Pre Intensive—Reflective Paper

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I have no known conflict of interest to disclose.

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Abstract

This paper is about the modalities utilized in my work as a mental health counselor. It is primarily focused on Solution Focused Brief Therapy (SFBT) and its wide range of effective treatment areas. There are a few brief thoughts about Cognitive Behavioral Therapy as well. I will describe the flexibility of SFBT, and it's holding the client up as being the expert on themselves and the therapist being the expert at asking questions (Roeden et al., 2014), to promote growth, thoughts, and more specifically, help the client open the door to their preferred future. I will discuss some of the tools used in SFBT to spur the client towards living their preferred future and see tools to assist the SFBT clinician in checking for confirmation that the sessions are indeed considered successful in the client's eyes. SFBT will be discussed as a strengths-based modality that does not ignore the problem but seeks to implement what the client would desire to be in the place of the problem.

Keywords: Solution Focused Brief Therapy (SFBT), preferred future, strength-based, miracle question, best hopes, been better

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What counseling theories do you draw from in your counseling, and why?

As I have begun my work as a counselor, I have integrated multiple ideas from various theories along the way. However, I have primarily leaned on two theories (i.e., Solution Focused Brief Therapy (SFBT) and Cognitive Behavioral Counseling (CBT)), with SFBT being my primary theoretical orientation. Interestingly, Bannink (2007) indicates that SFBT is a type of CBT, although others would adamantly deny this perspective. SFBT is demonstrated by Gingrich & Eisengart (2000) to be beneficial to multiple populations groups. They reviewed research that demonstrated the efficacy of SFBT with: anger (showed a drop from 67% to 40% in the clinical range using the State-Trait Anger Inventory) (Schorr 1997, as cited in Gingrich and Eisengart, 2000), depression (In a comparison to Interpersonal Psychotherapy for Depression) (Sundstrom 1993, as cited in Gingrich and Eisengart, 2000), parenting skills (Zimmerman, Jacobsen, MacIntyre, and Watson 1996, as cited in Gingrich and Eisengart, 2000), rehabilitation of orthopedic patients (by day 7, 68% of the SFBT group had returned to work as compared to 4% of the control group with the numbers at 30 days being 92% SFBT and 47% control) (Cockburn, Thomas, & Cockburn 1997, as cited in Gingrich and Eisengart, 2000), recidivism in prison population (at 12 months the SFBT group had a reciticism rate of 53% compared to 76% in the control and at 16 months 60% SFBT compared to 86% in the control) (Lindforss & Magnusson 1997, as cited in Gingrich and Eisengart, 2000), antisocial adolescent behaviors(20% in the SFBT and 42% in the control group became re-offenders) (Segman 1997, as cited in Gingrich

and Eisengart, 2000). There were five studies Gingrich & Eisengart (2000) deemed to be controlled. They also discussed another four moderately controlled studies showing the use of SFBT validity for counseling high school students, school-aged students, children in a high-risk residential facility, and couples therapy. In what was deemed studies with poor control groups but still valid, they found good evidence for using SFBT with problem drinking, families having a member with schizophrenia, families with parent-adolescent conflict, and other areas. Gingrich & Eisengart (2000) & Bond et al., (2013) said they believed more work is needed but found adequate evidence that SBFT may benefit clients. Gingrich and Peterson (2013) indicate SFBT has strong evidence of being effective with a wide range of issues and having the benefit of being a much briefer intervention. Hsu et al., (2021) display SFBT as a valid modality for use with child behavior problems but encourages further research to strengthen this position. Further, Gingrich and Peterson (2013) indicate that SFBT has become widely accepted due to its strength-based process and the brevity of the sessions needed for successful outcomes. The brevity allows for the cost of therapy to be less, along with the client's benefit from treatment more quickly from SFBT. The client can move on with a better life sooner than traditional modalities. Kim et al., (2016) call SFBT a strengths-based modality that is effective with substance abuse and trauma clients. Franklin et al., (2015) state that upon reviewing the available information on SFBT, it is clear that social workers can utilize SFBT with confidence. Roeden et al., (2014) let us know that their work shows SFBT as a valuable therapy tool.

