Capstone Project Assignment

Jeremy Gillentine

Department of Counselor Educator and Family Studies, Liberty University

Abstract

In this paper I will discuss the methods I use to assist clients in moving forward towards their desired future selves. The primary method I utilize is Solution Focused Brief Therapy (SFBT). Many locations where counselors will work are married to the traditional model of case conceptualization, treatment planning, etc. that can be useful but are not a necessarily part of the counseling process. SFBT is a fluid method that demands the preparation of the clinician (through the mastery of asking great questions) to meet the client where they are when arriving at a session. This mindset has the clinician adapting instead of a plan for the version of the client that comes into each session having to adapt. Every session with SFBT is assumed to be the last, so every moment has an added level of importance. I do have a brief discussion of how I use some principles from CBT and Mindfulness included. It is my hope this discussion will demonstrate I am not opposed to other methods. However, I certainly believe SFBT is superior in its adaptability, forward focus, promoting of hope, and strength-based approach to assisting the client in gaining focus in where they want to be—Their Preferred Future. I will also share a case to help discuss some principles of working in therapeutic alliance with clients. I will demonstrate this alliance to be profitable to help clients discover their preferred future and then to sculpt a map of moving in the direction of the goals established.

Keywords: SFBT, future, preferred future, best hopes, scaling

Capstone Project

As I begin, I will demonstrate the efficacy of SFBT and show how I would go about case conceptualization and treatment planning if I worked somewhere that required them. I will also discuss why I do not utilize them currently even though Meichenbaum (2009) says, "A clinician without a Case Conceptualization Model is like a captain of a ship without a rudder, aimlessly floating about with little or no direction." I firmly disagree with this as a false premise and conclusion. Rather than taking the captain's stance of steering the ship (my client), I see the client as the expert on themselves, while it is my job to be a professional at asking great questions. I will discuss how I see my role as being ready for the version of the client who shows up at each session rather than attempting to steer my client to the path I have chosen in my treatment plan. I will begin this journey with a more thorough look at SFBT and some principles from a couple of other modalities that I use in my practice on occasion.

Comprehensive Theoretically Grounded Model of Clinical Counseling

The primary comprehensive model that I follow is SFBT. This model began by Insoo Kim Berg and Steve DeShazer (1980) and gained its name in 1982. Berg and DeShazer started by using a video camera and a one-way mirror to begin to test and solidify the efficacy of SFBT. This model is quite flexible and works well with a broad range of presented issues in therapy. SFBT works well because it does not get stuck on the problems in the past but works to help guide the client to their desired future. SFBT also assists the client in identifying their hopes, so the client is

motivated to move towards their goals. The work by Franklin et al. (2017) lends significant support to the efficacy of SF modalities. The researchers further indicated the need for clinicians to intentionally include the strengths and resources techniques, learn best practices for when to utilize various SF techniques, co-construct outcomes with the client, and speak the SF language of change. The "active ingredient" of SFBT is the co-construction process. This alliance is a valuable piece of the process that allows the client to be the expert of themself and work in collaboration with the clinician.

The SFBT clinician who is well studied and has an astute understanding of SFBT will converse with their clients through the art of great questions. I use these skills to assist clients in understanding their goals and then help develop a good path in the direction of those goals. Clients are indeed their own best experts but occasionally get mired in the task of daily living and find they need a hand to get back on the path of their choosing. Neipp et al. (2021) did a study of 265 participants that showed SF modalities were as effective as the problem-focused modality [I believe there were some flaws in their process (e.g., cold computer questions with no ability for a therapist to adapt the questions to the individual). Additionally, the problem-focused question also had solution-focused suggestions embedded within).]. The positive outcomes, though a flawed process, do support the effectiveness of SF modalities.

There were many interesting distinctions regarding differences between the problem-focused modalities and the SF modalities. One of these is the contrast between problem-solving and solution building. Froerer and Connie (2016) point out the differences they see between problem-solving and the act of solution building. Solution building is to go in the therapeutic alliance from where the client is currently and to develop a map towards the client's preferred

future. Solution building contrasts with problem-solving in there is no need for a defined problem to solve, rather a self-directing towards where the client wants to be as they move forward. Another area discussed by the authors is the various tools available in SF work. They point out that these techniques (e.g., miracle question, scaling, preferred future) are not utilized as strict criteria used in rote rehearsal but are tools that help focus the client, in front of you, in a specific manner for them. The clinician learning the tools available through SFBT needs them to become second nature (internalized). This level of familiarization is a necessity for practicing SFBT. By being equipped with these core principles, the clinician can mold specific questions to prompt the client towards their desired path for change. This process truly is a beautiful process to witness! Braunstein and Grant (2016) indicate SF questions are indeed ones that are proven to bring about positive changes (better results as compared to problem-focused) such as improved positive and reduced negative emotions, improved self-value. These changes equip F, the individual in the case study, and other clients to deal with daily challenges and improve goal achievement.

Joubert and Guse (2021b) researched trauma victims in South Africa. Some clients found it therapeutically helpful to discuss the traumatic events, while most participants were thankful to avoid reliving the traumatic events. These found the future-focused therapy to be beneficial. The principle of not having to re-experience the trauma in therapy has opened the possibility of therapy to many who would have avoided it due to the fear of re-traumatization through traditional problem-focused modalities. Additionally, using SFBT for the treatment of those clients who have suffered through sexual traumas can find the modality to be one that helps the client to be empowered. This empowerment is a motivating factor to help the client move

forward in their desired direction (Jones et al., 2021). The idea of walking away from therapy empowered would seemingly appeal to the vast majority of people. Let us take a moment to see a couple of other modalities I occasionally utilize in my therapy work.

