The Clinician and Client Connection: Examining Theory in a Clinical Setting:
A Field Practicum with Lloydminster mental Health and addictions Services.

A Field Practicum Report
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Abstract

This paper is a reflection of my experiences at the Lloydminster Mental Health and Addictions Services office during my field practicum placement from June 2014 to September 2014. This paper looks at my previous background with mental health and includes a description of the agency with its challenges and barriers to service. My learning goals and objectives during my placement included: furthering my professional development and knowledge in the field of clinical counselling during my field hours. This included greater understanding of the theoretical frameworks of Cognitive Behaviour Therapy, Solution Focused and Client Centered and the importance of the client counsellor relationship. In this paper, I also examine three case studies where theoretical knowledge was applied in practice. I conclude with thoughts on the connections between the role of counsellors to clients, counsellors to agency and counsellors to self.
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Endings and New Beginnings

As this journey has come to an end, I remember “how intimidating the idea of going back to school was”. It had been a decade since I finished my Bachelor of Social Work degree and many years since I was in a classroom setting. I recall sitting in class on my first day and writing in my notebook, “What did I get myself into?”. However, I have enjoyed my time expanding my knowledge base and tackling the new challenges professors have sent my way. As my class time came to an end, I decided to complete my degree requirements with a field practicum placement and practicum report.

Finding a field placement in Lloydminster was more difficult than I expected, as there were few social work agencies where a master’s degree was necessary for a position. Yet I was fortunate to be able to find someone willing to supervise me in an area that I’ve always wanted to work in, which is mental health. This field of social work has always drawn my interest, as mental health makes an impact in the lives of nearly all Canadians, from individuals directly affected to their friends and family.

Over the course of my career and for the clients I have worked with, mental illness has been one of the strongest factors impacting peoples’s lives. Therefore, at the beginning of this report, I have chosen to briefly reflect on mental health as my field placement and my experiences have revolved around it. Mental health is such a domineering force and touches everyone around us. As such, if everyone had well balanced mental health, many social workers (including myself) would be out of a job.

The rest of my report is devoted to my field practicum involvement at the Lloydminster Mental Health and Addictions office. It covers my learning goals, personal experiences, and reflections. I also examine several counseling theoretical frameworks and include several case
examples taken from my practicum experience and how client progress was measured. Lastly, I close with final thoughts and considerations on my practicum and future goals.

**What is Mental Health?**

Before I move into discussing my field placement, I want to briefly address what mental health means and the impacts of poor mental health. Mental health affects us all, and it has left its mark on my own life. The Lloydminster Mental Health and Addictions office, where I did my field placement, was created to address the lack of good mental health care in the local community.

This past August 2014, The World Health Organization updated its definition of mental health. It describes mental health “as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2014, para 1). Essentially, if your mental state is balanced, you can cope with the stresses life throws your way. If your mental state is not stable, then problems will occur.

The Mental Health Association’s website (http://www.cmha.ca/media/fast-facts-about-mental-illness) cites that “mental illness indirectly affects all Canadians at some time through a family member, friend or colleague”. Thus, at some point in their lives, everyone will have to face mental illness either by experiencing it themselves or watching others go through it. The prevalent statistic currently listed across Canadian mental health websites (i.e, Statistics Canada - www.statcan.gc.ca, Canadian Mental Health Association - www.cmha.ca, Center for Addiction and Mental Health - www.camh.ca, Mental Health Commission of Canada - www.mentalhealthcommission.ca, and the Public Health Agency of Canada - www.phac-aspc.gc.ca), is that 20% of Canadians personally have to cope with mental health issues at some
point in their lives. Still, this statistic is not an accurate representation of the state of mental health in Canada. Dr. Scott Patten (as cited in Belluz, 2012) stated,

You cannot directly measure the proportion of people who have a mental illness in their lifetime since any sample that is representative of the population will have young people who may develop an illness in the future, so such figures are typically educated guesses (p. 1).

What is considered a diagnosable mental health problem ranges significantly and changes from year to year. Each subsequent publication of the *Diagnostic and Statistical Manual of Mental Disorders* redefines the borders of mental illness, defining new disorders and updating outdated concepts.

Countless Canadians still do not understand that mental illness stems from many interrelated causes such as genetics, environment, temperament, and biology. Unfortunately, mental health remains a taboo topic for many, and those who admit to difficulties with mental health are still branded as different and less worthy. While those who are going through mental illness may suffer stigmatization from outsiders, they also suffer internally. Those experiencing “mental illness may internalize mental illness stigma and experience diminished self-esteem and self-efficacy” (Watson, Corrigan, Larson, & Sell, 2007, para 1). Battling stigma on two fronts (internally and externally) can lead people to ignore or hide their mental illness.

Some people feel that they can beat their mental illness on their own and may shy away from service due to embarrassment. Others fear the effects of medication and drug dependency and resort to self-medication through drugs and alcohol or homeopathic remedies. Going undiagnosed and untreated can create further complications down the road for many people. While in many cases mental illness can be treated through medication, counseling, and the
patient’s willingness to commit to treatment, it will take further public acceptance to remove the feelings of shame and judgment that come with a mental health diagnosis.

Mental illness has more far reaching effects on people than just shame and judgment. Not only does it touch the lives of individuals and families, but mental health also has a resounding financial impact. The Mental Health Commission of Canada’s study, “Making the Case for Investing in Mental Health in Canada” (2013), estimated that mental illness costs the Canadian economy $50,000,000,000 per year. This study took into account the cost of treatment, long-term care, hospitalization, medication, social service agencies, income support, and disability payments. The study also estimates that over the next 30 years these same costs of treating mental illness will exceed $2.5 trillion.

The Mental Health Commission of Canada study also goes on to look at the impact on and cost to the Canadian workforce. In 2011, the commission study estimated that 21.4% of the working population experienced mental illness, which cost more than $6 billion in lost productivity. These estimates factor in employee absence, retraining, those leaving the workforce because of mental illness, and short or long-term disability. The commission study estimated the financial impact to be $16 billion by 2041, with a total cost of $198 billion.

Canada has come a long way from the days when those with mental illness were hidden out of sight and mind. While the common estimate is that 20% of Canadians will experience mental health problems, it is reasonable to assume 100% of Canadians will be impacted in some ways. Whether the impact is personal, emotional, family related, work related, or financial, mental health impacts us all. With greater understanding, prevention programs, and knowledge, these personal and financial costs can be reduced. Preventative treatment could also significantly lessen hospital stays or criminal justice cases.
Personal and Professional Experiences with Mental Health

My family moved to Lloydminster when I was nine, so I spent my formative years in this community. I have seen this city grow and change from a small city with a rural feel to a big city impacted by a multicultural population explosion. It was here at home where I saw many of my friends face failure and depression in their adult lives because there were few positive influences in their youth. Those failures helped to influence my original decision to go into social work.

I felt that many of their struggles in mental health could have been prevented or lessened with proactive outreach programs offered to their parents and themselves. Hopelessness, lack of supportive caregivers, substance abuse, self-harm, and destructive thoughts and behaviors impacted so many youth in my community and led to poor emotional well-being. Watching that happen and seeing those who were not able to reach their full potential struck a resounding chord within me. Many times I wanted to reach out and help but lacked the necessary tools to do so. I did not find my voice until I entered the social work program.

After graduating from university with my Bachelor of Social Work, I moved up to northern Alberta to work at the High Prairie Youth Assessment Center for youth ages 12 to 18 as a child care counselor. The center worked with youth who were at high risk for suicide and self-harm, running away, drug or alcohol dependency, and mental health disorders, as well as victims of abuse or abusers themselves, those who were facing potential time at correctional centers, and those whose behavioral issues would not allow for a regular foster placement. The kids came from across the province from many backgrounds; there were First Nations, Metis, and Caucasian youth.