Describe the procedures you use for the following phases of counseling.

Biological Assessment

When someone comes to me and begins to describe various issues that can, undoubtedly, be affected by their biological processes, I recommend they get with their medical doctor to see about getting a check-up. The doctor can then order the appropriate blood work if deemed necessary. Often clients are doing almost everything they can be doing wrong to their bodies without having malicious intent (e.g., smoking, drinking alcoholic beverages, multiple caffeinated drinks a day, not exercising). I encourage clients to take care of the issues they have control over to see if these changes help facilitate the desired change[s] before taking more drastic measures (i.e., medications).

Psychological Assessment

From a psychological perspective and biological causes have been ruled out, I would first look and listen for signs of distress beyond what I believe could be remedied by talk therapy alone. If the client's issues are beyond talk therapy alone, or medication could help move the healing process more smoothly—I may suggest a client see if their doctor would be willing to prescribe a mild drug to help with their issues (e.g., depression, anxiety). When difficulties are more severe, I may suggest they seek the services of a psychiatrist to assist them with balancing their body's chemical imbalance that seems to be occurring.

What seems to be more common is the client comes in with plenty of medications expecting them to work as an Aspirin would for a headache (pop in the pill, and the issue goes away). I typically have conversations with these types of clients about who prescribed these medications and why. Generally, the primary care doctor has done this to assist the client, the best way possible, without them taking action (e.g., exercise, eating correctly). When clients think all they need to do is take a pill and be better, it leads to a conversation about talking to

their doctor about the potential of lessening their dosage, hopefully leading to being weaned from the medications. For example, I had a client come in who decided to start seeing a psychiatrist between our sessions (a client with mild anxiety). The psychiatrist prescribed the client Prozac when he was already on Xanax. When we had our next session, the client had been on Prozac for three days and described how much better he felt from it. I explained that I am not a medical doctor, but my understanding of the medication is it takes much longer to work than three days. I shared that this is likely a great example of his mind believing it was helping, and therefore he felt better. I encouraged him to take credit for the improvement rather than giving credit to the medication. Weighing the pros and cons of the use of medications can be a bit complicated, especially when working with clients who have had substance abuse issues and having to depend on other providers who are qualified to prescribe medication to clients.

Social Assessment

From a social perspective, the client's desire for relationships is weighed in deciding if an issue needs to be addressed. Clients struggling with making social connections are encouraged to consider ways to increase the pool of potential interactions with other humans (e.g., gym membership, church attendance, social clubs, volunteer organizations). When it seems appropriate for clients to go straight to making these connections, opening doors to potential social events may be all that is needed. However, when a client has some deeper issues with being around others, it may take some time to slowly open their intellect back open to the possibilities of these interactions. Some people may simply be content with a small social network that may even be limited to family members.

Spiritual Assessment

In direct connection with the social assessment, I would typically also consider the client's spiritual outlook. Focusing on the spiritual is due to the social interactions that are a natural part of being connected with most spiritual circles. Bannink (2007) and Roeden et al., (2014) point out that in SFBT, the client is the expert on themselves and is encouraged to think about successes from the past, present, and the future. They are invited to create what Bannink refers to as positive 'self-fulfilling prophecies'. A large portion of the clients I have had, come to me through churches. When clients come to me from a spiritually charged source (as churches hopefully are), this allows me the ability to help that client to think about why they are affiliated with that group (past successes) and what effects it should have on them, and they on the church (present and future achievements). The discussion opens the door to Biblical ideas to help clients consider how to be the best version of themselves each day. We can then think about what it has looked like, does look like, and will look like, to live a life in alignment with the Godly principles they claim allegiance to and have a personal desire to mirror those principles in their lives. As Bannink pointed out, I walk with the client in session to help them create a 'self-fulfilling prophecy' by assisting them with getting on track with the Godly principles found in God's Word…when Godly principles are those ideals for which the client aspires to live.