Theories I apply in counseling

Though SFBT is my primary approach, I do utilize other approaches as well. The method I use the second most frequently is Cognitive Behavioral Therapy (CBT). CBT is one of the best researched and one of the most diversely applied modalities of all time. Hofmann (2021), in an article focused on Aaron Beck's 100th birthday (the founder of CBT), indicated that even with the vast amounts of research done regarding CBT (having counted at least 269 meta-analytic studies back in 2012), there is a continued need for further research to improve the modality. This improvement is needed even though the proven effectiveness of CBT with many diagnoses. With a theory such as CBT being this well studied, there continue to be ways of improving upon the great success it has already had over the years.

Similarly, Kazantzis et al. (2018) began with 4,923 studies that involved CBT, of which they narrowed to 30 studies to look at critically. The vast number they started with is indicative of the immense amount of research done regarding CBT. The overarching principles indicated the design of CBT is to improve the lives of clients. This improvement is accomplished by correcting problem thinking patterns and through the therapeutic alliance. Holfmann (2013) points his readers to correcting problematic cognitions will directly affect emotions and overall mental health. Indeed, helping a person think better about even a physical ailment can improve mood state.

The third modality I use on occasion is principles of Mindfulness (MF). A study comparing MF and CBT outcomes began with a waiting list group (control) of 28 for six months to see what changes occurred. They then divided the remaining participants up with 10 in the CBT group and 9 in the MF group. These groups performed almost equally on the outcomes, demonstrating MF is certainly a helpful tool. The principle I most frequently utilize from MF is the idea of being in the moment and experiencing the things that are occurring in those moments. Whitfield (2006) has this same idea in his work but specifies the person is to describe what they see with their own eyes rather than what they perceive someone wants them to be seeing. I find this simple principle helps individuals avoid overlooking the awesome things occurring around them in each moment. The tools I have discussed helps my clients to know where they want to go (SFBT), correct flawed thinking to improve emotional health (CBT), and help them to experience each moment which helps bring the color back to a life previously lived in black and white (MF). My next venture in this writing will be to carry you through some of the processes involved with clarifying the path my client and I will journey together on to accomplish the goals of their coming to therapy.

My comprehensive method of bio-psycho-social/multi-systemic-cultural/spiritual assessment

Burns et al. (2019) emphasized looking at clients from a holistic perspective in their work regarding biopsychosocial assessments. Clients come into counseling for many reasons that are either caused or exacerbated by things that occur internally (bio) and outside of themselves (social). Considering these factors when treating clients is crucial. Both the biological and social components are critical components considered in the therapeutic alliance between the clinician and client. For example, a client coming in with a sleep issue (e.g., insomnia) may lead to

questions: Do internal dilemmas vs. poor environment cause it? Is it side effects from depression or mania? Is it a potential hormone issue or inadequate psychosocial training? It is crucial to consider the factors of causation involved with each issue as specific to the client. In the following sections, I will display some of the elements I would use if required to do case planning.

Biological Assessment. When a client comes in for a session, I ask if they have been to their doctor for a physical examination. If they have not already done so, I strongly encourage them to make an appointment to get checked out. I know from first-hand experience what a deficiency can do to cause the human body to malfunction. I had primarily been someone who worked outdoors but then found myself helping someone out by running a store in a mall for forty-five days straight. Being indoors for such an extended period allowed my Vitamin D level to drop very low. As a result, I could not make myself go, which is not typical. For clients who are hesitant to go to their GP, I share this account of what could be occurring with them to help normalize a needed trip to their GP. It is critical to get this checkup done to help ensure we are not only talking when something such as a Vitamin D subscription is the client's primary need.

Psychological Assessment. The psychological assessment begins with a proper intake questionnaire that the client could fill out before arriving at the first session. Questions help me grasp the fundamental areas of interest the client is dealing with, so I can be more focused when we are together for our first meeting. Once the client is here with me, the task becomes one of listening to the types of answers provided by the client to the various questions and conversations we had while together. For example, if I noticed specific responses (e.g., I just cannot make myself go), I would be alerted to follow-up if the client had seen their doctor for a

checkup. When clients make remarks like these, I will probe deeper—Is this typical for you? Did your parents or siblings have these issues? Is there something new happening that is sucking the joy from your spirit? Has there been a death or separation? The idea is to determine if the events are psychoeducation driven, environmental, possibly genetic, or any reasonable explanation of causation that could spawn a resolution.

Once you get a good feel for the potential cause or causes (bio, psycho, social), you can help the client determine which avenue is best. Some examples are: 1) If a trip to the medical doctor may be appropriate. 2) If forward-focused psychoeducation is needed. 3) If supporting the client to discover their preferred future with a map in the general direction of those goals. Assessing for regression and progression and then adjusting questions according to the client's current level is a process that is ongoing throughout the therapeutic alliance. One of the things I love most about this work is the challenge of never knowing for sure what version of the client will come in and then adjust to assist them from where they are at that time.

Social/Multi-Systemic Assessment. The Social Assessment is a process that begins through the intake questionnaire. Clients fill out information regarding their family and some primary connections to others. The information given by the client helps me have a place to start. Gingerly probing questions help reveal if the client has a support network (e.g., feels loved, cared about, respected, encouraged) or is a person on a proverbial island (e.g., feels alone in a crowd, family conflicts, avoids or is avoided by coworkers and others). Once I grasp the social stability or lack of it, I can help the client see the value in their connections and follow the principle of what is working and do more of it or consider ways to increase the client's social connections. If it appears to be a lack of social stability, I think with the client what obstacles

may be hindering these connections, whether internal or external. This area of social relationships ties directly into our next section regarding clients' cultural and spiritual aspects.