Over my years at the center, I once again saw countless children with amazing talents, intellect, and caring natures failing to thrive. There were even several children whose parents
had at one time lived at the center themselves. Many of the issues these young people faced could have been stopped or lessened if they or their caregivers were given proper early intervention. Many of the kids just needed someone to confide in to help lift some of their burden. Very seldom did a child come to the center knowing any positive coping skills; instead, they lashed out physically in anger, sadness, and frustration. While there were a few exceptions of youth doing well after their center stay, many had to return to their same circumstances upon discharge.

My role at the center was to help youth develop basic life skills and learn to work around their cognitive or behavioural issues. Many of the skills counselors taught were based on self-care, self-soothing, and controlling negative impulsive reactions. Each child had a specific worker and a care plan that worked around natural positive and negative consequences. Success was rewarded, and natural consequences were fair. Every child had input into his or her care plan because such input helped children take interest in their own achievements order.

Shortly after I left that position, I was informed that one of my key kids (one of the youth I had directly supervised) had been murdered by his stepfather after his discharge from the center. For months we had monitored this youth closely, as he was considered high risk due to his numerous suicide attempts. Every time he left the center, the local RCMP detachment was called to bring him back. During two separate home visits with his family, he attempted to kill himself with an overdose of his grandmother’s OxyContin. After each overdose, he was found in time and taken to the hospital for treatment and suicide watch. Along with myself, other center workers tried many forms of mental health therapy with him, and eventually he stabilized enough to be discharged, only to go back to the same surroundings he had been taken from. Many of us who had worked with him felt we had failed in our duties.
Following my time at the center, I worked in Alberta’s AISH program (Assured Income for the Severely Handicapped) within the same Northern community. Many of my clients were children I had worked with at the center or their parents. A large percentage of the applicants I interviewed for the program listed depression as their number one disability, closely followed by other mental illnesses such as schizophrenia and bipolar disorder.

As High Prairie was a small community, there were limited amounts of help available through mental health services. The closest psychiatrist was over an hour and a half away, and for many people it was difficult to travel that distance given their lack of income or reliable transport. My clients frequently asked me for mental health services that were outside of my job duties and often treated me as their counselor. The demands on workers were high and led to burnout - which happened to me more than once.

**My Learning Goals and Objectives in Mental Health**

During my time at the Lloydminster Mental Health and Addiction Services in the Prairie North Health Region, my learning goal was to gain and employ graduate-level social work skills in counseling. I also wished to help clients who presented different concerns within the context of Lloydminster Community Counseling services. I decided to focus my time on six learning objectives over the course of my practicum hours.

My main objective was to further develop my clinical counseling abilities by working with a variety of clients. To do this, I would directly observe group and individual therapy sessions with my professional associate and other clinicians. This also tied into my desire to improve my knowledge of the connection between counselor and client in therapy through observation and practice. Unfortunately, I was not able to attend any group sessions due to office circumstances and the availability of staff during the summer months.
My Practicum Associate, allowed me to take on a full caseload after several weeks of observing individual counseling sessions. He felt I was ready to dive in and help out with the backlog of clients waiting for service. However, I was given leeway in how many clients I took on. My name was added to the list of available counselors taking on new clients for July, August, and September 2014. With the addition of me taking on cases, several clients who had been waiting for service were able to be bumped up to earlier appointments.

Within a number of days, I had built up a caseload of new clients for individual and couples counseling. Each client issue was unique and ranged from stress management, to communication skills to abuse and mistrust. Some clients came once or twice, while others would take multiple sessions to make progress. Typically, I would have arranged for another counselor to take on my clients before I finished my required hours. Fortunately, though, I was able to stay on at the office in a paid position and keep my clients. Several of my clients expressed relief that they did not need to switch counselors and start over with someone new.

Like the other counselors, I was able to arrange my own schedule for how many people I saw per day and when I saw new clients. It would stagger between several appointments to a full day. As sessions typically run from 40 to 60 minutes, those who provide counseling for adults see a maximum of six clients per day. Most counselors like to see four to five clients as it allows them to make client notes after each appointment. Characteristically, I saw 4 to 5 people per day, which allowed me to keep up with my client notes and other paperwork required for filing standards.

At first it was rather intimidating taking on clients by myself, but I quickly began to enjoy the helper role of counselor. My very first client came in wanting to learn new coping skills for learning to manage anxiety. I did an enormous amount of studying and making notes
on different anxiety coping tools before the appointment. After meeting with the client, I tried my best to go through the tools I thought were the most useful with her. After the session concluded, the client chose not to make a follow-up appointment, and I felt like I had not made an impact or imparted any new information. The client had looked skeptical of any ideas I provided and did not really attempt to go along with any of the demonstrated exercises. I spoke to my field supervisor about the appointment and how it seemed to go nowhere. He stated that at times you just get clients who say they want help but are not willing or open to change.

Another of my field placement goals was to strengthen my understanding of how theoretical counseling knowledge is applied in direct practice with clients. Before this summer, much of my working knowledge of applying counseling theory was from the classroom and books. I wanted to see how various counseling theories such as cognitive behavioral therapy, client-centered therapy and solution-focused therapy were put to work in a therapy session. Afterwards, as part of this report, I would provide a written examination of the counseling theories that I applied during my practicum. I studied my chosen theories and tried applying them in session when appropriate.

Another objective was to learn how to effectively practice screening and intake of new clients in the office and on the phone. I trained for several days under staff guidance in the intake screening process and learned how the office screened and directed clients to needed services. Eventually, I took on the intake worker role on several different days. There was a learning curve in terms of how to prioritize clients based on their needs and match them with the right services.

My last goals were to meet weekly with my field my Professional Associate to discuss whether my practicum was meeting my learning objectives and whether I had difficulties with
any of my clients. He truly took to heart the CASW Guidelines for Ethical Practice section 3.5.3 where “social workers foster in social work students knowledge and understanding of the social work profession, the Code of Ethics and other appropriate sources of ethical practices”

My practicum associate was a great support to me throughout my time at the office and treated me like any other staff member. He frequently met with me more than once a week to make sure my practicum goals were being met and to see if I had any concerns with clients. If a staff member’s door was open, he often popped his head in to say hi or listen to concerns. On top of this, his office door was always open, and he was available when I had questions on how to proceed with my clients or meet practicum goals. If he wasn’t available to me, he made sure that another clinician was, in case questions arose. My practicum associate also made sure that I attended several staff meetings and participated in a local HUB meeting.

Agency Profile and Services

My Welcome to Lloydminster Mental Health and Addiction Services

From June 2014 to September 2014, I worked in the area of adult counseling at the Lloydminster Mental Health and Addictions office. My academic supervisor was the Team Coordinator for the Lloydminster Mental Health and Addictions office. He is a graduate from the University of Regina Masters of Social Work program and is currently working towards a Ph.D. in Conflict Analysis and Resolution at the School of Humanities and Social Sciences through Nova Southeastern University.

Under his guidance, I took on a caseload of adults and couples that had requested counseling services. My role was to help them learn positive coping skills, better understand the factors at in their lives, and find resolution to move forward to a better level of mental health. In
addition to this, I took part in the intake screening of new clients coming in for counseling or addiction services.

**Prairie North Health Region’s Vision of Care**

The Lloydminster Mental Health and Addictions office is part of the greater Prairie North Health Region (PNHR), which covers a geographically diverse area from Meadow Lake, North Battleford, to both the Alberta and Saskatchewan sides of Lloydminster. A total of 13 Saskatchewan communities are served by PNHR. The health region offers a variety of services from two regional hospitals, a psychiatric rehabilitation hospital, forensic services, renal dialysis, chronic disease management, addiction services, adult and child/youth counseling, Telehealth, primary health care, population health and Kidsfirst.

On its website, pnrha.ca, and in Prairie North offices, the Prairie North Health Region shows its vision for the healthcare service for the area it serves. The region prides itself on the idea of “Healthy People. Healthy Communities”, with the values of “Respect; Excellence; Accountability; and Transparency”. Its mission statement is that “Prairie North Health Region works with individuals and communities to achieve the safest and best possible care, experience, and health for you”. It strives to provide quality service for people in the local communities and surrounding region.

