contributed to my expanding mindset and current therapeutic modus operandi, *progressing from past to present. As to what will be in the future, that is difficult to predict as the metamorphosis keeps happening, although some components remain essential ingredients and provide grounding and balance. "Que será, será" sums up the future succinctly.*

KEY WORDS: action plans; family business consultation; therapeutic alliance.

This above all:
To thine own self be true,
And it must follow, as the night the day.
Then canst not then be false to any man.

William Shakespeare's Hamlet
Act 1, Scene 111, pp. 426–427

THE BASIC FOUNDATIONS AND CURRENT EXTRAPOLATIONS

My "basic" training was as a psychodynamically oriented individual and group therapist. This approach entailed a process orientation to conducting both. I learned the theories and techniques of the revered masters of various psychoanalytic schools (Freud, 1933; Jung, 1933; Groddeck, 1961, etc.), the work of the ego psychologists (A. Freud, 1971), neo Freudians (Marcuse, 1955), and developmental

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psychologists. I was deeply steeped in the constructs of the id, ego and superego; the therapeutic alliance; theories of the unconscious, transference and counter transference; resistances and ego defenses (Brenner, 1955, 1982). These ideas undergirded my early therapeutic endeavors and still, in updated form, constitute an important part of my theoretical understanding of the developmental trajectory and of behavior dynamics.

Initially I worked within agency settings; since fees were based on ability to pay, no one was distressed when therapy was quite lengthy. Many patients were pleased to merit so much time and attention and agencies viewed client retention as a sign that the patient considered the therapy valuable. How much this has changed with the advent of managed care. In my own practice, I work solely on a fee for service basis, and take no insurance directly, as I strongly believe that all aspects of the treatment contract and therapy are and should be between patient and therapist and can only be negotiated and implemented in good faith and with informed consent when this is the situation. This solidifies the trust factor so essential in forming the strong therapist/patient bond.

Being based in family service agencies where children were often brought along when a parent had no baby sitter, it became clear that there was a disparity between what parents said they did with their children and how they actually parented them. I was intrigued by these discrepancies as well as the different interpretations members of the same couple gave to their motives and interactions. This led me to learn more about interpersonal theories (Sullivan, 1953; Fromm-Reichman, 1948; Green, 1964) and family dynamics. The latter became a central focus of my work and I remain immersed in family psychology (Kaslow, 2000a); the understanding of family systems and their patterns, processes, interactions, transactions, histories, hopes and dreams. (See Ackerman, Beatman and Sherman, 1961; Bowen, 1988; Satir, 1967) As the field burgeoned, so did my conceptual grasp and contributions to its knowledge base (Kaslow, 1981a; 1982a; 1996) I still find it much more illuminating to observe patients relating to one another than to hear their version of how they do it. This enables me to zero in on what is transpiring while it is unfolding and anchors the alliance to their current reality and observable behaviors, rather than to hearsay.

In my practice I see couples and families, individuals and groups. My approach has become increasingly integrative as I have tried to generate an understanding of the particular patient(s) that best illuminates their problems, issues, personality and character, assets and resiliencies, and then intervene to formulate and implement a viable and solid treatment plan (Kaslow, 1981a; 1990; Pinsof, 1995; Lebow, 2002).

My work has increasingly encompassed ideas about the patient's construction of reality (Gergen, Hoffman & Anderson, 1996; Reiss, 1981) and ideas drawn from narrative therapies (White, 1989; White & Epstom, 1990) and social constructionism. This has led to greater emphasis on co-constructing the therapeutic alliance, situation, contract and treatment plan. Patients respond by perceiving and

appreciating that they are partners in the relationship who help to shape the course and outcome of treatment. They thus have a higher commitment to initiating the changes agreed upon.

