CLINICAL REFLECTIONS:
CLIENT DIRECTED OUTCOME INFORMED PRACTICE

By

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Abstract

In this report I synthesize the skills and knowledge I gained through a clinical practicum at Touchstone Family Association. I present two metaphors to conceptualize therapeutic change. The first model conceptualizes the therapeutic process as a geography introduced by the client to the counsellor. The second model conceptualizes the relationship between thought, emotion, and behaviour as a framework to help me visualize the client as they move towards change. These reflections are supported by a literature that finds that positive therapeutic outcomes are attributed to context and relationship.

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positive outcomes. Norcross & Wampold (2011) describe effective therapy as the result of evidence-based therapy *relationships* and evidence-based *treatments* adapted to each patient's disorder and characteristics. The treatment is secondary to the quality of relationship.

In order to prioritize the client instead of theory I will share two conceptual models that I use to organize the theory and technique that underpin my practice. Metaphor permeates this paper. This way of thinking reflects the creative ways my mind works as I learn ways to effectively join and work with clients to bring helpful theories and techniques into each session. The first model, the 'clinical geography,' reveals the principles that drive the course of therapy from a Client Directed Outcome Informed (CDOI) perspective. The second model likens people to plants to help me orient to the client's thoughts, emotions, and behaviours.

These models provide the framework to understand people within the contexts and relationships of their lives (Bishop, 2002; Mullaly, 2002; Zapf, 2009). This is akin to examining the health of a leaf by looking at the tree and the forest that the leaf is a part. To further this metaphor, trees literally share sugars, nutrients, and chemical signals directly through naturally grafted roots and mycorrhizal networks (Henry & Quinby, 2010). Although not apparent to the casual observer, the health of a leaf is related to the overall health of the forest.

More complex examples of the interconnected nature of ecological systems exist in the marine based nitrogen found in core samples of western hemlock in the Pacific Northwest. Up to 24% of core samples contain a particular nitrogen isotope found only in marine sources, namely salmon (Reimchen & Mathewson, 2002). There is a direct

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Introduction

Outcome informed therapy is the result of broad research into the factors that contribute to positive therapeutic outcomes. Rosenzweig (2002) first presented the idea in 1936 that factors common across all theoretical approaches account for positive outcomes and require attention. Contemporary meta-analysis research demonstrates that positive therapeutic outcomes are primarily the result of extratherapeutic factors including events in the client's life (Wampold, 2011). The therapeutic alliance and the client's expectancy of change are the next most significant factors (Wampold, 2001). Less than 1% of change is attributed to a particular technique or approach (Norcross & Wampold, 2011; Wampold, 2001).

Similar to Rosenzweig's (2002) prediction, the common factors of a safe therapeutic alliance, collaboration, and working from the client's frame of reference account more towards positive outcomes than theory or technique (Duncan & Moynihan, 1994). Approaching clinical work from this outcome informed perspective prioritizes relationship and uses the client's frame of reference in a collaborative process towards change. These outcome informed findings are congruent with critics of psychotherapy. Collier (2006) warns that the limited adoption of Freudian psychology contributes to individual pathology. The medical model is not designed to recognize the systemic determinants of health. Duran and Duran (1995) describe psychology as "objectification… [and] nothing but ongoing social control and hegemony" (p.7). Decades of therapist and theory driven interventions, advanced research techniques and clinical trials suggest that factors common to all therapeutic approaches are significant for

positive outcomes. Norcross & Wampold (2011) describe effective therapy as the result of evidence-based therapy *relationships* and evidence-based *treatments* adapted to each patient's disorder and characteristics. The treatment is secondary to the quality of relationship.

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connection between the health of a needle of a western hemlock and the abundance of spawning salmon through a number of complex relationships.

Human well-being is similarly influenced by numerous relationships. People have historical, social, economic, interpersonal, and intrapersonal experiences and perceptions. One of the largest differences between humans and trees is the human ability to communicate with language. Instead of taking samples of heartwood to understand the nutrient cycles of a tree, humans are able to talk and explore the relationships that affect their health. Talk therapy is one way that people engage in change.

The therapeutic process is guided by goals agreeable to client and counsellor. Similar to a tree in a forest deciding where to grow a new branch to catch sunlight, effective change results from a strong therapeutic alliance, clear goals, and a process of creating an appropriate course of action. Nutrients, sunlight, and environmental factors contribute to the growth of a tree while goals, resources, and support can contribute to a client's desired change.