The vision that Prairie North has for delivering services to clients is one that I share. No matter what role I have worked in over the course of my career, it has always been my belief that as a social worker I have to try and do the best I can for my clients. That may mean I’m advocating on their behalf or just listening with a sympathetic ear. During my role as clinician this summer, I was able to do this for the 50 plus clients on my caseload.
Services Offered at Lloydminster Mental Health and Addictions Office

The Lloydminster Mental Health and Addictions office is home to six main services: child and youth counseling, child and youth addiction services, adult addictions, adult counseling, several group therapy programs, and mental health outreach services. The clinicians come from a variety of backgrounds, including social work, addictions, nursing, and psychology. While many clients come from Lloydminster, the office offers services to out of town clients as well. A number of the clients will travel upwards of two hours for service.

At present, there are three child and youth counselors and one child and youth addictions worker at the Lloydminster office. They work with youth 17 years of age and younger, and one worker will often work more with youth under the age of 12. The counselors come across such issues as abuse, bullying, divorce, and behavioural problems requiring anger skills management. Appointments are often kept brief due to children’s attention span and will include parents as part of the healing and learning process.

The child and youth addictions worker typically sees older youth with an array of addiction concerns. The worker will often liaise with the schools and students out in the community and make presentations on drugs and alcohol in the school systems. Due to heavy caseloads in Lloydminster, the child and youth addictions worker will often take on youth aged 12 and up for counseling services.

There are three addiction counselors at the office, and two are cross trained in addictions and adult counseling. They see many clients over the age of 18 with issues such as alcohol and drug abuse, gambling, and sex/pornography addictions. Numerous clients will come into the office asking for adult counseling when their main issue is addiction, while some clients come in for addiction services when their problems are more deeply rooted in mental health concerns.
Depending on the client’s level of need, some clients will be screened for both addictions and mental health counseling services or just for addictions. Sometimes after the first appointment the addictions or mental health counselor will decide whether the client needs both types of services or only one.

There are five adult counselors employed at the Lloydminster office: this includes my practicum associate taking on a caseload on top of his regular duties as Team Coordinator. Clients face issues such as stress, eating disorders, trauma, loss, violence and abuse, postpartum depression, divorce, general anxiety, suicidal ideation, or relationship counseling problems. Adult counselors will see people on an individual basis or as part of couples therapy. Most sessions for addictions and adult counseling run from 45 minutes to an hour. Typically clients attend several sessions with a counselor and then are evaluated to see whether they require further sessions.

There are also two registered nurses that work with mental health clients to ensure they are receiving necessary services and taking their medications properly. They see patients in the office and out in the greater community. Their caseload is typically filled with high needs clients, and they work with other community agencies to assist clients.

There are several group programs that are run monthly by various staff. This includes the support program “Safe Journeys”, where people with substance abuse and trauma come to build and develop coping skills to replace addictive behaviors, manage trauma symptoms, and prevent self-destructive behaviors. There is also a support group for people who live with a loved one suffering from dementia. The group provides a safe place to provide coping ideas and strategies and to address concerns they are experiencing. The office also runs the “Parenting with Purpose” program that helps parents improve their parenting skills, which both spouses are
encouraged to attend. The support groups are well attended by people from Lloydminster and local communities.

The Prairie North Health Region offers counseling to individuals and couples at no cost and will not turn away those in need of help. However, there is a high demand for services and only so many staff available to clients. Often, clients have to wait for an appointment past the prescribed period described in policy guidelines. Even with the addition of myself taking clients this summer, not much of a dent was made in the waiting list for appointments.

When initially screened in the intake process, clients are triaged depending on their level of need in three areas: support, coping skills, and symptoms. The areas are scored from one to ten, with a score of one being low needs and ten extremely high. Clients are scaled and seen in order of priority. For example, if a client is suicidal, he or she is triaged as high needs and seen within twenty-four hours. High scoring clients such as women with postpartum depression are seen within five business days. Those with lower scores are seen in 20 to 30 days depending on their needs.

Each clinician is in charge of his or her own scheduling, with specific times set up for new clients. Those spots are then written on the intake calendar. If a client needs to come in sooner than the next free appointment, clinicians are asked to make an exception. Both child and youth counsellors, and adult and addiction clinicians carry high caseloads of 50 plus clients due to a local high need population.
The Intake Process

When clients come in for help, they first go through the intake process. Potential clients can be referred by other agencies, come into the office, or call the center. Intake screening is all day, every day, and is considered high priority.

The screening process does not take long, but it is vital to the counseling process. Intake workers take down the client’s statistics, what area the client is requesting help in, and an overview of the problems the client is facing. This information lets the intake worker match clients up to the services they need and what counselors are available to take new clients. It also allows the intake worker to decide how soon the client needs services if the problem is life threatening, those clients are given the earliest appointment available. Appointment wait times differ depending on the urgency of the situation.

There is a core intake team made up of several workers, with other clinicians filling in as needed. The intake screening is a key process that outlines which services a client requires, what he or she is seeking help for his or her particulars, and which clinician he or she will see. Over the summer, I spent some time working in the intake office.

What I can say is that working in the intake office is a tremendously busy job. There is always something to do, something going on, and something urgent. The day is prioritized with outstanding intakes from the previous day, possible emergencies, and whatever the day throws at you. There is rarely down time. Files are carefully labeled, and prioritized by date, and all information must be carefully recorded in several different logs.

I quickly found that even if something small is mislabeled or misplaced that it can create chaos. Appointments become double booked, workers become frazzled, and for the next worker taking his or her turn at intake, it means a big mess to clean up. There is a lot to learn, and even
though I was careful with my documentation, I still made mistakes. It was a “live and learn” process.

There is not much to critique about the intake process. Over the years, the staff members have streamlined the steps and have made the forms as simple as possible to use. My only suggestion would be to hire a full-time, dedicated intake worker. It would possibly cut down on mistakes and free up staff for appointments. While working intake can be a nice change from counseling, it still takes away from time with clients and paperwork. However, agency budgets do not always allow for job creation.

The Agency and Community Outreach

The Lloydminster office reaches out to the community in many different ways. Many local agencies fax referrals directly to the office. The office, in turn, will fax out referrals to several local psychiatrists for clients. Several clinicians work with schools and other outlying agencies in regard to counseling and addiction awareness.

In addition to this, the office takes part in the Lloydminster HUB program that was established in December 2013. Lloydminster is one out of ten HUB programs currently running in Saskatchewan as part of Saskatchewan’s Government Child and Family Agenda. The Community Mobilization Hub program through the Building Partnerships to Reduce Crime initiative strives to reduce crime and victimization. The program brings together many local agencies, including Prairie North Health Region, both Alberta and Saskatchewan Ministries of Justice, Lloydminster RCMP detachment, the Alberta Ministry of Human Services, the Saskatchewan Ministry of Social Services, and the Public and Catholic school divisions. The Government of Saskatchewan’s September 26, 2014, online article on HUB states that “these
partners come together twice a week to help find ways to immediately connect individuals and families experiencing risk to meaningful supports and services”.

In his article on the HUB program in Saskatchewan, Matthew Liebenberg described HUB as “an interactive approach that involves various agencies in efforts to proactively address crime and safety issues in communities”. HUB has had some success in Lloydminster with different agencies connecting and collaborating on clients that need support in various areas of their lives. Agencies now talk and work together to meet the needs of the people they serve.

**Barriers to Service at the Lloydminster Office**

While the Lloydminster office does the best it can to meet the needs of the local population, they still face some barriers. The counseling positions that were created were based on working with Saskatchewan populations only. Being that Lloydminster is a border city, the amount of clients served from Alberta and the local Alberta areas were not considered in job creation. Due to strict budgets, locating funds for additional personnel can be a major process. The amount of clients each counselor takes on to meet local needs can make it difficult to provide quality service to everyone.

Since the Lloydminster Husky Upgrader (oil refinery) was built in the early 1990’s, Lloydminster has essentially been a boom town. With all the related services dedicated to the oil field, the local population has continued to rise significantly each year, alongside a growing transient population. This growing community requires more services than what was originally forecasted back in the ‘90’s’. Even our local hospital was not built to accommodate the amount of people who need help on a daily basis.