Multicultural/Spiritual Assessment. Multicultural assessments are critical to have light shed upon for the therapeutic alliance to work well. The importance is to avoid conflicts brought about by varying value systems between the client and the clinician. If I assume the client's cultural background aligns with my own, I may be offensive or simply misread a comment or statement because my worldview may see these areas differently. To illustrate, I had a former teacher and friend (Edwin Jones) who had been a missionary in New Zealand. The word fanny (female genitals) is considered vulgar (if reading this in NZ, I apologize). We may tell a child here in the United States; I will pop your fanny (child's hind-end) if you do not behave. [I used to go to church with an older lady we all lovingly referred to as Aunt Fanny.] A very different meaning between the two continents. I recall him telling the story as being an awkward moment for him in his work. This awkward moment is a simple example of a well-meaning person building an obstacle that would need addressing before moving forward graciously. I cannot possibly know all the differences that will arise culturally; however, being mindful that differences are genuine will undoubtedly help me avoid many potential pitfalls. Ignoring cultural uniqueness could cause the therapeutic alliance to derail or, at best, be delayed.

Spiritual assessments can help identify potential areas of conflict between the value system of the client and me, who has a Christian worldview. It could be a drastic difference, such as the client being non-religious, Buddhist, Catholic, Mormon, Hindu, Islamic, etc. In my specific location, it is more appt to be differences regarding interpretations of the Christian Bible. Suppose I simply read on the intake that the person is a Christian, and I am unaware of what

flavor they align with or the extent to which the client adheres to these principles. In that case, I may say or imply something foreign to them or in total opposition to what they believe. I feel compelled to declare the Bible truth does not change, even if there are so many versions (interpretations) of truth, but the counseling session is typically not the place to push or chase differing views. I feel it is my responsibility to be as aware as possible of varying belief systems and be as respectful as possible of the client's autonomy. We will now look at how these various observations come together to develop into a case conceptualization.

Case Conceptualization Process. My primary modality is SFBT. This theory supports the client in a therapeutic alliance that sees the client as the expert on themselves while I, as the therapist, am the expert at asking great questions. These questions help the client be enlightened to areas such as 1) Their preferred future desires; 2) Discover exceptions from the past when the problem was absent; 3) Discovering strengths from their past that are repeatable in the present and future; 4) Explore how they were able to do the things they are already doing; 5) How to be focused of the good that is occurring right in front of them daily. SFBT is a very fluid process that is in the moment with the client. I, as the counselor, do not take the stance of knowing what is best for my client but instead take the stance of not knowing. This stance allows me to have a curious approach. With good questions, the client will think about and consider options they may not have considered previously. All of this is to say I do not utilize a case conceptualization model (CCM) in my practice regularly. I do not presume to tell my clients what they need. I take the stance in every session that this session may be the last. At the end of a session, I ask if this will be our last time together or if they believe another session would be beneficial.

If I worked somewhere that required a CCM for the file, I believe I would make use of the CCM presented by Donald Meichenbaum at the Melissa Institute Conference in May 2008. This process includes doing an intake interview that, for me, both encompasses aspects of the before-session questionnaire as well as the first session to fill in any areas not made clear or skipped. This time of gathering appropriate information seeks information such as; 1) Why the client has come? 2) Who may have sent them? 3) What is going on that has prompted our session? 4) Are there days that are better for the client than others, etc. I inquire if this thing or things is/are affecting their daily life (e.g., home, work, friendships). Are there things/places/ people that make the issue[s] better or worse? Is this new or lifelong? Is this unique to you, or do you see this occurring in friends around you (environmental) or family members (genetic)? Have you ever considered or gone to treatment for this in the past? Was this helpful then? If so, what parts did you see as beneficial?

Once I understand the client's needs, I would first ask them what area they believe needs our attention. For example, with SFBT, I ask the client about their best hopes for our time together. However, this occurs each session. I would say that Socratic teaching is a good illustration of how I typically go about seeking progress in a session. I also ask the client what their best hopes are from each session and for their future. For example, when a client speaks of depression, I ask them questions such as: What would they like to have in place of depression? What would that look like for you? What would be happening that would let you know that this better thing was becoming a reality? What would your coworkers, friends, family, etc., notice that would allow them to know we are making progress?

The next step Meichenbaum covers, I would never bring up intentionally but would explore it if the client were to bring it up: What problems do you see will hinder your progress? This question helps to open the client's mind to all the things that can go wrong rather than the stance of SFBT to direct the client's focus to what can go right. The final idea is for the client to put the CCM in their own words to take ownership of the plan. Meichenbaum even recommends collaborating with "significant others" to make any adjustments that may be needed. The general idea behind the CCM is to create a smoother process to move from client session to DSM-5 diagnosis if required or appropriate.

DSM-5 Diagnostic Process. The DSM-5 is a tool that can be beneficial in the mental health world. Once again, I do not use diagnosis, generally. I believe people tend to become or live up to labels assigned to them. Human nature seems to promote clinging to a designation as a sentence with no escape (e.g., the Alcoholics Anonymous groups teach those individuals who have suffered the effects of their drinking too much (past or present) are not former alcoholics but are always alcoholics). In my work utilizing SFBT, it is typically not necessary to establish a diagnosis. Instead, I accept the client where they are and ask them where they would rather be. We then work towards unlocking the micro-steps that will incrementally move them in the direction they are desiring. However, when referring clients to other mental health providers or collaborating with supervisors and colleagues, I find a standardized platform, such as the DSM-5, to discuss ideas useful.

When using the DSM-5, I look through it until I arrive at a diagnosis that aligns with the client's symptomology. Many of the diagnoses are broken down into nuance to get as close as possible to the client's symptomology. It is essential to look at the specifics of each diagnosis to

avoid over or under-diagnosis. There are many good diagnostic assessments on the DSM website that are available to assist the clinician in making good diagnoses and help with informed case planning. One real dilemma some practitioners find themselves in is trying to justify a diagnosis to ensure they can get the best payment possible for their services being provided to clients when compensation comes from a third-party payer. The clinician's remuneration tied to diagnosis is where the real temptation comes into play to over-diagnose a client. This idea is sickening to me when a clinician forces clients into a diagnosis that may follow them and cause them to be potentially stigmatized.