Clinical Interview Process

The interview process is simply one that encompasses a series of questions to provoke thought from the client: What has been better since making the appointment?; What are your best hopes from our time together?; What would you like to be happening in place of the described problem?; What would we do that would let you know our time together was good?; What would your friends/coworkers/family/etc. notice that would allow them to understand our time together

was beneficial? I would then use questions to pull out the client's preferred future using tools such as the Miracle Question (a tool to help the client imagine what would be better when the desired future is their reality). Also, by asking about times in their life when the 'better' they want has occurred (Cepeda & Davenport, 2006). Helping the client see successes, and the possibility of repeating those preferred experiences gets the client's mind open to options.

Determining an accurate DSM-5 diagnosis

In SFBT, there is, typically, no need to push a client into a diagnosis. Currently, I do not take insurance. My present thoughts say that I would need to have a book-supported diagnosis if I took insurance and needed the diagnosis to satisfy the payer. When you place a label on a person, you may have implanted the idea that they cannot help what is happening (an illness) or have given them an excuse not to work towards the better life that can be achieved by many (if not most) people coming to therapy. There is a time and place for diagnosis, but it does not seem beneficial for most clients. SFBT is more flexible and can help people in many areas of both difficulty and times of simply desiring to strengthen one's life.

There are times when being aware of the criterion found in the DSM-5 are valuable to know. Such an example would be when the practitioner (operating from the SFBT modality) is getting out of their areas of potential effectiveness. The clinician would need to recommend a skilled practitioner in dealing with some diagnosis (e.g., schizophrenia or other issues that cause hallucinations) that are likely beyond being resolved by talk therapy alone. Getting expert help is not to say SFBT cannot help these examples, but it is to say that teaming up with a good psychiatrist would be a wise plan at times. Further, it is necessary to be aware of and know how to use the DSM-5 when being engaged in research. In almost every research study, the common

terminology found in the DSM-5 is helpful to identify issues in a manner that is well defined, so everyone involved is calling an apple an apple rather than varying interpretations.

Formulating an accurate case conceptualization

SFBT does not have a complex set of guidelines for case conceptualization. In SFBT, case conceptualization could be described as quite fluid. It is displayed in Franklin et al., (2015) work that SFBT is a strengths-based tool that collaborates between the client and the practitioner to arrive at the solution or goal of the client. In SFBT, the client is the best possible source of what is valuable and will work for the client. In SFBT, it is not a case of the therapist deciding what outcomes need to be addressed by the client, but rather a co-construction of how this desired future will look. They then begin to formulate together ways for the client to arrive at that desired destination.

Collaborating with clients to develop evidence and best practice-based treatment plan

Bannink (2007) discusses a great analogy from Aristotle regarding an archer. If the archer knows the target, he is far more likely to hit the target. Bannink goes on to say that with clients, we should aim for the target rather than multiple targets. Knowing the target is to refine the focus and then see the means of achieving the goal. With SFBT, the whole concept boils down to the therapist asking good questions that help the client specify where he seeks to be and then paint a picture of how this could reasonably become his reality. Bannink says the point is to change the coded information in the client's mind to progress to the destination they desire. The client cannot simply dump the old way of thinking but must be helped to learn a new path to proceed on into the future. One of the most well-known tools in the SFBT tool bag is what is known as

the miracle question. This question is used to help prompt the client towards acquiring the preferred future rather than continuing in the problem-focused (current state of mind) that many have when deciding to come to therapy.

Structure and phases of treatment

In SFBT, you have various indicators that can arise that lead to the next question. First, you have the making of the appointment. Making the appointment is an essential step because it is the client deciding to take steps towards change. Then at the first session, the therapist may begin by asking what has been better since making the appointment or before the session (Roeden et al., 2014). From there, the client may be asked what their best hopes are for the session. Typically the client will begin problem talk (e.g., stop being depressed), to which the counselor may respond, What would you rather experience in its place? The counselor then uses various tools (questions) to help the client begin to paint the future they desire and bring out glimmers of when this preferred future has been demonstrated previously in the clients' life. SFBT works to disrupt problem thinking patterns (Havens (2003, as quoted by Bond et al., 2013). The SFBT process is repeated until you get the right combination of questions that sparks the idea that the client's desired future can become the client's actual reality. Moving towards the preferred future is done incrementally through describing what it would be like when the preferred future is reality, which in essence opens up the path to this being, at least, possible to obtain.