Missed or no-show client appointments are another source of frustration that counselors face. I have never been more appreciative of people who arrive early or call ahead to cancel
their appointments. With no shows, there is usually no notice given to allow the counselor to call another client to make an earlier appointment time. While the time is never wasted due to paperwork demands, it can mess up your schedule by trying to track and call clients to rebook for a new time. There is only a small amount of time the counselors can give each client, especially when they are trying to squeeze in emergency appointment times.

Finally, Lloydminster currently does not have a local public transportation service, and there are no plans in the immediate future to build one. This can mean it is difficult and expensive for clients who have no reliable source of transport. Taxi fare is not cheap in this city, and while walking across the city is feasible in summer, in winter it’s not. At the discretion of each counselor, low income clients can qualify for taxi vouchers. For out of town clients facing similar challenges, it can make it downright impossible to make appointment times. Yet counselors can close client files if there have been several no shows or no contact for some time.

**Ethics and Field Practicum**

**Ethical Considerations at the Office**

Prairie North’s policies adheres closely to the Canadian Association of Social Workers (CASW) Code of Ethics and Guidelines for Ethical Practice. As per the guidelines, section 1.5 on privacy is as follows:

Social workers respect clients’ right to privacy. Social workers do not solicit private information from clients unless it is required to provide services or to conduct social work research. Once information is shared or observed in a professional context, standards of confidentiality apply. Social workers protect clients’ identity and only disclose confidential information to other parties (including family members) with the informed consent of clients or the clients’
legally authorized representatives, or when required by law or court order. This obligation continues indefinitely after the social worker has ceased contact with the client. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others (see section 1.6 regarding protection of vulnerable members of society). In all instances, social workers disclose the least amount of confidential information necessary to achieve the desired purpose.

Prairie North prides itself on maintaining high standards of patient confidentiality and privacy. At the start of his or her employment, each worker (or student) signs an oath of confidentiality, a promise which everyone strives to uphold. Prairie North has strict employment guidelines on this matter and will investigate any worker who is reported to have breached clients’ privacy. If this is the case it can result in employee termination.

When a worker meets with a new client for the first time, the clinician discusses with the client the therapeutic process and that the client has the right to refuse services, or ask for another clinician, as well as the right to privacy. This fits in with the CASW Code of Ethics Guidelines section 1.51, which states that “social workers discuss with clients the nature of confidentiality and limitations of clients” right to confidentiality at the earliest opportunity in their relationship”. It is explained to clients that the only time confidentiality is breached is when there is a serious concern that the client is thought to be suicidal or homicidal. If that situation was to occur, the proper authorities would be contacted. When the client is in the office, they would be walked over to the hospital by
the clinician (the office is directly next to the hospital). In the case of a child feeling suicidal, his or her guardians would be contacted as well.

In the case of suicidal clients, first the counselor and the client work together to create a safety plan in case the client has thoughts of suicide outside of the appointment time. The safety plan includes what steps a client needs to take if he or she wants to harm him or herself. For example, he or she would notify a close family member or friend, go to the hospital, or call his or her counselor to set up an appointment.

Client files are kept up-to-date in case they are required by law to be used legally used in court. Case notes are kept short and to the point to help ensure patient privacy. Files can be accessed by clients if they so choose; however, any information about another person that is in the file would be redacted (i.e., couples counseling notes). In addition, workers are not allowed to access any hard copy or digital files beyond their own. All files are kept in a secure locked location, and it is recorded who has the file out. At the end of each day, workers return their files and appointment books to a closed secure room.

If a counselor needs advice or assistance on a case, he or she can consult with another worker familiar with the file or a direct supervisor. All conversations about a client are kept away from public areas where others can hear. Discussions around clients are kept behind shut doors.

In the case of couples or family counseling, the health region assigns several workers to the file. One clinician will work with the individual client, and another will be assigned to the couple or family. Recently a client addressed the concern that the information he disclosed in his individual counseling session would be brought up in the joint counseling session. I assured my client that this would not be the case, as the
information from his individual sessions stayed confidential and would not be brought up in his couple’s session.

**Personal Ethical Considerations**

Throughout my practicum, I came across several minor conflicts of interest involving myself and others. When I was on intake screening one day, I realized that I was speaking to the spouse of someone I went to high school with. I set up the caller’s appointment, however I asked a colleague to call and do the intake of the person I knew. This happened again with another colleague who asked me to call and do the intake of someone they knew. During another session, I had a client whose former fiancé was a clinician in our office. I informed my client that the information was confidential and would not be shared with that colleague.

On a more personal note, I had several clients where there was no client/clinician connection. One client in particular was upset that I hadn’t read the self-help book he had and didn’t know what it was he was talking about. Although I offered to go through the book and discuss it during our following session, and offered that if that session were to fail, then the client would be transferred to another clinician, the client never returned. Another client, immediately after leaving my office, requested a different counselor. While it was somewhat frustrating, it was a good learning experience in knowing what fits and what does not.
Theoretical Frameworks Used in Field Practicum

Cognitive Behavioral Therapy

There were several theoretical counseling theories that I wanted to apply during my field practicum. Initially, I chose to look to cognitive behavioral therapy (CBT), as it is educational talk therapy, goal orientated, and time limited. Dr. Barry M. Gregory (2013) wrote;

CBT is an umbrella term combining many traditional and innovative cognitive and behavioral theories and therapies. It has a rich collection of proven techniques designed to help people challenge negative thoughts, learn positive new behaviors, prevent relapse, set goals, regulate emotions, dispute irrational beliefs, and solve problems (para., 2).

Gregory (2013) also outlines that “CBT interventions help people navigate tough challenges and build happier, more meaningful lives” (para 3). He also goes on to suggest that use of CBT therapy can help clients learn new coping skills “to become more mindful of the present moment and more accepting of unpleasant situations, thoughts, feelings, and behaviours” (Gregory, 2013, para 3).

As Dr. Gregory stated, CBT is rooted in the here and now. The United Kingdom National Health Services defines the basic foundation of CBT is that “thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap you in a vicious cycle” (“Cognitive Behavioral Therapy,” n.d., para 2). Psychologist Dr. Donald Meichenbaum was one of the first to work with and develop CBT approaches. In the Instructors Manual for Cognitive Behavioural Therapy with Donald Meichenbaum PhD, Meichenbaum is quoted as describing his approach “as one that is sensitive to the interconnection between thoughts, feelings, and behaviour and resultant consequences” (Randall, W. C., & Seid, E. L. (2009), p. 11).
The manual details that Meichenbaum’s method “empowers clients to identify their own agency in their emotional and behavioural experiences and to develop skills to manage how their thoughts, feelings and behaviours interact and influence one another” (Randall & Seid, 2009, p. 11).

Under a CBT therapist, clients become aware of how everyday circumstances can trigger negative thoughts, strong emotions, and poor behavior choices. With help, clients begin to break down their problems into separate parts: thoughts, physical responses, and actions. Therapists then work with the patient on how to best address the maladaptive behaviors, thoughts, and emotional responses. Eventually clients develop better, more stable, and more realistic feelings, thoughts, and actions.

Cognitive behavioral therapy was initially designed for depression and some anxiety disorders. However, it has been tested over time to work well with those who have mood or personality disorders, phobias, substance abuse issues, post-traumatic stress disorder, anxiety, or concerns around eating. This therapeutic approach has also shown progress in helping patients cope with long-term physical health conditions such as irritable bowel syndrome and chronic fatigue syndrome (Cognitive behaviourial therapy (CBT) (n.d.).