Generally, the mental health world has attempted to pigeonhole clients into various diagnoses by using a scientific model of symptomology that determines what "illness" a person has. There are certainly many who indeed suffer from issues that are not environmental and will need more than talk therapy and the more general mood medications. Still, the vast majority who come into the typical counseling offices do not need a diagnosis from the DSM-5. Mental health is more fluid and less rigid than many seem to believe. To describe therapy as art seems like a more appropriate term because of the dynamics, such as the personalities of the various practitioners across the globe and different methodologies of applying various techniques. Practitioners artfully providing modalities and establishing therapeutic alliances are crucial for the client's success. Let us now look at how these ideas flow into a plan of treatment for the client.

Treatment Planning Process. Like the previous sections, I do not use a formal treatment planning process in my practice. SFBT is a method that takes whatever version of the client that comes through the door (both physically or by video) and works from there towards where they

desire to go—Their Preferred Future. In other art forms of therapy (e.g., CBT and many others), the therapist often takes the lead, deciding where they believe the client needs to go and then sets out to point them in that direction through a strategic plan. As mentioned above, I utilize some aspects of CBT and Mindfulness in my practice, but my work with SFBT drives most of my work. I ask questions to pull out from the client where they want to go, but I do not presume to tell them where they are going or how they will get there. I know not all practitioners of other methods take control from their clients. Still, the details behind many modalities lend themselves to the practitioner taking control as the professional.

If I worked in a clinic that required a treatment plan on file, I would take the knowledge gained through the many steps already discussed above and formulate my best assessment of where the client needs to go. To arrive at this assessment, I would 1) Weigh the knowledge gained from the pre-session intake. 2) Weigh the information from our first session. 3) Consider the biopsychosocial information, cultural and religious views, the case conceptualization, and any DSM-5 diagnosis. I would then tell my client how many sessions I believe they needed. I would also develop a plan for what we should do in each session and homework to reinforce the session content. Practitioners who follow a method as just described will perform a service that helps the client move forward to a better version of themselves (assuming they are willing to be flexible and not married to their plan). However, they have done an enormous amount of prep work that often will be in an area different than where the client is focused when arriving at a session. SFBT allows you to be ready for the current version of the client who comes in instead of pushing the client from where they are that day to where you need them to be to follow your

predetermined plan. Along the way, I consider how I know I am making a difference in my clients' lives.

Method of Outcomes Assessment During the Treatment Phase. Using SFBT, I find myself constantly assessing if we are making progress. My assessing is typically an informal weighing of where the client has indicated they wish to go and if we are progressing or have stalled. Much of this assessment occurs by weighing the client's current demeanor and preferred future talk compared to previous sessions. I also pick up on nuances of things we have discussed in sessions that the client has passively mentioned as being applied in their daily lives. I cannot help but have joy in my heart when a principle discovered in session by the client is put into practice and then indicates it has made a positive mark on their world.

Another outcome assessment method I use is scaling questions (and I should use these a lot more). I use scaling questions to get the client's perspective of where we are in the path to success as determined by them. Using this valuable tool helps bring out other areas to explore as well. Say, for example, a person wants to be less nervous in a crowd of people, and I ask: At your child's volleyball game, on a scale of one to ten (one is the least comfortable possible and ten being the most comfortable possible) where do you feel you were? If they say two, many concepts will think, oh no—What have I done wrong?!? With SFBT, this is an opportunity to ask —How did you do that? This question gives ownership to the client that they have done something to be at a two. Promoting the level of two as progress allows for a conversation regarding how they made this achievement. The client then begins to open their eyes to the possibility of this being a strength that can lead to growth. I had a client once where I found myself becoming stuck. By the client's body language, I thought we were going in the wrong

direction, even to the point suicidalities became a thought I feared may be present or developing. So, I stopped and asked—On the scale, where would you say you are right now regarding hope? The client answered a seven (I was expecting a one or even a zero). I had to keep my delight at bay when I asked—And what allows you to be at a seven right now at this moment? The client responded (with a why are you asking me this look), because of life itself. This response opened a discussion to the privilege of being alive, which, as you know, is the opposite of suicide. I continue to be amazed at the many techniques that I can utilize. I continue to learn more each day. When sensing the end of our time together for regular sessions comes about, the question turns to—Now what?

Aftercare/Maintenance Planning Process. I have had several versions of how long a client comes to see me. For example, I have had a client struggling with a relationship with their spouse. The client mainly wanted to bounce some ideas off another human. This person only came for one session, seemed satisfied with our discussion; I asked if another session would be helpful; the client said we covered what was needed. I made it clear he is welcome to schedule another session in the future if a need ever came up. Then, out the door, the client went with a smile.

Some clients seem to think they would never end coming in for sessions regardless of their progress or impact on their finances. I would feel compelled to encourage them to move towards an ending date and may eventually need to terminate if they are unwilling. I would prefer they decide to end counseling on their own (which is likely to happen). However, there comes a time when the client knows what changes they desire to occur and how to make them, but they continue to avoid implementing them into their lives. At some point, it becomes an

ethical question to allow this type of person to continue. When I do believe the end of the client coming in for regular sessions is upon us, I try to be more intentional about reinforcing points of interest and growth that have occurred or discussed to help them leave reminded of their successes. Now that I have discussed the various aspects of working with clients, I will discuss this with a case example.