Chapter One

Heading South

I reinsured my 1987 Volkswagen Jetta and headed south on highway 97 from Prince George to Richmond. The route follows the approximate contours of the Fraser River. For the last two years I have enjoyed living downstream from the confluence of the Fraser and Nechako rivers. Prince George is a historical place where water and people have met for over a thousand years. The L'hedli T'enneh people called this place home long before there were railways and highways. My destination was the town of Ladner,

now part of South Delta, on the southern side of where the Fraser meets the Pacific Ocean. Despite the distance I felt connected to my partner Laura in Prince George in my new home.

Driving south in early April was an accelerated experience of spring. I noticed the ice break up on the cottonwood river, though the lakes held on to their ice as large frozen lily pads and the shadows of trees held the remaining patches of snow. Further south, the snow was replaced by new grass. This is the season where both snowmobiles and canoes are seen in the backs of trucks on the highways.

Clear cuts are seen along both sides of the highway. These swaths of missing forest are accounted for in the log yards and piles of pulp, at the numerous mills throughout the interior. The forest is sawn and chipped to become lumber, particle board, and paper. Both raw logs and finished products are shipped by road and rail to the ports of Prince Rupert, Squamish, and Vancouver.

I see an economic model that breaks down the complexity of a forest into the smallest components to be reshaped into particleboard, laminated beams, paper, and cardboard. In a social sense, Cree scholar Michael Hart (2002) describes social work in similar ways, as ontological imperialism characterized by systems predicated on "breaking ecologies down into the smallest ideas, objects and/or events possible, so that each part can be classified and defined" (p. 29).

Now, to be fair, I am biased. Many people are employed and most people perceive the forest industry as prosperous. I paid for my undergraduate degree by planting trees spending up to 14-hour days in cut blocks and forest roads. But, there's a

beauty for me in wholeness. I will take a moment to explain the coffee table that I made with my partner Laura and my dad as an example.

When I was young I lived with my family in Port Hardy, a small industry based community on the north end of Vancouver Island. In the mid 1980's my dad found an unusually large Arbutus tree washed up on the beach after a storm. Arbutus wood is notorious for being difficult to work with as it is warps and splits as it dries. An enthusiastic carpenter, my dad milled this tree into boards with his chainsaw. We moved these planks with us over the next three decades before taking the time to turn it into a unique, beautiful table.

People often touch the table upon entering our house. The time we spent working the wood enhances the intricate designs, colours, and shape of the Arbutus. As friends and family appreciate the table, our invested time becomes opportunities for story.

I began contemplating working with people in ways that respond to individual needs and strengths. The time we invested brought a unique beauty, function, and meaning that is incomparable to a table made from 2X4 and plywood. Just as time and intention brought the coffee table into being, how can I work with people to create change in their own unique circumstances? The social disintegration characteristic of resource based towns (Schmidt, 2000) is similar to the trauma experienced by the forest and the trees. Can this explain people's reluctance to seek counselling, as a fear of being 'run through the mill'? I aspire to work with people in ways that realize the unique beauty, needs, and abilities of each person I work with.

Rationale for Practicum

Social work professionals take multiple roles and capacities including policy, group therapy, community development, and individual counselling (Collier, 2006). My interest in working with individuals, groups, and families, through TFA is to advance my clinical skills and synthesize a practice framework that reflects the structural, social, and historic influences on people's functioning. Working at TFA has proven to be an incredible opportunity to experience growth and to set me on a trajectory of continued learning throughout my career.

Goals for Growth

Two broad goals frame my intended learning. The first, was to engage in clinical work to strengthen my clinical skills through practice. The second, was to create a practice framework to help guide my clinical understanding and confidence. This was partially motivated by Duran's (2006) description that assumptions and biases become "shadows" that are unknowingly projected as pathology (p.37). I hoped to become better able to help people and not be overwhelmed by clients' intense circumstances or experiences. Using metaphor to model the therapeutic process helped orient me to appropriate clinical judgments.

These learning goals were conducive to the CDOI approach I had been immersed in at TFA. This initial goal to create an ontological model became focused on the ways that the clinical process was shaped to help the client realize change in their life.

My Theory of Change

Goals exist within an implicit theory of change. In my case I had proposed that a combination of practice, reflection, supervision, workshops, and report writing would

facilitate my development as a counsellor. This was an effective theory of change as evidenced by the increasing density of my clinical sense and my ability to work with complex clients towards positive outcomes. Exploring a client's theory of change has proven to be an incredibly valuable tool that I have learned during my practicum.