Since its development in the 1950’s to the 1970’s, cognitive behavioural therapy has continued to grow and advance. What has been called the third wave of CBT, has pushed what was once considered a simplistic method concentrating on operant learning and classical conditioning to an in-depth empowering therapeutic approach. Dr. Beppe Micallef-Trigona, in her article The Third Wave of CBT (n.d.), wrote that “third wave therapies are expanding their targets from the mere reduction of symptoms to the development of skills aimed at significantly improving the quality and quantity of activity in which the patient finds value.”
The third wave introduced “themes new to behavioral psychotherapies: metacognition, cognitive fusion, emotions, acceptance, mindfulness, dialectics, spirituality and therapeutic relationship” (Kahl, Winter & Schweiger (n.d.) p. 1). Third wave therapies “target[ed] the process of thoughts rather than their content” (Hunot et al, 2013, p. 2). This new generation of therapies includes acceptance and commitment therapy, cognitive behavioral analysis system of psychotherapy, behavioral activation, metacognitive therapy, dialectical behavioral therapy, mindfulness-based cognitive therapy, and schema therapy.

Hunot et al’s (2013) study, “Third Wave Cognitive and Behavioral Therapies Versus Other Psychological Therapies for Depression”, stated that third wave approaches are becoming an increasingly common feature of clinical practice, both as treatments and as relapse prevention interventions, for a wide range of common mental disorders. To date, however, the evidence base for third wave CBT approaches compared with other psychological therapies is of very low quality, leaving the review authors unable to draw any conclusions as to their relative effects, either as individual approaches or as a collective approach, in the treatment of acute depression to draw any conclusions as to their relative effects, either as individual approaches or as a collective approach, in the treatment of acute depression. (p. 25)

Hofmann, Sawyer, and Fang (2010) also concluded that “before embracing these more novel strategies for routine clinical care, they will need to be subjected to empirical tests” (p. 7). While traditional CBT has been studied, tested, and proven to work, these new variations will take time to reach the same recognition.

Cognitive behavioral therapy does have its limits and drawbacks as a therapeutic approach. It can be argued that because CBT only looks at current problems and targets specific
issues, it does not address the possibility of an underlying mental health condition or the root cause of the issue, such as traumatic occurrences in childhood. For those clients who need help addressing problems that involve more complex systems or family structures, CBT can be a poor fit. Due to its structured nature, CBT may also not be appropriate for people with complex mental health needs or those with learning disabilities (Cognitive behavioural therapy (CBT) (n.d.)).

As CBT deals primarily with what is happening in the present, it does not help those clients who want to focus on past wounds. Clients can feel that the approach doesn’t acknowledge the importance of their backgrounds and that it is superficial because of the emphasis on positive thinking. CBT therapy may make some clients think their emotions are being downplayed because of the emphasis put on thought-oriented and logical thinking. However, with past trauma, CBT can help negate some of the memory triggers.

To fully reap the benefits of CBT, clients need to be fully commit to the process of changing their feelings, thoughts, and behaviors. Without full client participation, a therapist cannot assist or guide a client to his or her goal. For instance, clients who are mandated to seek counseling by court order may not be willing or ready to receive help. The Lloydminster office does receive many mandated requests from both Alberta and Saskatchewan corrections for men and women on probation.

It does take commitment, regular appointment attendance, and completion of homework assignments therapists assign on behalf of the client. At times, clients can experience emotional upheaval and periods of anxiousness when confronting their negative thought patterns. Nicholas A. Roes (2011) wrote,

CBT can backfire with certain clients. Sometimes clients hear cognitive approaches as
judgmental, and attribute their “inappropriate” or “distorted” thinking to a basic flaw in their humanity. CBT even could be confused by clients with a moral model, where clients conclude that bad things happen to them because they are bad people with bad thoughts and feelings. CBT also can present a problem for clients with anxiety, especially if a focus on their thoughts is part of their troubles to begin with. It could give ruminators another thing to worry about, and could increase anxiety rather than alleviate it. (p. 1)

He further states that “CBT might keep depressed clients in their dark places for so long that it could feel like a punishment. Some clients might be at a point in their lives where they can’t handle their most suppressed thoughts, and in these instances it is not wise to rip the lid off them.” (p.1).

Roes used the example of a CBT homework assignment of a decisional balance sheet that records the risks and benefits of a client’s choice. For those clients who have ambivalent tendencies, such an assignment can help them make appropriate choices. Kendra Cherry (n.d.) wrote that “virtually all people can identify goals they want to accomplish, things they would like to change and things they would like to achieve. However, most people also realize that putting these plans into action is not quite so simple” (p. 1). Roes (2011) further writes that those worksheets can be counter-therapeutic when the client already knows which choice is best, but keeps having trouble making it. In these cases, the decisional balance sheet might reinforce clients’ opinions of themselves as losers, or failures who are incapable of correctly making even the most obvious choices (p.1).

**Client Case #1 CBT Approach.**

I found I pulled from some areas of CBT, especially with the use of the worksheets. One
resource that was useful for me was *The CBT Toolbox: A Workbook for Clients and Clinicians* by Jeff Riggenbach (2013). His approach was simple and was meant for use by both clinicians and those who wanted to help themselves. Riggenbach breaks down CBT into a linear chain of events: Event > Thoughts > Feelings > Actions > Results.

When I was working with clients who saw themselves in a negative light, correcting those thought patterns was difficult when they had been ingrained in a person’s psyche. I noticed that CBT was effective in helping some women who had been in abusive co-dependent relationships.

One female client in particular had fled a highly physically, mentally, and sexually abusive relationship with her two young children. To complicate matters further, she was grieving the loss of a recent pregnancy. This had been one of numerous previous attempts to flee the situation. Before, she had been stopped by guilt, threats to herself and children, and his threats of suicide if she were to leave.

The client was very young, poor, and unemployed, and had no labor skills to speak of. Her children were under the age of four and asking for their father. She was sick with worry that she wouldn’t have a place to live if she didn’t meet the requirements of the local women’s shelter’s second-stage housing. Her spirit had been broken by the one person who should have been there to elevate her up.

During our initial meeting, she could barely meet my gaze. Slowly, the soft, low words came from her mouth about what had happened. Eventually, the words became a rushing torrent of her account. When she became comfortable with me, we began our initial work on her feelings and thoughts on co-dependency. She experienced large amounts of guilt and shame for leaving him, for taking his children away, and for losing their child. My client also believed that
it was her fault that he had threatened suicide and put a knife to her throat.

After several appointments, I saw a gradual change in her thought patterns. She began to realize that it was not her fault, but his. My client began to understand that she was not the reason he abused her; the reason was his own failings. With these changes, the desire to run back to him lessened and began to go away.

Next, we worked on building up her feelings of self-worth. The client began to keep a journal of her negative and positive thoughts. For every negative note, she would have to counter it with two positive thoughts. She began to enjoy the exercise and even started it again after her four-year-old used her journal as a coloring book. It was rewarding to see her shoulders straighten from her hunched defensive posture and to see her regain self-confidence. I am happy to report that she is doing well and making long-term plans for herself and her children.

**Client-Centered or Person-Centered Therapy**

I also wanted to explore an older therapeutic model such as client-centered therapy or person-centered therapy (PCT). This model is also referred to as person-centered counseling, person-centered psychotherapy, or Rogerian psychotherapy. It is a form of talk psychotherapy that was developed by Carl Rogers throughout the 1940s and 1950s. Wikipedia (2014) describes that “the goal of PCT is to provide clients with an opportunity to develop a sense of self where they can realize how their attitudes, feelings and behavior are being negatively affected.” The focus is on the clients’ subjective view and perceptions of the world.

In PCT, we move away from the idea of the therapist being the expert who knows what’s best for the client and toward the concept that clients are capable of realizing and reaching their own full potential. Even the language changed as Saul McLeod (2008) noted that “one major
The difference between humanistic counselors and other therapists is that they refer to those in therapy as ‘clients,’ not ‘patients’” (p. XX).

The therapist and client work as equal partners; however, the ownership of improving the client’s life is the responsibility of the client, not the therapist. During Rogers’s time, this was a decidedly radical contrast from the traditional approach of the therapists diagnosing and treating the patient. He helped to change the idea that the client is not an object or problem to be labeled or fixed, but rather is someone who can be worked with. McLeod (2008) stated that “Rogerians hope to help their clients to achieve personal growth and eventually to self-actualize” versus “just liberating clients from their pasts, as psychodynamic therapists aim to do.” (para. 12).