During the 1980s I became engaged in doing divorce therapy and divorce mediation (Kaslow, 1981b, 1987, 1993b, 1994a, 1995, 1999a; Schwartz & Kaslow, 1997), and working with remarried couples and families (Kaslow, 1988; 1998a). I also took trainings in human sexuality and sexual dysfunctions topics and became a sex therapist and trainer of sex therapists (Kaslow, 1989). It had become apparent that marital conflicts often manifested themselves in sexual issues and sometimes precipitated one or both partners seeking excitement, reassurance, satisfaction and affirmation in an affair. I pursued more information on this aspect of couples' relationships, trying to grasp how such triangulation could stabilize or destabilize an unhappy marriage, and how it might be used by the parties to fulfill their needs and/or further their objectives. (Brown, 1991; Kaslow, 1993a; Lusterman, 1998; Pittman, 1989). Many patients feel relieved talking about their affair to someone who listens attentively, does not chastise, understands that it can feel wonderful to them, and then has them sort out the implications and consequences of their behavior. Such explorations strengthen the therapeutic rapport and the patient's ability to make their own decision.

INTERNATIONAL INFLUENCES

Since my first trip to Japan in 1973 to conduct a workshop on intervening with couples experiencing marital discord, I have made an average of two journeys per year to do workshops abroad in addition to frequent guest lecturing throughout the United States (Kaslow, 2000a) Dealing with concerns presented by patients and therapists in four dozen plus countries necessitated expanding my multi-cultural, multi-ethnic and religious, and international perspective knowledge base, and multifaceted sensitivity and competence (Kaslow, 1982a) long before these ideas became politically correct in the therapeutic realm (Sue & Sue, 1990).

My fascination with family psychology internationally led me to help found the International Family Therapy Association (IFTA) and become its first President (1987–1990), and to being instrumental in establishing the International Academy of Family Psychologists (IAFP) in 1990 in Japan and serving as its current President (1998–2002). These involvements have fostered numerous collaborative ventures with foreign colleagues and has led to participation in many international conferences (Kaslow, 2000c).

A kaleidoscopic lens, allowing for an ever evolving view, meant recognizing and accepting some fundamental precepts which influence my every day therapy, namely:

— There are multiple points of view that are valuable and need to be respected, i.e, there is not one "right" way, theory or intervention strategy.

— There are diverse ways of defining reality, and what is and is not acceptable and permissible. "Absolutes" impede making connections with people and responding to different life circumstances and contexts.
— Each patient, family, and organization must be seen as a unique entity, with its own identity, problems, and idiosyncratic interpretations. Each must be assessed in its own terms and not fit into any pre-determined diagnoses or treatment plan.
— We must be attuned to and respectful of all types of diversity and not super-impose our ideas. We can discuss where our beliefs and values may differ *after* we have become familiar with theirs and how and why their system of meaning came to be.
— Patients, trainees, and consultees respond well to discussions of what our differences may mean to them, how we can negotiate these so that a strong and meaningful therapeutic alliance can be forged, and often comment on how meaningful this part of the experience has been for them.

OTHER SIGNIFICANT INFLUENCES

Three other pursuits have had tremendous impact on shaping my current constructions of personal and professional reality and how I choose to interact and intervene. They are:

— My annual involvement, since 1994, in leading a dialogue group between survivors of *holocaust* victims and perpetrators. These sessions are held in conjunction with the yearly conferences of IFTA and have taken place in such far flung countries as Germany, Hungary, Israel, Mexico, Norway, and the United States. The group is comprised solely of mental health professionals who have a personal holocaust legacy and/or are engaged in treating survivors. Generally, participants are divided equally between German and Jewish IFTA members and those residing in the host country. Many come back year after year as they find the group compelling and informative and that their transactions have had a healing effect and are conducive to reconciliation and new, vital understandings (Kaslow, 1994b, 1997, 1999b, 2000b; Sichrovsky, 1988). Being privy to their pain and shame, and their willingness to pour out the hidden wellsprings of long stored up bitter memories has made me much gentler, humbler and able to be silent as patients recount their woes. These experiences have also taught me that there are secrets that are too dreadful to be told, or that the time is not yet ripe; and my patients appreciate not being pushed when they do not wish to go deeper into their inner world.
— I became involved in *family business consultation* in the early 1980s. This was a logical extension of my involvement in working with families, and of

my activities in industrial organizational/psychology. When doing family business consulting (Kaslow, 1993c, 1998b; Frankenburg, 1999, Family Business Review, 1988–2001), one thinks in terms of short and long term goals, business plans with contingency sections in the advent of an emergency, mission statements which contain an articulation of values and objectives, succession plans, the boundary between the business of the family (personal side) and the family business (business issues and decisions) as well as action plans to implement achieving goals that have been set. These experiences have augmented my awareness of how families can pull together when they share a common mission and understand that combined effort contributes to everyone's benefiting, or they can be torn asunder by long-standing intrafamilial rivalries which lead to maneuverings geared to gains for oneself rather than for the benefit of the entire family unit.