Case Study

The following is an account of a case with the names changed. The counseling relationship with Fredda (F) (age 55) began with a phone call. F was wondering if I was the counseling guy her mom had spoken to her about recently. F's mom is a regular church-going person (though F is not currently attending) and had heard of me through her church. After a short discussion about the events going on, F made an appointment for the following week. I got her contact information and sent her the intake information. F was prompt to fill out the information and submit it. F had been dealing with depression that was causing her not to want to get up on many days. F has a full-time job that she has had for around 18 years and is nearing retiring. A concern is that she would not make it the remaining year to retire.

F had experienced a stressful childhood. F's dad was abusive, occasionally physically, but mostly verbally. F has her mom and sister (the sister deals with many of the exact issues), and the dad is dead. Many of the current struggles began when F's dad died. F is in her second marriage. F's first marriage had many battles that have compounded the effects the dad had on F. F and her first husband had two boys together, but unfortunately, the ex-husband picked up where F's dad left off. The husband was also occasionally physically abusive but primarily verbally abusive. F was constantly concerned about her sons growing up while observing the terrible way their dad

treated their mom and women in general. F had an affair, and that was the end of the first marriage. To this very day, F feels terrible about the infidelity and continues to think of herself as flawed. About a year before her dad passed away, F met her current husband, who seems to treat F very well. Though being encouraged and loved by F's current husband, F continues to struggle with self-image due to the terrible training she received as a child and young adult about who she is as a person (Stinking Thinking!).

F has many health issues. Many of these issues are potentially self-induced, while others are likely genetic and environmental. F is a Type B Diabetic who also deals with inflammation issues (has been to Rheumatologists who treat her like—Why are you here?). F does not exercise; smokes two packs of cigarettes a day; drinks multiple caffeine drinks a day; has a poor diet. F is considerably overweight for her age and size; has a stressful job at times while being boring at other times; shares custody of her two boys with her ex-husband. F is conflicted about needing to be in church and being torn between not wanting to go and her husband having a different faith tradition. Hence, their beliefs are primarily different (F Bible only where the husband has charismatic views). These differences prevent them from attending church together or enjoying the grace that can be theirs' in Christ together. The various issues about religion contribute to not attending at all, which leads to worry about her sons' who have started to attend churches that are different from what F aligns with doctrinally.

In our first session, some of the various issues F deals with came up in our conversation. I first recommended she go to her regular doctor to get a general checkup (I found out in our second session the blood work all looked good). F was already on a couple of different antidepressants medications that her GP prescribed a long time ago. It was apparent that F was

struggling with some depression issues. F began to share the level and potential causes in subsequent sessions. It became evident that her father and ex-husband had done quite a number on her by treating her like she was less than significant. F tells of times as a child when her dad would unload a bunch of his PTSD Vietnam flashback stories to her that was very rough in content. It was as if in one since he thought she was strong by telling her these things but then saw her as dirty since she knew his dark secrets. F's dad even went so far as to put in his Will that his insurance money would divide among his wife, other daughter, grandkids (including F's kids), but F was to get nothing. F saw this as one final jab from the grave. It is not difficult to see why F has depressive issues, especially when her first husband was also a mean-spirited person like her dad had been.

In the case summary, I mentioned that F's mom and sister are still alive and active in one another's lives. The current husband and kids are all actively engaged with each other in what appears to be healthy ways. F's coworkers are not perfect relationships to her but are active and mostly healthy. F has several valued people in her inner circle and others who are a little further from the center but still valued. F does continue to have some struggles from the spiritual side of things. F desires to be active in church and spiritual matters but finds it difficult to follow through with these desires. I believe this is partially due to her dad being such a disappointment and him being very active in the church (no one at church had any idea what kind of man he was at home). The unbalanced thoughts of what religious beliefs should look like between F's current husband and herself exacerbate F's spiritual dilemmas. From a general cultural standpoint, F's dynamic is similar to mine, with very few apparent differences other than F being female (e.g., Caucasian, grew up in rural Alabama, and attended Churches of Christ).

The description of the issues was close to the symptoms of Mild Recurrent Major Depressive Disorder (296.31) (MDD). Nearly any other mental health provider would have diagnosis F with MDD (F has recently gone to a psychiatrist who has put her on Trintellix, which is for MDD, as I understand the label). I do not see the advantage of telling someone they have MDD. It is bad enough to come into counseling stating they are depressed, but to say 'not just depressed but majorly depressed and it is a disorder' simply does not sound helpful. It sounds harmful from my perspective. Again, to have the common terminology from professional to professional is good, but I hope never to use these words with a client! F does not meet enough of the symptoms for MDD fully as I see it. F does meet depressed mood, partially diminished pleasure in most activities, occasional insomnia, occasional fatigue, feelings of worthlessness, and guilt (five of the eight symptoms listed in the DSM-5 are required where she meets only two solidly). It would be better to diagnose F with Persistent Depressive Disorder (300.4) (PDD). For more days than not over at least two years, F has a depressed mood, low energy, low self-esteem but denies any thoughts of suicide.

The treatment plan would be for F to come in as frequently and as many times as is determined to be effectual by her. I would have estimated approximately ten sessions but would be perfectly happy if F had only done one session or 15 sessions. Each session typically begins the same with the question—What has been better since our last time together (at the first session, after any intake follow-up, I ask what has been better since you made the appointment?)? I had clients who brought the idea of 'what has been better' up themselves in later sessions when I got distracted (e.g., previous session running long), and I failed to ask, What has been better? It was as if their brain had begun to be programmed to consider what had

been better. First efforts are usually a struggle (I do not know, etc.) because of the generally negative training to think a significant part of the population inadvertently receives.

Our time then leads to the question—What are your best hopes for our time together? F may say—I just do not want to be depressed. I would ask F—What would you want in place of the depression? F may say—I would rather have joy. I would ask—What would that look like when joy is present in your life? What could we do that would let you know that joy was closer to being your reality? What could we accomplish to allow the people around you to understand our time together has been productive? What would your family and friends see that would let them know our time has been successful? I may have to ask these questions in multiple ways before the client can grasp the heart of the questions and then produce an answer. Clients typically do not consider these concepts due to being blinded (drowning in) the problem thoughts.