As I became aware of my own theory of change I saw the reasons I have pursued this degree with increasing clarity. I had difficulty accessing professional development and clinical skills in my prior work life. When I began this program, I pursued coursework and practicums to guide my clinical development. The experience of recognizing my own implicit theory of change has empowered me to recognize and address client's theory of change. This is important as sometimes a person's theory of change may contribute to the problems that they face. I feel more competent as a counsellor now that I am able to recognize the disadvantageous role that a person's theory of change can play in their change process.

Limitations of the Study

This is a reflective report of my practicum experience and is not meant to be instructional or authoritative. As a written document this report represents the reflections and perspectives that I have had during the summer of 2013. I anticipate rereading this report in the years and decades to come as a snapshot of my development and perspectives at this point in my life.

Definition of Terms

There are a number of terms used to describe helping professionals throughout this report. Barker (2003) broadly defines a counsellor as a professional or volunteer who provides counselling services. Barker defines a therapist as a professional who "has had

extensive training and supervised experience and often uses specialized techniques, tools, medications and resources" (p. 434). Therapist is commonly used in the literature and is used throughout this paper as a reflection of the literature. I identify as a counsellor.

The therapeutic process is described in the literature in numerous ways including counselling, therapy, and psychotherapy. Barker (2003) defines counselling as a "procedure" often used in clinical social work to guide individuals, families, groups, and communities by giving advice, delineating alternatives, articulating goals, and providing information (Barker, 2003, p. 100). Therapy is defined as a systematic process designed to remedy or cure some disease, disability, or problem (Barker, 2003). Psychotherapy connotes expertise of a therapist trained in specific types of psychotherapy to which a "therapeutic relationship is established to help resolve symptoms of mental disorder, psychosocial stress, relationship problems, and difficulties coping in the social environment" (Barker, 2003, p. 349).

The therapeutic work I've been part of during my practicum at TFA is defined in parts of each of these definitions, as the work takes place in an intentional therapeutic alliance, is systematic, and involves individuals, couples, and families. These terms will be used synonymously throughout the paper to describe the nature of my work at TFA.

Multiple names are ascribed to the people accessing counselling. Client is most commonly used at TFA to describe an individual, couple, or family engaged in counselling. Patient is used in a medical context and appears in the literature. I prefer to use the term client or person. It is important for me to acknowledge clients as people, as the work happens between people, not technicians and problems. Both client and person will be used to identify the individuals and families that I work with.

Writing Style

I've chosen to write this report in the first person to situate this information as part of my story. This is important to me, as I do not see a benefit in pursuing objective truth. I embrace the inevitable subjectivity of experience and the ongoing creation of multiple truths. Eric Maisel (2012) suggests that people have difficulty accepting meaning in their psychological experience out of an innate fear that there isn't more to life than this. "They would rather that meaning reside somewhere, even if they can't access that place or understand it, than to have it live right inside them as an artifact of existence" (Maisel, 2012, p. 69). This report is part of my story and perspectives of the human experience.

The reflective process of this practicum report is conducive to pushing many of the norms present in the dominant vernacular epitomized by the Diagnostic and Statistical Manual (DSM) of mental disorders (APA, 2000). Clients and therapists are both human. Both may have degrees and diagnosis. Duran (2006) describes diagnosis as a naming ceremony that can contribute to difficulty and hardship. The casual voice I write with is my attempt to be human and accessible. Power hides in the ways words work together by holding assumptions that perpetuate certain truths as universal. It is my hope that there is space for the reader to interact with these words and be aware of this.

I use metaphor throughout this paper to communicate complex ideas and meanings. Psychology is saturated with metaphor in order to describe the human experience. Duran (2006) reminds the reader that psyche, feeling, soul, depression, and anxiety are all ways of describing the human experience. Metaphor can be useful in therapy by engaging creativity and effectively naming complex experiences (Witztum,

Hart, & Friedman, 1988). Metaphor can be introduced by either client or counsellor to deepen and describe the human experience.