The importance of specific *contracting* between the family business members and the consultant has become crystal clear and parallels the importance of clearly articulated contracts signed with each family member who has a position (or applies for one) in the family firm. I now use similarly explicit contracts with therapy patients, which are discussed and modified if necessary, before they are signed at the close of the first session. Patients report finding such clarity and integrity valuable and conducive to making a connection more quickly.

Although I've always asked patients "what brings you here" (the presenting problem), and "why at this time," I now raise, much earlier in the treatment process, such questions as: (1) What do you hope to accomplish? (2) What are your goals for therapy? (3) What is the outcome you seek? If there are several patients, just as I engage in dialogue with the various members of the family business team, I am likely to ask each person to formulate their individual objectives as well as those they have for the family as a unit. Once these are elucidated in writing by each person present, they are shared and an attempt is made to combine and synthesize these into goals that encompass what they all want as a group. Then we co-construct the treatment plan that becomes the map for the implementation phase. This approach garners much greater involvement and participation than a more hierarchical relationship and approach does.

Time lines may be set which help place the realization of expectations into perspective as to when specific actions should occur and what steps need to be taken to ensure that this happens. Periodically progress and achievements are evaluated, credit is given to those who participated in making it happen (incentives and bonuses can be used in addition to verbal praise) and attention is paid to obstacles which have stymied progress.

In therapy, this shifts to consideration of both internal, intrapsychic constraints (such as passivity, fear of failure or of success, unwillingness to

take responsibility for one's behavior and its consequences, depression or high anxiety) and external, interpersonal or systemic impediments (such as a too dictatorial, possessive parent or partner, chronic illness, severe financial limitations) to achieving goals. Once these are identified, and it is emphasized that one can never change another person, I narrow the lens and ask what for me is a focal question.

— What are *you* willing to work on changing or taking responsibility for doing?

If a person is vague or evasive, I ask them to give the question more thought and to formulate their thinking for the next meeting. When others are present, they usually echo this request. Approaching it this way limits the person's opportunity to project all of the responsibility for what has, has not, or will occur onto others and recognize their own pattern of being in the world—be it passive, dependent, reactive, accusatory, negative or fearful. They now have an opportunity to be proactive, make their voice heard, and have their ideas listened to. Failure to do so is interpreted as a *choice* to do nothing. Placing the spotlight on the importance of each person taking responsibility for his or her own ideas, behaviors and contributions and modifying these for the benefit of all has proven a very effective route to pursue both in family business consultation and in therapy practice. People respond positively to such opportunities to be heard and included in the deliberations and solutions.

Another aspect of the two practices that has become increasingly isomorphic is the inclusion of a contingency plan in case of emergency. The emergency can be a natural disaster such as a flood or hurricane that damages the family home or business site, it can be the sudden death or a debilitating illness of the firm's Chief Executive Officer (CEO) or of one's spouse or child, or a people-made catastrophe such as the recent terrorist attacks. It is important to raise the "what if" queries regarding the establishment of back up and retrieval systems for data; whether there is adequate and appropriate insurance, if trusts and wills are current, and if not, what actions need to be taken and by whom. Often these are unpleasant issues that they would rather not think about but they are important ones to address for everyone's peace of mind and to insure the survival of the business and the family. I find patients grateful that these issues, which have been considered taboo within the family, are broached and become discussable.

— The third force impacting on my practice has been working in *Palm Beach County*, one of the most affluent areas in the United States. Many of my patients, consultees and neighbors include the rich, the talented, the brilliant and the famous. For them it is a world of great privilege undergirded by a sense of entitlement. However, even though with all of their wealth they can acquire the major toys that allegedly symbolize having reached

a pinnacle of success, their Jaguars and Ferraris, designer clothes, palatial homes, yachts and private planes often do not bring happiness and they feel empty and edgy while realizing ostensibly they "have it all." Those who were "trust fund babies" often lack confidence in their own abilities: their inheritances have rendered it unnecessary to work and so they are uncertain about their own competence. Those who are extremely talented in entertainment or sports fields are unsure whether their "friends" and fans really like and respect them for who they are or only because they are famous. Those at the top rungs of the political ladders are oft criticized or flattered for the stance they take and sometimes question people's motives and seeming friendships.