Conducting outcomes assessment

In SFBT, an outcome assessment is a constantly evolving idea. As the client and therapist work together to seek the client's preferred future, the practitioner may use questions like, What

has worked in the past?; When has the problem not been present?; What would your friend notice that would indicate things are better?; etc. The path typically becomes more defined but can change, to a certain degree, based on how the client is navigating the task they undertake daily. For example, the client may come into counseling thinking they want a promotion at work, but then (once they get on the moving forward train) find that changing jobs may provide a better footing for where they desire to be in their life. You can check the success periodically with scaling questions to put a numerical value to a feeling or path to know if this is indeed having a positive effect or if the collaboration needs to adjust to a different approach or goal orientation (Roeden et al., (2014); Cepeda & Davenport (2006)).

Aftercare planning

I try to help clients develop relationships that will outlast my time with the client in my practice. Fortunately, many of my clients come to me through churches. Being part of a community allows for a wide range of people the client already has an association with that can be there to fill the need for relationships. Relationships are indeed key to both having someone who will be there for you, but also someone for whom you can be there for when the need arises (a primary function of the Church as God has indeed so marvelously designed her—1 John 4:7-21). Clients who are not church-going people are encouraged to attempt to put themselves in places where healthy relationships can form (e.g., gyms, clubs, hobbies). Humans are relational beings and indeed need others in our lives who desire a relationship with us as well. Roeden et al., (2014) point us to the use of what he calls consolidation questions. At the end of therapy, these questions help the client become more focused on continuing the progress that has happened through counseling. The essence is to help the client to achieve a trajectory for success.

One space only

Describe in detail what you consider important to include in a case conceptualization and why.

As stated above, SFBT does not have an absolute standard for case conceptualization. However, when developing a case conceptualization, it is imperative that you, as the practitioner and the client, work as a team to build upon the desired outcome/future of the client (Froerer & Connie, 2016). Roeden et al., (2014) help us consider the idea that the client is the expert on themselves while the therapist is the expert on asking questions. The idea is that the therapist leads from ‘one step behind,' helping the client explore their reality and then consider successes and the path/direction they desire to go towards (Cepeda & Davenport (2006). Roeden et al., (2014) help us see the idea of developing smaller goals rather than larger goals. Goal development is achieved through the process of asking questions and thinking exercises such as the miracle question. When the client is speaking about the miracle occurrence (description of what life looks like when the preferred future is present), the therapist would ask; What else? or Then what? type questions to help the client continue with the description. Another part of the plan is to help the client discuss strengths they have. It would be typical for a therapist to ask, How did you do that? Questions like this are to help the client consider what they did to affect the outcome being discussed and what they could accomplish when applying this skill to other areas of their lives. People often fail to consider the value of their efforts, assuming that a thing just happened. In the case formulation, the therapist would consider ways to help the client

realize that their actions are indeed productive in various areas of their lives and that those skills could indeed be a force for positive progress if used, purposefully, elsewhere in their lives.

What is your understanding of the importance of knowing and applying evidence-based/ best practices in counseling?

It is critical to use evidence-based modalities to assure that you are giving your clients the best help possible. Research provides evidence that various theories are valid or need to be refined. SFBT is indeed a reasonably new approach in the field of counseling. It has undergone a variety of studies but needs further analysis to improve upon its already growing area of validity. Hsu et al., (2021) (who included studies from January 1, 1990 —February 21, 2019) shared a total of twenty studies that met their criteria. They found that SFBT outperformed other modalities with externalized issues but found little statistical significance for SFBT over other modalities on internal matters. They stated that this finding was not a negative towards SFBT due to the validity of the comparison modality. Their study found that SFBT is better with some issues and similar on other issues when compared to other well-established modalities. Their study found SFBT to be a valid/evidence-based tool to assist clients.

What evidence-based practices would you use to counsel a 9-year old suffering with OCD?