It is not my intention to convince the reader of anything. In an interview with Hall (2007) respected Okanagan Elder Jeanette Armstrong describes a dialogue tool that communicates how I aspire to communicate with these words. The name of the tool, "naw'qinwixw" (p. 8), describes water dripping really slowly, one drop at a time. This water is dropping onto the top of the head, or mountain. This action of dripping water onto the head is a mutual process that people do for each other to put knowledge into each other's mind in a way that is a slow infusion into the whole system of thought (Armstrong & Hall).

Throughout this report I draw parallels between social, psychological, and ecological experiences. I will compare the mountaineering skills and intuition that I use while hiking to the clinical sensibilities I have learning to use to navigate through each client's clinical geography. Just as water responds predictably to gravity shaping the land and plants seek the energy of sunlight, there are clinical principles that inform effective therapeutic processes that support people in creating desired change. I invite you to join me creatively in the hopes of meeting each other in the complexity of human experience as gardeners working to nurture and support the growth of unique and unknown plants.

Chapter Two

Touchstone Family Association

TFA provides individual, family, and group counselling in the community of Richmond BC. As a non-profit, community based agency, TFA offers counselling and

conflict resolution to the community through partnerships with MCFD, Richmond family police, Richmond addiction services, and the solicitor general of BC. As part of the family preservation and reunification team I worked with non-mandated clients. I received clinical supervision from Grant Grobman, a registered clinical psychologist, and participated in regular team meetings.

Client Directed Outcome Informed Practice

Outcome informed therapy evaluates clinical interventions as measured by positive change of the therapeutic process. Therapy is more effective than non-treatment, however there is contention concerning what is responsible for these positive outcomes (Wampold, 2001). Medical model studies designed to test the efficacy of therapeutic approaches provide inconclusive results, while contextual understandings of therapy suggest that factors common to all therapies attribute to positive outcomes (Wampold, 2001). Medical model studies typically compare different therapies and techniques to discern evidence towards a theory or technique effective for particular client demographics. These studies seek to demonstrate effective therapy by isolating active therapeutic principles. Clinical trials are conducted with manualized treatment procedures to determine effective treatment approaches. Techniques and theories have been compared and tested for efficacy for decades.

In an article first published in 1936 Rosenzweig (2002) suggested that factors common to all therapies were responsible for change. Rosenzweig suggests that the complexity of psychological events overwhelms any one theoretical interpretation. Instead of searching for a conclusive theory he suggests that all therapies are relevant to a greater, or lesser degree, and are worth consideration.

Rosenzweig's (2002) perception of common factors of therapy continues to be explored in recent meta-analysis'. A meta-analysis conducted by Wampold, Mondin, Moody, Stich, Benson, and Ahn (1997) found little difference in outcomes between therapies. This meta-analysis included studies directly comparing two or more specific psychotherapeutic treatments selected from reputable journals between 1970 and 1995. Studies were selected for statistical relevance. Psychotherapies were considered relevant if administered by a masters degree clinician working with a treatment plan tailored to the patient. Treatments had to be described within the article with reference to psychological processes, a treatment manual must have been used to guide the psychotherapy, and the active ingredients of the treatment defined and referenced.

Wampold et al. (1997) found minimal difference between therapeutic approaches or technique. Similar to Rosenzweig's (2002) earlier suggestion, the findings suggest that less than 1% of outcomes are attributable to the psychotherapeutic approach used (Wampold et al., 1997). The authors conclude, however, that "it is not appropriate to conclude that every treatment is equally effective with every patient" (Wampold et al., 1997, p. 211).

Improper research design can confuse the effect of common factors with a clinician's efficacy. Studies that attribute change to particular approach or technique are unable to account for therapist effects (Wampold, 2001). Studies designed to account for therapist effect reduce the significance of approach and technique to insignificant levels. Therapist effects are attributed 6 – 9% of outcome, while 1% or d = .20 is attributed to therapeutic approach (Wampold, 2001).

Lambert and Barley (2001) present a breakdown of therapeutic factors that contribute to positive outcomes. The largest factor (40%) is attributed to factors outside of therapy (Knight, 2012; Lambert & Barley, 2001; Martin, Garske, & Davis, 2000). These extratherapeutic factors include spontaneous remission, fortuitous events, social supports, and situational changes. Common factors account for 30% of change. Common factors are defined as the client's perception of safety, trust, and connection in the therapeutic alliance. It is important to note that the working alliance is the single largest factor within the clinician's control to affect positive change in this regard. Specific techniques account for 15% of outcome while the remaining 15% is attributed to the client's perspective of hope and expectancy for change (Duncan & Sparks, 2002; Lambert & Barley, 2001).