There are no set techniques to follow, as there are in CBT. Rather, there is an absence of methods. Instead, PCT relies on the skill of the therapist. Rogers described the therapeutic environment as one where people could relax and feel free from both physical and mental harm. PCT is considered a non-directive approach. What structure there is comes from the client, who decides what his or her own problem is and what can be done about it. Josefowitz and Myran (2006, August 15) wrote about how goal setting works in PCT therapy. They state that setting goals is a process of collaboration, where the therapist listens to the client and encourages the client to articulate concrete specific goals that can be achieved. Ideally, the therapist is able to help the client articulate his goals with greater concreteness and specificity, which is congruent with the patient’s goals/aspirations (p.331).

The key, though, to PCT therapy is the quality of the relationship between the client and the therapist. If that bond does not form, the therapy will go nowhere. The therapist plays the role of friend who listens and helps guide the client through to a confident state. Elizabeth Freire (2013) wrote that “behind the techniques and precise formulations of every psychotherapeutic
model, the technical apparatus and manualised protocols, there is an encounter between two human beings. What unfolds in this encounter is the fabric of the therapeutic process” (p. 3).

I strongly identified with the role that a PCT therapist plays in the appointment. I found that if clients can register me as a friend or a guide rather than their expectation of a formal therapist, they will do better in a session. Rogers emphasized the need for clinicians to be empathetic, genuine, nonjudgmental, and accepting. Admittedly, this can be harder to do with some people in sessions. As Rogers (1980) states, “The more the therapist is himself or herself in the relationship, putting up no professional front or personal facade, the greater is the likelihood that the client will change and grow in a constructive manner” (p. 115).

In order for client growth to occur, there are several further criteria that need to be met. Clients coming to therapy frequently have difficulties with self-image and often feel exposed. The client needs to feel safe and secure enough in order to share with his or her therapist. Whatever is said, either positive or negative, must be accepted as-is. People will not share if they feel condemned or scorned. If this need is not met, the session will go nowhere.

The client needs to feel that his or her therapist is empathetic to his or her situation. Often, this reassurance can be given through small amounts of praise and affirmation. As sessions move along and clients feel more comfortable with the therapist, more personal and sensitive details come forth. Josefowitz and Myran (2006) wrote that “the client has to trust that his goals and objectives will be valued by the therapist and that he can risk disclosing issues where he may be ashamed or embarrassed” (p. 331). Clients need to feel that they will not be judged or graded in any way, or they will not disclose what they need to in session.

Client-centered therapy has been criticized over the years because of its indistinct concepts and guidelines and the refusal to diagnose clients. The conclusion of therapy is
dependent on the client’s self-evaluation. People who suffer from mental illness may not respond well, as their self-perceptions may be already be malformed beyond what PCT can handle. Additionally, people who are shy and withdrawn may find it hard to speak out and be open with a therapist.

Carol MacDougall (2002) wrote that “therapist nondirectiveness for some clients may be frustrating, counterproductive, and seen as passive and lacking involvement or a willingness to help” (p. 13). MacDougall (2002) also points out that therapists should keep checking with the client “about the impact of all therapeutic behaviours rather than assuming their intentions have been received” (p. 13). This point is also valid for the other therapeutic approaches covered in this paper.

**Client Case #2 PCT Approach.**

I really appreciated what Carl Rogers wrote in *A Way of Being*. He says,

Very early in my work as a therapist, I discovered that simply listening to my client, very attentively, was an important way of being helpful. So when I was in doubt as to what I should do in some active way, I listened. It seemed surprising to me that such a passive kind of interaction could be so useful. A little later a social worker, who had a background of Rankian training, helped me to learn that the most effective approach was to listen for the feelings, the emotions, whose patterns could be discerned through the client’s words. I believe she was the one who suggested that the best response was to “reflect” these feelings back to the client—“reflect” becoming in time a word that made me cringe. But at that time, it improved my work as therapist, and I was grateful (p. 137).

The idea is that by simply listening to your clients instead of trying to keep a step ahead of them and to anticipate their needs, one can become a better therapist. The idea that active, empathetic
listening could be just as powerful as any other therapeutic tool made an impression upon me. It changed the way I approached several of my clients.

My next client example is an older retired gentleman I worked with over several sessions. He was going through a personal crisis, as his second wife had left him for another man. The client had thought that his relationship with his wife was strong and that everything was fine. For him, this was marriage through thick or thin. He was extremely shocked and hurt when he found out that she had cheated. My client was forced to move out on his own and start all over again with new furnishings. This was a far cry from what he had envisioned for his golden years. He hated the loneliness and felt it keenly.

During the past decade, he had supported her throughout her breast cancer treatments. He had driven her to her appointments, cared for her after treatments, and was her support system. The client had respected her choice of little to no sex due to her feeling unwell from the medication she was on. However, he still felt there was intimacy in their relationship.

When he came to the office, he was in extreme distress and spent most of the first appointment in tears. He was afraid for his wife, as this other man had a reputation for being a gigolo. The client felt his wife could be taken advantage of, used, and later discarded. My client had heard a rumor that the other man had a reputation of seeing several women at once. Eventually, my client confronted the other man and felt better for it.

My role in therapy was to listen and empathize with him. He knew what he needed to do to get past the hurt, but it was helpful for him to have someone there to listen. I would ask several guiding questions during each session or ask him to expand more on a thought. There was no real direction to each session, but the overall goal was to help find ways to adjust to his new living situation and single life.
Eventually, the client decided that it was just going to take him time. He found ways to keep himself active in the community, increase his social activities, and stay connected to family and friends. We left his file open for a while so that he had the reassurance of someone who would be there to listen.

**Solution-Focused Brief Therapy**

Another therapy that I wanted to expand on was solution-focused brief therapy (SFBT). This therapy had its beginnings in the late 1970s after Steve de Shazer and his wife Insoo Kim Berg expanded on brief therapy with their colleagues. The therapist needs to present an “overall attitude [that] is positive, respectful, and hopeful” (de Shazer, Dolan et al., 2006, p. 4.) The counselor needs to believe that his or her clients have a strong resilience inside themselves with the knowledge, forte, and understanding to create change. In an interview by Victor Yalom and Bart Rubin (n.d.), Insoo Kim Berg sums up SFBT as “instead of problem solving, we focus on solution-building. Which sounds like a play on words, but it’s a profoundly different paradigm. We’re not worrying about the problems” (p. 1).

I preferred the role of the therapist in solution-focused brief therapy versus cognitive behavioral therapy. The therapist plays the role of a guide and tries to help clients broaden rather than limit their solution choices. The therapist accepts the client accept the client for who he or she is and tries to refrain from passing judgment. Sessions are not about finding the deeper meaning of the client’s issue, but rather finding positive ways to move on. Insoo Kim Berg (Yalom & Rubin, 2003): “Because we are asking them about their own plan. Not my agenda for you, but your plan. You didn’t even know you have a plan. You actually don’t when you first walk in. You tell me you have no idea what to do. And then in the process of talking, you start to gradually, through this building process, to develop a blueprint.”
Shazer (2006) wrote in his book, *More Than Miracles: The State of the Art of Solution-Focused Brief Therapy*, about the major tenants of SFBT. He starts with, “If it isn’t broken, don’t fix it,” a simple idea, but one that is quite important. He says,

Nothing would seem more absurd than to intervene upon a situation that is already resolved. While this seems obvious, in reality there are some schools of psychotherapy that would encourage therapy in spite of improvement—for example, for “growth,” to “solidify gains,” or to get to “deeper meanings and structures.” SFBT is antithetical to these. If there is no problem, there should be no therapy. (p. 1)

Shazer’s other tenants are also straightforward, such as, “If it works, do more of it” (p. 2). It’s not the role of a SFBT therapist to critique how a client is solving his or her difficulties but to encourage the client to keep up and maintain that behavior. But if it’s not doing the job, try something else. As he stated, “An odd reality of human nature is the tendency to continue to try to solve problems by repeating the same things that have not worked in the past” (p. 2).