You can see a very well-designed chart in the Appendix that demonstrates a recommended path to treat Obsessive-Compulsive Disorder (OCD). Dailey et al., (2014) bring to light the clear idea that counselors need to be sure to single out OCD from other potential causes of the disruption, such as medical causes, medications or other substances, or other disorders altogether. An interesting specifier pointed out for OCD versus other psychotic disorders is that, with OCD, the person will recognize the compulsions or phobias as being ‘unreasonable.'

When it comes to the treatment of OCD, Koran et al., (2007), Rosa (2008, as cited in Fenske & Petersen 2015), & The Canadian Psychiatric Association (2006, as cited in Fenske & Petersen 2015) mention CBT as being the therapy based tool that is recommended to help those dealing with OCD (i.e., exposure and response therapy). However, Koran et al., (2007) point out that the use of SSRI medication is generally needed to treat OCD effectively. On the chart, you can see two paths laid out. One is through therapy (CBT), and the other is with SSRIs (that can be associated with CBT but not a must). Koran et al., (2007) say that when dealing with someone with OCD who has depression as a significant part of the issues being dealt with, CBT, interpersonal therapy, or short-term psychodynamic therapy for depression should be placed as the highest priority.

Though there does not seem to be any research presently with SFBT being used to treat OCD, Hall et al., (2020), in a discussion of cystic fibrosis (CF), state that SFBT is versatile, indicating it could be helpful in many areas. Hall et al., (2020) say that SFBT with CF clients helps to increase effective coping strategies, builds resiliency, and strengthens the relationship. It would be reasonable to expect a similar benefit from those dealing with OCD. SFBT could help the client envision times when the problem had not been present and then digest the differences that were present that made those times better. Hall et al., (2020) work with CF shared a therapeutic intervention with a family whose child had CF and felt as though he was treated like CF rather than a person/son/brother. They were able to bring out a time when the problem was not present and then help the parents see the young man's desires through this example, which helped to solidify what was needed by their son. This example could be a benefit of the use of SFBT with OCD clients.

What evidence-based practices would you use to counsel an adult with moderate levels of depression?

As has been stated through this writing, my primary go-to is SFBT. It is a strengths-based approach that helps clients dealing with many issues (in this case, depression) to consider what they would prefer in place of their depression. SFBT helps the client build on what they would desire their future to look like and then build upon that desire by looking into how living in the preferred manner would look. Providing these glimpses into that preferred future allows the client to see the possibilities. Then those possibilities begin to become their reality, little by little, as the client progresses forward (what Froerer & Connie (2016) call solution building).

My secondary go-to is Cognitive Behavioral Therapy (CBT). CBT helps the client begin to think about the way they are thinking about issues, how that thinking leads to the way they feel, and then on to the way they act—in this case, depression. This process will allow the client to begin to think more purposefully about their thoughts regarding various areas of life and the potential for the way they choose to think about these to affect them profoundly. For example, I typically use a scenario regarding being cut off in traffic. If you think the person is a jerk with malicious intent, you become angry, and they may seek restitution in a less than desirable means. However, I tell my clients about a time I was driving, and a giant spider proceeded to crawl up my leg (in the dark) while I was wearing shorts. This example is given to help the client see there could be an alternative cause (other than the jerk who does not care that you were there). This alternative idea allows you to give the driver the benefit of the doubt. This process begins to enable the client to see how small choices can have huge effects.

What methods do you use for evaluating counseling effectiveness during the treatment process?

In SFBT, scaling questions are used to check the progress that is happening. The therapist will use a scale from 0-10 (0 being the worst ever and 10 being the best). Throughout the relationship, the counselor will use these questions to scale where the client is currently. For example, Bannink (2007) tells the story of a teacher having issues at school and struggling to return to work. At his first session, he was at a 1. At his second session two weeks later, the client was at a 4. An ongoing demonstration of improvement lets the therapist know whether they are on the right track or need to divert in another direction. In SFBT, the therapist would be apt to compliment the client on such swift progress. The therapist would then ask what it would take to get to a 5. If perceiving 1 point is too much, the therapist may ask what it would take to achieve a 4.5. The use of scaling allows the therapist to stay aware of the effectiveness of the treatment process.