Many a *wealthy* older man ponders whether the beautiful, much younger woman on his arm and in his bed is really there because she loves him. He may be vaguely aware that attractive, charming young women rarely get involved with *poor* older men. Many rich patients are worried about their children, who are often raised by nannies, driven to extra curricular activities by chauffeurs, attend toney private schools, and often get involved with using expensive drugs and alcohol. They are raised around the party scene, much of it connected to the local charity balls and cocktail receptions at their homes and country clubs, which serve as major fund raising events for the various philanthropies and are therefore laudatory happenings. The parent-child attachments are tenuous, friendships are shallow and may vanish if one suffers serious financial re-verses. Divorce rates are high and commitments are ephemeral. These stereotypical images characterize some of my patients.

These people often enter therapy with suspicion and the therapist, in this instance, me, may be perceived as another member of their staff expected to do their bidding. They may request, or even demand, that I shift a patient who has a standing appointment in the time slot they want because it interferes with their golf or bridge game, or a meeting about a big business deal. Some feel free to cancel the last minute or just not show up if an interesting invitation pops up. Consideration is not one of their attributes and engaging in a strong therapeutic alliance is an enigma since few people have ever proven trustworthy and most relationships have been fleeting. They have felt abandoned, unwanted, spurned, exploited and all of the other emotions their poorer counterparts feel, and they may be equally afraid to allow a therapist to enter their inner world and to get to know them.

They would rather keep up the "everything is wonderful" façade than risk seeing and feeling their vulnerabilities and raising questions about their values, beliefs and life styles. Like all patients, they need reassurance, which accrues slowly, that I understand their world and can enter it knowledgeably in therapy, and often, in real life. I find such "joining" is imperative.

WHAT'S IN A WORD? CHANGING THE LANGUAGE

Andersen (1996) has stated that "Language is not Innocent." Our words convey intent or covert meaning as well as content or overt meaning. I have found that many of my patients and consultees resent the words "homework" and "assignment." They interpret these as infantilizing and pejorative as they evoke memories of being a school child being told what to do by an omniscient teacher. Even when we carefully craft the homework together, they take umbrage at the concept. Most of them function well in many arenas of life and are perceived as successful; homework feels insulting to them. They evidence a similar reaction to the term "treatment plans." The concept "action plan" is more congruent with their thinking.

POSTSCRIPT

What has occurred is that I have shifted my own thinking to a more collaborative, less hierarchical model, which still enables me to share my ideas and "expertise," I find that they resonate with my talking in terms of (1) what changes would you be interested in and willing to make; (2) what action plan are you willing to devise conjointly with me and with others involved; (3) what time lines do you want to establish, and (4) how will you know that you have achieved the goals you have set individually and as a family or business entity. They perceive that their strengths and competencies are respected, that we are allies and collaborators in the enterprise, that something is being accomplished *with* them and not *to* them. The entire consultation or therapy process has become more respectful, characterized by a clearer focus on pursuing meaningful objectives, and more enjoyable.

For me, the idea of a conjointly fashioned action plan rather than a treatment plan lends itself to a more collaborative, ethical and efficacious modus operandi and is a decidedly more gratifying way to practice. The framework is biopsychosocial, contextual, and ecosystemic, and cultural variables are taken into account. I find this growth inducing model more attractive as do consultees and clients in the various venues in which I practice; it is also conducive to a stronger working alliance. It conveys respect for everyone's competence and enlists their attributes in the service of their ego and of their hopes and dreams, and helps in the creation of a more desired business reality and/or marital and family relationship. Attentive listening and empathy now co-exist in my style with active, enthusiastic interactions like making suggestions, helping to forge dynamic action plans, and staying engaged to make certain follow-through occurs. I am both a participant in the therapeutic process and an observer who provides input and cogent feedback.

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