At some point, I ask a version of the miracle question to help build a mental image of their preferred future. Then, to help draw out more thoughts or to get more details, I use what I heard Elliot Connie (EC) mention in his SFBT YouTube series describing how to get more details. EC says to ask simple questions—What Else? Then What? And what would happen next? Tell me more about that? This imagery begins to unlock the client's mind to the possibilities (2019). Once I grasp what the client is seeking, I ask about exceptions from their life where glimpses or even periods of joy have been present. These glimpses help to show them they have been able to do this in the past, which lets them know it is possible and therefore repeatable (Finlayson et al., 2021).

Another thing that I use very often, I also heard from EC. He says to pay attention to when things are going well and then discuss why they are going well. As an example, consider things with a married couple such as F and her husband. EC points out that typically when a person says to their spouse—We have to talk, it is typical to assume it will be an unpleasant encounter. However, EC suggests that we notice when things are going well and then say—We need to talk. This talk discusses what is going well and how do we do more of that (2019). I have encouraged F to consider this concept. On the coattails of that principle, I connect the idea from Dr. Randy Carlson, who teaches about living the 'intentional life' (cite). I use this to reinforce the concepts mentioned by EC about discussing the good things that are happening—BE INTENTIONAL!! These desires take intentionality to implement them into one's everyday reality successfully.

Each session is the same basic concepts repeated until the client decides they are ready for our sessions to end. The whole plan never needs me to know what the problems were in their lives that have occurred (Joubert & Guse, 2021a). I do not avoid the topic of their problems (as described above in the client's case detail) if the client wants to talk about it, but I do find it productive to intentionally not dwell on the problem talk. I often use the statement we cannot change our past but can affect what is happening right now and into our future. I often remind my clients (like F) that we are doing good to control ourselves, so we certainly cannot control other people's actions.

Many of my clients are Christians, so I sometimes take the opportunity to share about Paul from the New Testament of the Bible. Paul was persecuted, shipwrecked, put in prison, etc., yet pushed forward to be able to make a statement like "I have competed well; I have finished

the race; I have kept the faith! Finally, the crown of righteousness is reserved for me. The Lord, the righteous Judge, will award it to me in that day - and not to me only, but also to all who have set their affection on his appearing." (2 Timothy 4:7 NET). Paul also made some of the most egregious errors of judgment against the Church yet found himself literally in the light of God (Acts 9 NET). Reminding them that Paul had many struggles in life, yet through continually being intentional about following the teachings from God, he was able to overcome them.

Further, I remind them that sometimes we have made Bible characters out as some type of superheroes with superhuman strength. However, Paul (as were most of the individuals discussed in the Bible) was a simple man (just as we are), and if he can overcome the many trials and temptations of life, they can as well. When a client does decide to discontinue sessions, I encourage them to continue the hard work of progressing towards their desired future and that my door is always open if they feel a session in the future would be helpful.

Conclusion

I hope it has been clear that the SFBT modality of assisting clients in arriving at their preferred future selves is a productive way of helping the clients succeed on their terms. SFBT is a modality receiving an increase in empirical data. Increases in empirical data continue to improve SFBT's effectiveness to become a more accepted method and modality. These improvements continue to help counselors use SFBT with great confidence. I would like to convince the entire mental health world to make SFBT their modality for effectively assisting their clients in growing and developing. SFBT is a valuable tool for helping point clients towards the future they long for but are typically unable to unlock these destinations desired due to problem-focused thoughts. I recommend all mental health services practitioners to look further

into SFBT as a tool that will help achieve the goal of helping clients. I also encourage those who have the talents to perform research to continue testing and improving upon the efficacy of SFBT.

References

Anclair, M., Lappalainen, R., Muotka, J., & Hiltunen, A. J. (2018). Cognitive Behavioural Therapy and Mindfulness for stress and burnout: A waiting list controlled pilot study comparing treatments for parents of children with chronic conditions. *Scandinavian Journal of Caring Sciences, 32*(1), 389-396. https://doi.org/10.1111/scs.12473

Braunstein, K., & Grant, A. M. (2016). Approaching solutions or avoiding problems? the differential effects of approach and avoidance goals with solution-focused and problem-focused coaching questions. *Coaching : An International Journal of Theory, Research & Practice, 9*(2), 93-109. https://doi.org/10.1080/17521882.2016.1186705

Burns, A., Dannecker, E., & Austin, M. J. (2019). Revisiting the biological perspective in the use of biopsychosocial assessments in social work. *Journal of Human Behavior in the Social Environment, 29*(2), 177-194. https://doi.org/10.1080/10911359.2018.1500505

Carlson, R. Intentional Living (Radio). https://theintentionallife.com

De Shazer, S., & Berg, I. K. (1997). 'What works?' remarks on research aspects of Solution-Focused brief therapy. *Journal of Family Therapy, 19*(2), 121- 124. https://doi.org/10.1111/1467-6427.00043

Hofmann, S. G. (2021). The future of Cognitive Behavioral Therapy. *Cognitive Therapy and Research, 45*(3), 383-384. https://doi.org/10.1007/s10608-021-10232-6

Hofmann, S. G., Asmundson, G. J. G., & Beck, A. T. (2013). The science of Cognitive Therapy: Theories and directions in Behavior Therapy: ACT and contemporary CBT. *Behavior Therapy, 44*(2), 199-212.