What do you do if the treatment plan you developed is ineffective at addressing your client's presenting problems?

SFBT is a very fluid approach that allows the clinician and the client to work together, continually, to seek a path that will direct the client toward their preferred future. If there appears to be a hindrance to progress, the clinician should consider various ways to ask the thought-provoking questions that help open the client's mind to the possibilities that await them. Kayrouz, R., & Hansen, S. (2020) point out that with specific cultural groups, the idea of the Miracle Question (MQ) may not align with their group's vision of how the world works. Therefore, it may be necessary to ask the MQ in another manner. For example, they suggest a

Bounce Back question or wording that promotes the connection with the earth (Native American), their ancestors or elders (Chinese), etc.

Further, Kayrouz, R., & Hansen, S. (2020) noted phrases found in various research to help the clinician to align with that of the client (e.g., "wise self," "magic wand," "click my fingers," "harmony with people and things," "at your best," "fresh start," "on track," "preferred future," "wish for life," "dream," "something big is possible," "concerns no longer being present," and "the problem is solved"). There are many ways that the essence of the MQ can be achieved with consideration by the therapist. The therapist continues to work with the clients and ask questions that will help the sessions get to where they need to be effective at addressing the client's concerns and pointing them towards their preferred future.

How do you prepare counselees to maintain gains made in counseling post-termination?

Throughout the time I can spend with clients, I do my best to help them see the strengths they have, use every day, but are generally unaware that these are personal strengths. They assume everyone can do that thing, or they were simply born with that ability. Ill-mannered people have trained some to think about themselves derogatorily (negative self-talk). The idea with SFBT is to help the client become aware of just how amazing they are and proceed into life with that mindset. With SFBT, it is about assisting the client in opening their mind to the possibilities of what can be and then moving towards that end once the images are brought forward through the counseling experience. This foundational growth is hoped to spur on a continued path that leads to a healthy, joy filled path that the client can experience throughout their lives.

What important points stand out in the ACA Ethics Codes (ACA, 2014) and the ACA Counselor Competencies to you as you read these and why?

It is evident in the documents reviewed that the leadership for the mental health world seeks to keep the best interest of clients, trainees, licensees, etc., at the forefront of those affiliated with the mental health fields. The documents referenced help us do our best to avoid offending others who may be seeking help from the services we provide. The mental health profession is unique in the way we are allowed to be involved with our clients in some of the most intimate, vulnerable times in their lives. These documents help us to stay vigilant to avoid: taking advantage, causing harm, discrimination (reminding us of the diversity of the population), being loose with information (client records), falling behind on current theory (continuing education), unethical research practices, etc. These documents remind us of the great privilege of working with clients and addressing issues that many fail to consider without being reminded regularly.

As you read the ACA Ethics Codes (ACA, 2014) and the ACA Counselor Competencies, what do you find challenging and why?

The biggest issue that I have is how to draw the line appropriately in the area of personal values. Personal values are an issue because I do not see my value system as one of the ways to live but the way to live. God has created us and gave us His Word to show us how to live as He would have us to live. Thankfully, most of my clients come to me through churches because I am affiliated with the Christian worldview, so this is not typically an issue. However, I am reminded of my very first client. He was a teenager with two moms, a homosexual brother, and who himself had the police raid his home due to possession of child pornography and also was having

sex with his girlfriend. The client let me know they (his family) all prayed that counseling would go well before coming into the session. I handled the sessions without asking how this made sense to them, but it was a struggle. The root of the problem for the whole family was dealing with sin. I wanted to share this so badly with them! All of this is to say I find this ethics rule to be a challenge, but I believe I understand the spirit and intent of the rule.

Along the same lines, I find it challenging how often the homosexual lifestyle is brought up and how I am supposed to keep up to date with the current terms the LGBQIQA prefers to be called. I could not help but notice how much longer the competencies were dealing with the subject and how it was made part of the multi-racial competency information as if being homosexual is a racial identifier. It is as if that lifestyle choice being considered equal to heterosexuality is not sufficient, but needs all of the cisgender (a new term to me) people to acknowledge and promote the homosexual lifestyle. This section is an area I struggle with, but as demonstrated in the example above, I can assist clients who accept the homosexual worldview without pushing Godly Truths on them.