These findings are considered to be unscientific and simplistic by Wampold (2001). Through extensive meta-analysis Wampold (2001) attributes the majority of change (87%) to extratherapeutic factors. The remaining 13% attributed to psychotherapy is attributed to common factors (70%), specific effects (8%), leaving the remaining 22% unrelated to any specific ingredient. Wampold (2001) emphasizes the significance that technique and theory account for less than 1% of change of the 13% of outcomes attributed to the therapeutic encounter.

For example an American study examined the efficacy of CBT, Interpersonal Psychotherapy (IPT), imipramine, and a control group of case management (Wampold, 2001). The research was conducted at three sites with therapists trained in each modality. Manuals were used to standardize treatments of large sample size. "In spite of the large samples" Wampold reports, "none of the differences between the treatments vaguely

approached significance" (p. 107). The reported effect size for completers favoured IPT by 0.13. Individual variables ranged in effect size from 0.02 to 0.29 (Wampold, 2001). Relatively equal numbers of people benefited from each approach, including placebo conditions, medication, and therapy, leaving inconclusive results.

Client perceptions of the therapeutic alliance are related to outcome. The most advanced clinical trial conducted in 1996 found correlation between early and mean ratings of therapeutic alliance, related to positive outcomes (Wampold, 2001). The patient rating of the therapeutic alliance on the third session accounted for 8% of variance in outcome, while the mean alliance rating accounted for 21% of variance in outcome (Wampold, 2001). Treatment type accounted for 2% of outcome variance, though this is a weak finding as the study included a case management control group.

Most recently the American Psychological Association (APA) conducted a meta-analysis with a panel of experts to reach a consensus on the consistency of the numerous meta-analyses (Norcross & Wampold, 2011). This meta-analysis required studies to have: (a) a minimum number of supportive studies, (b) consistent results, (c) a measure of the magnitude of positive relationship between therapeutic element and outcome, (d) a direct link between element and outcome, (e) experimental rigor, and (f) external validity.

The task force found that low quality alliance when working with individuals, lack of cohesion in group therapy, and discordance with couples or families, characterize poor outcomes (Norcross & Wampold, 2011). Clinical trials that pit one therapy against another in a quest to find the best approach are no longer relevant. Effective therapy is the function of an inclusive, evolving therapeutic alliance. It is within this relationship that technique and approach become effective. Best practice is no longer centered around

the therapist and their knowledge, but a relational process realized by working with the client.

The strongest finding from the APA study were that adapting the therapeutic relationship to particular patient characteristics and diagnosis enhance treatment efficacy. Adaptation to the client reactance/resistance, preference, culture and religion/spirituality increased positive outcomes from therapy. Adaption to clients' stages of change and coping styles were found to be probably effective. Adaption to client expectations and attachement style did not possess sufficient research to substantiate efficacy (Norcross & Wampold, 2011). The task force concludes that "concurrent use of evidence-based therapy relationships and evidence-based tretments adapted to the patient's disorder and characteristics is likely to generate the best outcome" (Norcross & Wampold, 2011, p. 129).

Clinical trials that involve manual based 'pure' approaches to attend to a single disorder do not reflect psychotherapy in real life practice (Duncan, 2002). Norcross and Wampold (2011) comments that "given the large number of factors contributing to treatment outcome and the inherent complexity of psychotherapy, we do not expect larger, overpowering effects of any single facet" (p. 131). There are a number of helpful facets that have small and medium effects towards outcome in the form of adapting therapy to the person seeking help.

Prioritizing the common factors of therapy helps clients create endogenous change rather than theory driven change of the medical model (Duncan, 2002). By creating space for the client's voice throughout the course of therapy the client:

> emerges as a thinking, deciding agent whose deliberations about his or her life and the best course of action are reasonable and well executed, a part of a never-ending story with many possible conclusions (Duncan, 2002, p. 50).

Evaluating therapy by positive outcomes clearly reveals that relationship and collaboration with client are of utmost importance.

Duncan and Moynihan (1994) emphasize the significance of using the client's frame of reference to guide the therapeutic process. Successful outcomes are realized by working from the client's informal theory about their situation. This includes the client's thoughts, beliefs, attitudes, and feelings about the nature of their problem. Effective therapy is the result of a creative process in which technique is embedded within the therapeutic relationship that prioritizes collaboration between counsellor and client before techniques or theories. This is the central tenant to CDOI therapy.