Connie, E. (2019, January 17). 100 SFBT Questions Explained [Video]. *YouTube.* https://www.youtube.com/watch?v=4AwueRS4RWM&t=4209s

Finlayson, B. T., Jones, E., & Pickens, J. C. (2021). Solution focused brief therapy telemental health suicide intervention. *Contemporary Family Therapy,* 1-12. https://doi.org/10.1007/s10591-021-09599-1

Franklin, C., Zhang, A., Froerer, A., & Johnson, S. (2017). Solution Focused Brief Therapy: A systematic review and meta-summary of process research. *Journal of Marital and Family Therapy, 43*(1), 16-30. https://doi.org/10.1111/jmft.12193

Froerer, A. S., & Connie, E. E. (2016). Solution-building, the foundation of Solution-Focused Brief Therapy: A qualitative delphi study. *Journal of Family Psychotherapy, 27*(1), 20-34. https://doi.org/10.1080/08975353.2016.1136545

Jones, E. R., Lauricella, D., D'Aniello, C., Smith, M., & Romney, J. (2021). Integrating Internal Family Systems and Solutions Focused Brief Therapy to treat survivors of sexual trauma. *Contemporary Family Therapy,* https://doi.org/10.1007/s10591-021-09571-z

Joubert, J., & Guse, T. (2021a). A solution-focused brief therapy (SFBT) intervention model to facilitate hope and subjective well-being among trauma survivors. *Journal of Contemporary Psychotherapy, 51*(4), 303-310. https://doi.org/10.1007/s10879-021-09511-w

Joubert, J., & Guse, T. (2021b). Implementing Solution-Focused Brief Therapy to facilitate hope and subjective well-being among South African trauma survivors: A case study. *Counseling and Psychotherapy Research,* https://doi.org/10.1002/capr.12416

Kazantzis, N., Luong, H. K., Usatoff, A. S., Impala, T., Yew, R. Y., & Hofmann, S. G. (2018). The processes of Cognitive Behavioral Therapy: A review of meta-analyses. *Cognitive Therapy and Research, 42*(4), 349-357. https://doi.org/10.1007/s10608-018-9920-y

Meichenbaum, D. (2009). Psych-Cultural Assessment and Interventions: The Need For A Case Conceptualization Model. From:

https://www.melissainstitute.org/documents/13AConferenceMay2009.pdf

Neipp, M., Beyebach, M., Sanchez-Prada, A., & Delgado Álvarez, María del Carmen. (2021). Solution-Focused versus Problem-Focused questions: Differential effects of miracles, exceptions, and scales. *Journal of Family Therapy,*

https://doi.org/10.1111/1467-6427.12345

Whitfield, H. J. (2006). Towards case-specific applications of Mindfulness-based Cognitive-Behavioural Therapies: A Mindfulness-based rational emotive Behaviour Therapy. *Counselling Psychology Quarterly, 19*(2), 205-217. https://doi.org/10.1080/09515070600919536

Appendix I

Case Conceptualization of the Case Presented in the Case Study

Fredda (F) is a 55-year-old Caucasian female client who has a past of being traumatized by the men in her life. F's dad was both verbally and occasionally physically abusive to her, and F's first husband picked right up where the dad left off. F ultimately cheated on her first husband, which ended in divorce. F has two boys from her first husband, ages 15 and 19. F remarried about seven years ago to a man who holds her in high regard. Things seemed to be going well until F's dad died, which seemed to open old wounds by the dad's final jab by including his wife, other daughter, grandchildren (including F's children) but intentionally writing F out of the Will. F sees this as her dad got the last laugh from the grave. F shares many terrible things the dad did over the years. One such event is he would unload his traumatic stories on her regarding his service during Vietnam. On the one hand, it seemed as though he felt she was strong and able to handle it but then seemed to turn on her for knowing his dark secrets. On the other hand, F's poor training led her to think negative thoughts about herself even though plenty of evidence exists to demonstrate F's competence and value as a human being.

F's flawed thought process regarding herself for most of her life has led to F coming in with depression as her primary concern. F's depression is beginning to affect her daily activities. F struggles to get up some days. It has taken many years of training to think the way she does currently. It may take some time to adjust her pattern of negative thoughts to self-acceptance and joy, especially when F struggles to get up and go more so recently. Whether F is at work, on vacation, or attending a child's event, she feels even worse when she does not manage to get up and go. Depression can be (is) a cyclical problem! F has managed to keep the same job for 18 ½ years successfully. F has been a mom, and evidence points towards her being a good mom. F has functioned as a productive citizen even though the training she experienced taught her she is nothing according to the men in her earlier life. F enjoys spending time with family. Spending time with family (especially her husband and kids) is what brings joy to her life. If F can manage to get going each day, she ends up doing okay, but the struggle is primarily the getting going.

There are no known mental health comorbidities present with F. However, F does experience some medical and environmental issues. F is diabetic, deals with some inflammation issues, is overweight, drinks multiple caffeine beverages daily, smokes two packs of cigarettes each day, does not exercise, eats an unbalanced diet, etc. The idea is nearly everything F can be doing, short of drugs and alcohol, to mistreat her body is occurring. F is on a couple of different antidepressants and other medications. F seems to have bought into the idea that you can take a pill to cure problems, even when self-destructive modes of daily operations partially cause the issues. F has been to a Rheumatologist who treated her like—Why are you here? This reaction has made some issues even worse because the doctor's response makes F feel dumb. F has recently started seeing a psychiatrist who added Trintellix to the medications F is taking.

F has a variety of stressors that range from negative memories of the past with her dad, similar memories with her ex-husband, and stresses with work. F has some recurring thoughts about the should have, could have, would have. F second-guesses many of the things that occurred in her past (e.g., raising her sons). F's current environment is the best she has ever experienced, but she is constantly concerned her current husband is cheating. He has had an indiscretion with another lady of a physical nature (about five years ago) and another lady that was more of an emotional connection that he hid from F (about six months ago). The indiscretions cause F to occasionally look at phone records for recurring phone numbers and ask her husband for reassurance he is being faithful. There do not appear to be any developmental setbacks that F struggles with currently.