Just as a matter of interest, I was rather intrigued by specific guidelines having to remind people not too: take advantage of clients, sexually harass clients, share confidential information, do false advertising, cause injury to research participants, etc. It is a shame to think that we need rules such as these. If we are not reminded of past failures like these, history will indeed repeat itself.

Include a conclusion that synthesizes the contents of the paper and brings it to a meaningful conclusion.

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Appendix

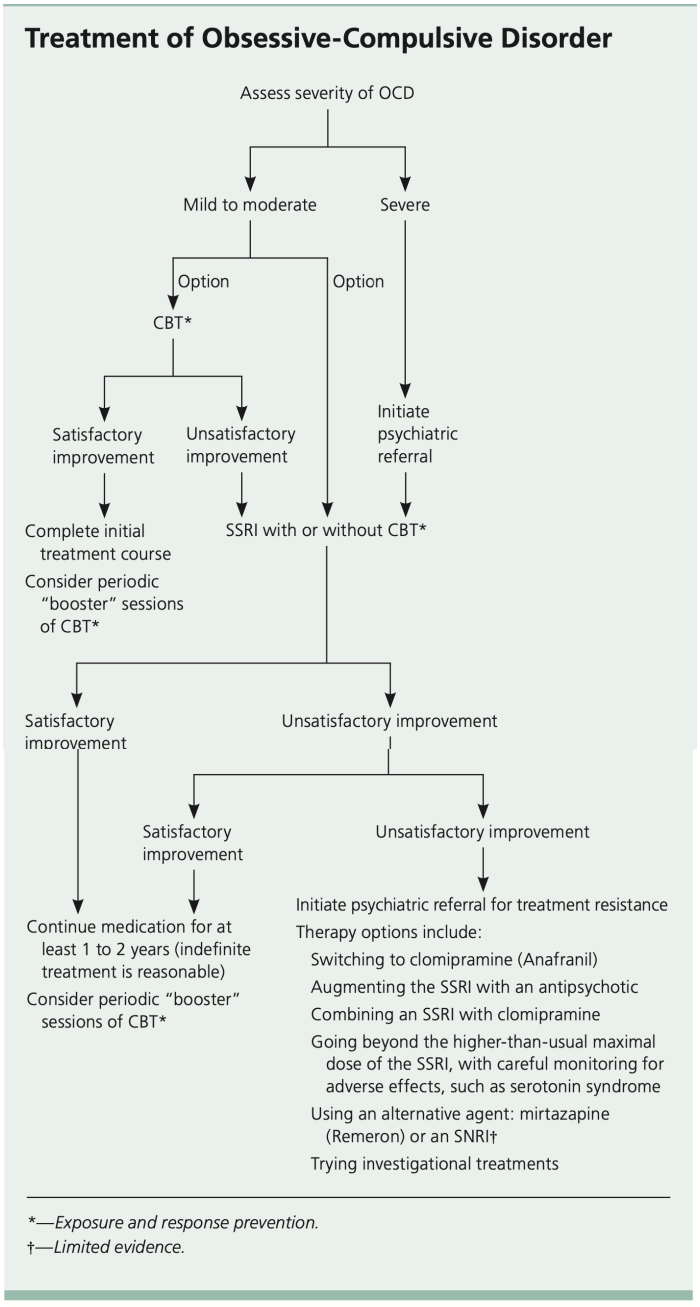

Figure 1. Algorithm for the treatment of OCD. (CBT= cognitive behavior therapy; OCD = obsessive-compulsive disorder; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI= selective serotonin reuptake inhibitor.)

Koran et al., (2007)

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I appreciate the thought and time you put into developing this engaging paper, Jeremy. I enjoyed reading about all the wonderful work you are doing!

I hope you find the feedback helpful as you further develop your academic writing and clinical skills.

May you continue to flourish throughout the course Jeremy and enjoy creating your second paper.

Please be sure to apply all this feedback to that paper.