Duncan (2002) describes this as a shift from expert technician to collaborative healer. Change results from within the client with the help of the counsellor rather than theory. Duncan suggests that the counsellor must hold the client as central to the therapeutic process in order to access the endogenous knowledge, strengths, and expertise of the client, which outweigh any model or technique. Working collaboratively, the client is able to bring an incredible amount of extratherapeutic knowledge into session. This increases clinical efficacy as the clinician has increased access to 87% of extratherapeutic factors attributed to change (Wampold, 2001).

My experience working from a CDOI approach at TFA has concretized my previously intuitive priority of relationship and curiosity. Counselling is not a treatment

dispensed by a professional to a patient, but a process of change that is entered into by client and therapist working together as allies (Duncan & Sparks, 2002).

An experience during supervision early in my practicum accelerated my understanding of CDOI in my practice. I described to Grant, my supervisor, how I helped a client connect with a deep emotion during a first session. I felt proud. At the time I thought that helping people become in touch with themselves as an obvious success. Grant simply commented that he was curious if this would be helpful for the client to make change in his life.

I stopped in my tracks as I realized that I acted on an assumed theory of change. I became aware that I assumed that emotional experience and insight leads to growth and change. This deepened awareness allowed me to better access a level of conversation with clients to discuss their own theory of change. Being aware of this assumption enables me to engage in conversation that increases collaboration and strengthens the therapeutic alliance. Speaking at this level is particularly important as an assumed theory of change can contribute to the problem. Working from the client's frame of reference facilitates change (Duncan & Moynihan, 1994).

Therapeutic Alliance

Yalom (2002) describes the primacy of the therapeutic alliance by stating "nothing takes precedence over the care and maintenance of my relationship to the patient" (p. 9). Research substantiates the importance of a strong therapeutic alliance. Anker, Owen, Duncan, and Sparks (2010) find significant relationship between therapeutic alliance and therapy outcomes. Lambert and Barley (2001) similarly find a positive association between a safe, warm, and secure therapeutic alliance and positive

therapeutic outcomes. These common factors are more strongly related to outcome than specialized treatment interventions. A therapist's congruency, unconditional positive regard, and accurate empathic understanding, encourages a therapeutic relationship that facilitates the potential for change and development.

An experienced TFA clinician discussed with me the importance of being inspired by the people that I work with. "If you can't find something in the person that inspires you, that you can love about them" she said, "then they are better off working with somebody else". This was a profound thought for me. Accessing a respect for the person, especially if they are a 'difficult client', is a positive source of energy to work from. I can think of a client I worked with in the past in which his ability to survive was the aspect that I loved about him despite the ways that he challenged me. Duncan (2002) supports this sentiment by urging the reader to refuse jargon and labeling in order to involve clients as equal, worthy, and essential parts of the treatment team. Working from a place of genuine love and respect is part of the foundation to achieve collaboration.

Person-centered therapy shares some principles with a CDOI approach. Carl Rogers (1965) articulates the need for clients to realize autonomy and self-determination in their lives and in session. This requires a belief in the client's inherent capacity to "move away from maladjustment and toward psychological health" (Corey, 2009, p. 169). Yalom (2002) describes the self-actualizing force within the client as an acorn. Given the opportunity to sprout and mature an acorn becomes an oak tree. The therapist helps create the space for growth by reducing and removing obstacles while the client directs the process of growth. The therapist must believe that the client knows, just as the acorn, how to grow.

The person, not the problem, is the focus. Rogers (1965) emphasizes the necessity of a strong therapeutic alliance to effectively realize change. The collaborative structure of therapy empowers the client to affect positive change as they draw on internal resources rather than seeking external answers. Change emerges as the client gains insight and ability to access inner resources (Lambert & Barley, 2001). A person "more in contact with what they are experiencing at the present moment, less bound in the past", writes Corey (2009), is "freer to make decisions, and increasingly trusting in themselves to manage their own lives" (p. 172). In this way health describes being centered in one's life.