F has been to counselors in the past for the same issues she is coming to me for presently. F reports things being better for a while but has been off since her dad died around five years ago. F is currently seeing a psychiatrist, her GP, and me. F is regular to our sessions and seeing the psychiatrist and her GP. However, F has taken some of the thoughts regarding spending time with family to heart and put them into practice but has made no strides to change even one self-destructive habit. F does seem very satisfied with our sessions together. F has made some small strides towards improvement.

F has many evident strengths. F has a positive history with: her work, sons, survived an unkind father, survived an unkind ex-husband, has a boss that displays contempt for F. The irony is F (friends with the current boss long before they ever worked together) was instrumental in her current boss getting a job with F's employer in the first place. F's employer passed over F with the big promotion (the promotion F had worked her whole career to achieve) and gave it to the

current boss instead (F's friend). Even though F has many struggles, she still manages on most occasions to do the things she needs to do to help keep things going, whether at work or home. Many people care about F, including her mom, sister, husband, and sons. F is an essential part of where she works and in her family life. If F ceased either dynamic, there would certainly be a void in her life.

F continues the 'stinking thinking' that has plagued her for much of her life. If F continues not to implement the principles of SFBT, CBT, and MF, F will continue to suffer.

SFBT—Thinking of where she wants to be and working towards those goals.

CBT—Reframing her struggles from her past to see the strengths she has because of them, etc.

MF— Live in the present moments rather than continually being drowned by the terrible things of the past.

Thankfully, F has family support that loves and cares about F, hopefully giving F the strength to be propelled forward towards her preferred future.

As F and I work together, she will have small victories along the way that will awaken her inner strengths to eventually equip F to balance the scales of self-defeat with the power of self-motivation to succeed. As F becomes more accustomed to moving towards her preferred goal rather than being drug back to her past, F will slowly become more consistent as living the life she chooses. Ultimately, I hope to assist F to be self-sustaining by learning to think towards where she desires to be and then moving towards that goal. F continues to come to sessions and has even had her husband attend one session with her. He was very encouraging and attempted to lift her to the person he sees in her that she is still struggling to see in herself.

The only apparent barrier present with F from an individual aspect is continuing to dwell on the past. F and I will need to develop her thought pattern to shift from the past to living in the present and prepare for her desired future. The only real obstacle is continually dealing with her ex-husband because of shared custody with her sons from a social perspective. There are some issues regarding coworkers, but F seems to be coping with the work issues. F has some struggles from her desire to be more spiritually minded but has difficulty implementing these desires. Overall, the outlook for F is good, but I will need to work very hard to ask great questions to help F progress the journey on the road to her preferred future.

Appendix II

Evidence-Based Treatment Plan of the case presented in the Case Study

Problem or Concern	Measurable Treatment Goal	Treatment Interventions (Be Specific)	Expected Number of Sessions Devoted to Reaching This Goal	Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal	Aftercare Plan/ Follow-Up (Means of maintaining treatment gains) (Include titration of treatment dosage)
Depression					

F will learn to lessen the level of negative self-talk	F will learn positive vocabulary for healthier self-talk	Positive Self-talk training, introduce positive self-talk vocabulary	One session focus and throughout our work together	F will be able to repeat back some of the vocabulary words at her next session	At the end of the final session, encourage F to continue the pattern of positive self-talk
F will learn how to decrease the number of negative thoughts of her past	F will learn to be aware of the existence of pleasant events, consider what has been better, and to discuss this with self	Questions such as: What has been better training	Every session we have together	The presence of 'what has been better talk' in conversation	At the end of the final session, encourage F to continue the pattern of being aware of pleasant events
F will learn to consider what she desires to happen, her preferred future rather than dwelling on what she does not want to occur	F will learn to think about her future and what she prefers to take place and take steps towards it	Tools such as the miracle question	Every session we have together	The presence of talking of future desires in her sessions	At the end of the final session, encourage F to continue the pattern of looking forward
F will learn to use scaling for herself to measure current awareness rather than existing like a ship without a rudder	F will learn to think of various aspects of life with scaling to assist in mental astuteness	The use of scaling questions in session to demonstrate the functionality	Every session we have together	Pay attention to the comfort of responses to scaling questions in her sessions	At the end of the final session, encourage F to continue the pattern of scaling different thoughts
F will learn to think of successes in her life, even when things were not pleasant, as opposed to not seeing the forest for the	F will learn to think on past events considering successes rather than the rut of only acknowledging the negative	The use of when has this desire been present in your past questions	Every session we have together	Noticing the fluency of the client's ability to consider past events in seeking exceptions	At the end of the final session, encourage F to continue the pattern of considering preferred occurrences from her past

F will learn to think about her resources (e.g., family, friends) rather than feeling stranded on an island	F will learn to consider the reality of the blessings that surround her	Questions such as: Who would notice there has been a change? Who could you ask to help with X?	Every session we have together	I will be noticing F's ability to recognize the people who are there for her daily.	At the end of the final session, encourage F to continue the pattern of loving and accepting love from family and friends
F will learn to continually weigh situations from a best hopes perspective rather than just letting life	F will learn to. Avoid catastrophizing but instead, think of her best hopes for each scenario	Each session will begin with: What are your best hopes for our time together?	Every session we have together	I will pay close attention to the ease at which F can describe her best hopes in each session	At the end of the final session, encourage F to continue the pattern of considering her best hopes

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I very much appreciate the extensive amount of time you put into developing your capstone project. Overall, I found your paper thoughtful, transparent, and, as I stated earlier, engaging!

I've given you important pointers for the QE that I hope you carefully review and keep in mind. Additionally, keep working on developing the genre of scholarly writing by reading the literature and applying what you learn in your future writing.

May you have much success on the QE and throughout the program Jeremy! Onward and Upward!