In sessions, if a client does not follow through on or does not like a homework assignment, something else can be suggested. I found this to be the case with a few clients that I had. If they didn’t like the homework, we would change it to something easier or look at the subject from a different viewpoint. Change in clients is accomplished by one small triumph at a time; small steps eventually lead up to bigger ones. These steps, in turn, help clients move further along in therapy sessions, eventually leading to the end of therapy. The future is never set in stone, and adjustments can be made along the journey.

During client sessions, the therapist has several essential techniques to rely on. When working with several clients, I asked if they had been in similar stressful situations before. If they had, I would question what solutions had previously worked for them. If there had been
something that was effective, had they tried that solution again? Was it working, or did something else need to be tried? If they had found something, why had they stopped?

When working with clients, an SFBT clinician relies on the use of questions during sessions with their clients. There are no direct confrontations or interpretations made. Questions are future focused. During the first session of SFBT, the therapist asks the miracle question: What will be different when the problem has been resolved? After all, the long-term goal is for the client to reach his or her vision of what life will be like. Clients respond well to praise and gentle encouragement that shows them they are on the right path. Clinicians can also gently nudge a client along the right path if the client is going in the right direction but is hesitant to go down that path.

Scaling questions are also part of a solution-focused therapist’s toolbox. Questioning clients about how they are feeling now and what would have to happen to feel much better help therapists gauge their clients’ well-being. Simple scales from one to ten are simple to understand and quick to go over with clients. They also help a clinician note whether progress has been made or not from previous sessions.

There are several drawbacks to this therapy. To be effective in this approach, therapists need to take their clients and what they say in session seriously. The clients’ goals may differ from what the therapist thinks they should be working on. For example, a client may want to work on becoming more successful at work, whereas the therapist sees the real need as something else like early childhood trauma. Evan George (2010) wrote,

For the worker who has developed professionally in a culture dominated by the idea of underlying causation, this change might be hard to make and the worker will tend to be
constantly assailed with a worry that her work is superficial and failing to get to the root of the problem. (p. 1)

If the client feels that he or she has meet his or her goal in therapy but not dealt with the perceived underlying cause, the therapist has to accept that the client is done.

**Client Case #3 SFBT Approach.**

My last client example is from a case I had early in the summer. My clients were a couple who were experiencing some marital issues and decided to seek counseling. The wife had children from a previous relationship, and the husband had taken on the role of full-time dad to the three kids. To frustrate matters for them, they had to live in her parents’ basement due to financial strain. The wife was on disability due to a back injury, and the husband was on sick leave awaiting surgery. Needless to say, money was tight.

There were several issues that were also at play in their relationship. The husband had a tendency to drink heavily when he was around others who drank. Her father also drank, and her husband would drink with him. His drinking made his wife angry, as he was not a nice guy when he was intoxicated.

The husband felt she was too critical of him and harassed him over small matters. He felt that they were not on the same page about parenting and that his wife undermined his role as a dad. The husband was critical of how his wife let her teenage daughter use her cell phone long into the night. Apparently, there had been some concerns over some inappropriate texting.

My first question to both of them was whether they wanted to make the relationship work. Both answered yes and were willing to make the effort. We went on to speak about how they saw their relationship working out and what they wanted from each other. From
there, we discussed when their relationship had been working and what were they doing differently from then.

The wife mentioned that they had been more affectionate toward each other. At this point, she was sitting as far away as she could get from him on the couch. Her body language was very closed off, while his was open. She said that when they started seeing each other, they would share a notebook and write love messages to each other every day. The wife missed that and wanted to do it again.

Her spouse agreed it was a good idea and was willing to do it again. We discussed modifying the notebook to include one statement about what they were angry at the other for and one loving supporting one. The inclusion they liked, as they had trouble expressing to each other what was driving them crazy about the other without yelling.

During that first appointment, the husband agreed to go to an addictions counselor at our office. The wife was happy that he was making the commitment, and to my knowledge, he followed through. However, the husband felt he did not have an addiction to alcohol and that his spouse was exaggerating his alcohol consumption.

The couple was planning a family trip to Edmonton and agreed to start fresh. Unfortunately, the weekend did not go as planned. The husband drank excessively, and they got into a terrible fight. This information came out in their second session. However, they were willing to give the notebook another chance. By the third session, things had gone better between them. The notebook had proven successful and had opened the lines of communication between them. They found they were fighting less and not getting angry over petty matters.

During that third session, the husband addressed the parenting problems. Together in the session, they worked out a reasonable list of rules, awards, and natural consequences for each
child. Both felt like they were on the same page, finally. The couple was quite excited during that session, as they finally had found a home of their own.

Sadly, that was the last session they attended. They missed several appointments, but I did speak to the wife when she rebooked their session. She reported that the new rules were working out and that the kids were responding well to the changes. Both of them were also backing each other’s decisions. The notebook was being passed around less but was still being used when they needed to get something off their chests. I was pleased with their progress and eventually closed the file.

**Use of Therapeutic Approaches**

During my client sessions, I found myself pulling from many different therapies instead of just sticking to one type. Clients coming for counseling come in with a variety of issues, and the concept of a one-size-fits-all theoretical framework just does not work. Conforming to one form of therapy can mean a therapist is not meeting his or her client’s needs. For example, clients needing to work on deep childhood trauma may not do well working with a CBT therapist.

After meeting with a client for the first time, my decision on what therapeutic form to use was based on the client’s level of need, symptoms, and commitment to change. After several sessions, if my client was not responding to the therapy, I would try to adapt or change styles. At the end of my field hours, I came to the conclusion: that to be effective as a clinician, one needs to take the best from each therapy and, in turn, put that into practice. It is okay to specialize in one therapeutic style, but familiarity with others can only improve you as a counselor.

I had several clients who had seen a therapist before and felt that their therapist was not listening to their problems. Their previous therapists only approached their problems in one
One woman I met with had sought counseling for severe sexual trauma in the past. She had attended several sessions with another therapist who only concentrated on how she was feeling in the present. While the therapist gave her some good suggestions on daily coping, they did not address her deep wounds. Eventually, the client gave up going and did not try anything else for a period of years. Several years later, she tried counseling and was assigned to me. I felt some progress was made using some solution-focused techniques, but the client ended up missing her last sessions and did not return.

I did pull some other techniques into my work. For example, I encouraged role playing with one client, a couple who had difficulties speaking to their daughter. The daughter was creating a lot of stress and taking advantage of my client. My client was apprehensive and lacked confidence when it came to speaking up for themselves. Together, we worked on a dialogue and approach, with me playing the role of the daughter. By the end of the session, the client felt more at ease with the idea of speaking up to the daughter.

I also suggested mind–body exercises to many clients. There were several relaxation techniques—progressive muscle relaxation, anxiety coping mechanisms, meditation, and mindfulness exercises—I would demonstrate in session. I encouraged clients to start slowly and work up to longer periods with the meditation and mindfulness exercises. There was also a great iPhone app that I suggested to several clients, as it had guided mindfulness routines and tracked emotional well-being.

As previously mentioned in the CBT client case, I suggested journaling for my client. I went on to recommend this to several other clients. With the journaling, I advised clients to just write when they felt they needed to. In my own experience, I have found daily journaling tiresome, and it becomes a chore. I did not want my clients to experience something similar.
Some clients kept a journal with them and write down both the positive and negative goings-on in their lives. Most clients reported that it was helpful and would write several pages at a time when they needed to express things. I also suggested including doodles and pictures in their journals.

With many of my younger clients, I suggested using their phones to journal. Some chose to use the notes application, and others found journaling apps to use. The reason I recommended the use of the phone is because most everyone carries a smartphone these days. It’s always on hand, and most people text faster than they handwrite. The bonus is that the phone and some apps can be pass locked, ensuring privacy.

I used two other written exercises: letters and storytelling. Two of my clients had unresolved anger toward people in their lives. Due to various reasons, they were not able to confront the person who had caused the issue. I used the idea of writing a letter to the person who caused them pain, expressing all their feelings. Instead of sending it in the mail, the clients had the option to burn or destroy it.