Outcome Rating Scale

TFA uses two tools to help the client be at the center of therapy: the Outcome Rating Scale (ORS) (Appendix A), and Session Rating Scale (SRS) (Appendix B). The ORS is used at the beginning of each session to measure the client's previous week related to their goals of service. This guides the therapeutic process relative to the client's identified goals (Miller, Duncan, Brown, Sparks, & Claud, 2003). The SRS is used at the end of each session to evaluate the quality of therapeutic alliance (Duncan et al., 2003; Martin et al., 2000). The client evaluates the therapeutic process and alliance to facilitate feedback for the clinician and create accountability (Duncan, 2002). Duncan (2011) presents these in a manual designed to help front line clinicians adopt evidence based scales.

The ORS is structured in four scales with a cumulative score of 40 (Appendix A). The ORS is used in each session throughout the course of therapy, which creates a visual graph of the client's subjective change in relation to their goals. Duncan (2011) describes

a requisite culture of feedback with the client. This means that the practitioner must genuinely believe that the client's perceptions and theories of change matter.

Duncan (2011) describes the ORS as "a bare skeleton to which clients must add the flesh and blood of their experience, into which they breathe life with their perceptions" (p. 24). The four bare bone scales measure 1) individual, 2) relational, 3) social, and 4) overall well-being. Scores are totaled and tracked on a graph. Over time a trajectory of change emerges which can be helpful in recognizing the work that has taken place over time that may not feel apparent to the client at any particular moment. At the beginning of each session the client and I use the ORS as a touchstone to evaluate the previous week in terms of their goals in relation to the graphed trajectory of change since their intake. An online version of the tool automatically graphs the scores over the course of therapy.

Downward trends can be a rich source of information. The online instrument allows for a view of each scale over the course of treatment. "I notice that you have ranked yourself a little lower than last week, and it seems like the family scale moved from 7.8 last week to 4.5, does this make sense to you?" It has been my experience that this simple tool can help clients remain goal centered, increasing the efficiency and potency of their work.

Research supports the efficacy of these tools. Norsworthy and Rowlands (2009) conducted a study with 74 therapists. Each therapist acted as their own control measuring client outcomes without using feedback measures, and then using the ORS and SRS. Repeated use of the measures resulted in statistically significant improvements of $d = 0.51$ and $d = 0.49$ compared with non-use.

Session Rating Scale

Client perceptions of therapist-provided variables are the most consistent predictor of improvement (Duncan & Moynihan, 1994). For this reason the SRS was developed to be a thermometer that measures the temperature of the therapeutic alliance (Duncan, 2011). The tool is structured the same as the ORS and the four scales evaluate the relationship, goals and topics, approach and method, and overall connection (Appendix B). The SRS is completed at the end of each session. Each scale is marked intuitively by the client on and is graphed over the course of therapy.

Scores are similarly calculated out of a possible 40 points and graphed over the course of therapy. This graph is a touchstone to chart differences between sessions to guide the therapeutic process in a direction that leads to change. There is a cut off line at 36/40 that is considered to be the range for a positive alliance. Instances where the alliance is rated below that mark are discussed to improve the ways you are working together. This epitomizes the culture of feedback as it normalizes immediacy and being able to talk through dynamics in the therapeutic alliance. An alliance that strengthens over time is a significant predictor of positive outcomes (Duncan, 2011).

Chapter Three

Methodology

In the spirit of relationship reflected in CDOI approaches to therapy that value the humanness of the therapeutic alliance I have engaged in a personal reflective practice over the duration of this practicum to distil my learning. Montigny (2011) champions reflective social relations as a living practice to discover and explore the nuances and

contradictions of one's interactions. I have reflected in a number of ways, including journaling, supervision, peer supervision, watching my taped sessions, poetry, research, and conversation with colleagues.

This open, reflective, process has honoured the complexity of my experience and the people that I've worked with. I have embraced a reflective practice that has allowed me to encounter and learn about myself. This ability to see myself in new ways is an attribute that will continue with my practice as a self reflective counsellor.

The writing of this report is a culmination of these reflective processes and the events of my days. This includes sitting with clients, co-facilitating a restorative justice circle, attending workshops, supervision, and clinical meetings. Supervision with Grant Grobman proved to be one of the most accelerating components of growth and reflection.

I took the opportunity to review and reflect on a number of clinical resources. These were each largely new to me and the intention of including them in this report helps me incorporate them into my practice by deepening my understanding through writing. These include a parent child play resource (Bratton, Landreth, Kellam, & Blackard, 2006), collaborative problem solving (Greene et al., 2004; Greene, Ablon, & Goring, 2003), the Duluth model, motivational interviewing (Miller & Rollnick, 2002), and aboriginal approaches to healing (Duran, 2006; Hart, 2002).