The storytelling exercise I used with several clients who had been sexually, physically, and emotionally abused from childhood to adulthood. The concept was that the clients would retell their stories in the third person and choose a strong name for their own characters. The third-person technique was to give them some emotional distance from what was happening. Several clients found that writing the story was cathartic: Once it was written, they could close that chapter of their lives. One client chose to delete the story as they wrote it, and another kept it.
Measuring Progress with Clients

Session Tools

Measuring progress and response to sessions with clients can be difficult. Aside from what a client relates in session, the therapist has to gauge where the client is in his or her journey. The Lloydminster office includes two tools that are used before and after a counseling session to measure outcome. They are titled the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS).

The scales “are brief measures for tracking client functioning and the quality of the therapeutic alliance. Each instrument takes less than a minute for consumers to complete and for clinicians to score and interpret” (Miller, 2012, p 1). The tools are universal and designed for therapists from any theoretical background. Also, they can be adapted for the use of adults, children, or groups. The scales are now widely used by many practitioners and agencies. They have quickly replaced older scales due to the quick rating of the individual, relational, and social well-being and functioning of clients. The “outcome evaluation can be used to enlighten clinical decision-making and improve treatment effectiveness” (Miller, 2012, p 1).

The ORS examines the well-being of a client in four ways. The first measurement examines how a client is feeling on a personal level. The next is interpersonal, how the client relates to his or her family and close relationships. The third scale measures how a client is doing on a greater social level with areas like work, friends, or school. Lastly, the last scale examines how a client is relating to his or her greater world.

The SRS assesses the how the client feels his or her partnership with the clinician is going in four ways. It first examines the relationship bond and how well the client feels he or she is being heard by the therapist. The next measurement looks at the goals/topics the client
wants to address and whether they are being met in session. The third measurement addresses whether the client feels his or her therapist’s approach/methods are working. Lastly, the client rates how the session went overall.

I found the scales simple to explain to my clients and useful to gauge how things were going. Most of my clients easily understood them and did not mind filling them out. The scales are straightforward, as each section is measured using a line ten centimeters long. The client just makes a dash where he or she feels he or she is on that day. It takes seconds to measure and is easy to jot down in client notes. Any mark made to the left indicates more difficulties, while marks to the right mean fewer problems.

**Critiquing Session Tools**

Most of the time, clients had no issue filling out the forms once they were explained to them. However, there were a few sessions during which I did not ask clients to fill out the scales, especially the ORS. During those sessions, my clients were usually in emotional distress and not able to focus on anything else. To ask them to fill a form at that time I considered to be unnecessary and unwarranted. There were also a few clients who struggled to even put down a dash as to how they were feeling because they could not decide how they felt. A few clients would look to me for help to figure out how they felt, commenting that they just did not know.

Sometimes I felt uncomfortable giving the SRS to my clients, especially at the beginning of my placement. I thought my clients might feel pressured into rating me more highly than they felt I should be because they filled the form out when I was still in the room. Most often, I turned around to look at my calendar to book their next appointments. I did score many perfect ratings, but others would rate me realistically. One of the first clients rated me a near zero due to
the fact I had not read the same help book he had. That session was definitely a live-and-learn situation.

With most of my clients, I made it a point to ask them for feedback on how the sessions were going. I wanted to make sure that we were focusing on the right areas during our time together and to understand whether there was something that needed to change. I encouraged them to speak out to make sure their needs were being met and to understand what their options were if they were not. Their answers often guided me regarding what was successful and what needed to be changed.

**Length of Sessions**

Sessions are typically from forty to sixty minutes long, with children’s appointments running shorter due to their shorter attention spans. At times, the sessions can be just the right length, as clients can feel exhausted from debriefing all that is happening in their lives. There are also times when the session length is too short and clients feel cut off. It is tempting to let sessions run over when clients are upset or making headway.

Clinicians can see up to six clients per day, which can be draining. With one client after another, one needs to pay strict attention to time. Checking one’s watch becomes an art, as it can be awkward checking the clock during a meeting. It can make clients feel hurried and annoyed if they feel their therapist is clock-watching versus paying attention to them. Clients need to feel that they are being heard and acknowledged.

The number of sessions per client can vary from a single session to multiple sessions. Much of the time, it depends on how a client is progressing. Alas, only so much time can be allotted to each client. Most clinicians try to give clients four sessions and then re-evaluate. If clients need more help, often clinicians will consult their supervisors for direction.
Attempting to move clients quickly through the system in order to finish service can be stressful. One can question whether he or she is doing as much possible to help clients or just doing what he or she can do to keep up with increased caseloads. Trying to maintain the balance between old clients and new intakes can take more hours in a given day than one has. On top of this, emergency clients pop up that need immediate attention. Attempting to fit it all in is a challenge.

**Personal Thoughts on the Counseling Experience**

**Clinician and Client Relationship**

One of the largest lessons I learned this summer was the importance of the connection between the client and the therapist. Every time I met with a client, I attempted to make sure the client was comfortable and knew about our privacy and session policies. Also, I made sure the office was well equipped with several Kleenex boxes. Even just making the office a little homier with a few personal touches here and there helps client relax.

As previously mentioned in the ethics portion of this paper, I had several clients where no connection was made. With the client who was angry over my unfamiliarity with a certain self-help book, I did try to make a connection with the client. I offered to meet with the client again after reviewing the book myself. And if that failed, I could move the client to another counselor. The client never did return, and I initially had my misgivings over the situation. However, my practicum associate reminded me that you do not always win them over, and that is okay.

As with the SRS, I made sure to ask clients how they were doing and whether they felt their goals were being met during sessions. It was a good way to touch base with clients and see if they felt the tools were useful. I attempted to make sure that my clients were aware of the fact that if the sessions with me were not working, that they had the option of switching counselors.
A few people shied away from discussing how things were going at first, but with time, they would speak up.

The clinician walks a fine line between therapist and friend. On the one hand, a clinician needs to be friendly and open but still needs to be a guide. It is intimidating going for counseling when you have never done so before and you do not know what to expect. Many people were often nervous and tense until the ice was broken, and then they realized it was not an intimidating process. I saw that just casual chitchat at the beginning of a session with questions about family or work went a long way toward making a client feel comfortable and relaxed.

Sadly, clients often do not recognize that they have made any progress in therapy. Even just pointing out and praising the small steps forward helps. Praise is good for everyone and nice to hear, especially if one is not getting any from other areas in one’s life.

Many Canadians still perceive therapy as for “crazy people” or as “someone dictating to them what’s wrong in their lives.” That negative perception puts many people off counseling, and they only come when they are in crisis. My personal belief is that everyone can benefit from attending counseling, even counselors. As previously stated, mental health issues touch all of us at some point.

**Clinician and Self**

I think it is important to include a section on self-care for the clinician. I noticed in my work that most people (both client’s and clinicians) fail in this area. Women, especially, tend to neglect this area in their lives. Several women said that they feel selfish taking that time for themselves when there are other tasks that need doing. Just taking those few minutes for mindfulness and remembering to eat properly and get regular sleep can make all the difference in one’s outlook on life.
The importance of having a good working relationship with one’s agency and supervisors can not be understated. Having been in several toxic work environments in my career, I can attest that they affected the quality of my life and work. Happily, I can report that my time at the Lloydminster office was a great experience: I felt included and that my ideas were valued. My practicum associate was a great support and made sure I had the resources to succeed.

**Concluding Thoughts**

This paper has summarized my journey as an MSW practicum student with the Lloydminster Mental Health and Addictions Services office. In the pursuit of my degree, I was able to expand and gain confidence in my skills as a social worker and have become a better practitioner because of it. Throughout my practicum, I have strengthened my counseling skills, theoretical knowledge, and increased my awareness of mental health issues. I understand how the importance of a strong connection between counselor and client is needed to help move the counseling progress forward.

Under the guidance of my practicum associate and his team, I have gained more assurance in my skills and ability to meet the needs of my clients. This experience was more than I could have hoped for, and it helped me find my niche as a social worker. It has made me examine who I am and who I want to be as a social worker. I now have a job that I love and look forward to coming in each day to meet the challenges that await me.
References