Chapter Four

Literature Review

Effective therapy requires more than a safe therapeutic alliance, just as Yalom's (2002) acorn requires more than soil and water to germinate and mature into the

giant oak trees I picture in my mind. Mental health, personal growth, and maturation are shaped by appropriate interventions within trusting, stable relationships. Just as soil amendments are an ineffective response for an oak sapling overgrazed by foraging deer, communication techniques may be ineffective with a person who lacks the ability to self-regulate. Effective interventions appropriately address the needs of the person by starting with the client's perception of the problem and their informal theory of change.

The parallel of plants and people is helpful for me as it sensitizes me to the historical context of each person I work with. When certain plants in my vegetable garden are struggling I respond with the knowledge I have to shape the environment to be conducive for its particular needs. When there is crop failure, I investigate the environmental variables over the course of the seasons, to make sense of the plant's struggle. There are a number of ways to contextualize people in their lives. Attachment theory makes sense of human infant needs for stable attuned parenting (Neufeld & Maté, 2004). Trauma informed approaches understand the effects of disrupted attachments and the neurological affects of chronic stress, anxiety, and abuse (Haskell & Randall, 2009; Van der Kolk, 2009). Families are similarly understood as emotional systems that shape a child's self concept and relationship with the world. We will look at these theoretical underpinnings to understand people within their life course. Just as it is unrealistic to expect a plant to thrive despite environmental or experiential adversity, this literature informs the helper to the needs and functions of the people I work with.

Attachment Theory. Attachment theory understands the nature of parent-child, adolescent, and adult relationships. Children need physical, emotional, and psychological proximity early in life. Attuned parenting provides external emotional regulation for a

child where parents mirror containing and accepting feelings as an important and worthy aspect of a child's self. Children raised in safe, predictable relationships characteristically mature into adults able to maintain stable relationships, exercise conflict resolution skills, and demonstrate self-confidence (Maté, 2008). Neufeld and Maté (2004) describe attachment being "at the heart of relationships and social functioning" (p. 16).

Positive attachment with one's primary caregivers creates the foundation for a child's ability to self-regulate. It is important to note that 80% of a child's brain development occurs during the first year of life (Maté, 2008). Predictable attuned parenting facilitates this development.

An absence of attuned parenting adversely affects a child's ability to develop a healthy self-concept and capacity to self-regulate. This can manifest as difficulty maintaining relationships as a child and as an adult. The lack of capacity places children at a disadvantage to mature into healthy adults and are associated with an increased likelihood of adverse experiences later in life (Tafet & Bernardini, 2003).

Attachment styles established in childhood are predictive of adult health. Bifulco et al. (2006) find a predictive relationship between insecure attachment styles during childhood and adult mental health disorders. "Even adults who are relatively self-orienting can feel a bit lost when not in contact with the person in their lives who functions as their working compass point" (Neufeld & Maté, 2004, p. 19). In a study examining stress responses in adults, Levine and Heller (2011) test the affects of adult attachment between adult partners by giving an electrical shock to one partner alone and with the company of their partner. The experiment measured participant's blood pressure, heart rate, hormones, and rate of respiration as they received an electrical shock. All of

the measured physiological indicators were reduced when participants held their partner's hand when receiving the shock (Levine & Heller, 2011).

Attachment theory has been used to understand intergenerational trauma. Haskell and Randall (2009) describe the complex trauma resulting from Indian Residential Schools (IRS) as a "social context, complex trauma" (p. 74). Indigenous people across Canada have survived the disrupted attachment of IRS in numerous ways. Alcohol and substance misuse is understood to be a prevalent way of surviving (Braveheart & DeBruyn, 2000). The volatile environments and relationships created by these psychological coping mechanisms perpetuate adverse experiences for the next generation.

Contextualizing maladaptive behaviours challenges pathology and creates opportunities for genuine healing interventions. Disrupted attachments can present in a myriad of ways as children mature into adults. To understand symptoms as maladaptive behaviors and coping behaviors focuses interventions to address a person's inability to self-regulate in the context of a person's life. Left unnamed, this pattern can be confusing and contribute to further cultural dysfunction (Duran, 2006). From this attachment perspective parental behavior is not assumed to be rational choice but a reflection of the parent's psychological needs and coping behaviors. Therapeutic experiences that bring choice, direction, and meaning, offer an opportunity to build the necessary skills to live in new ways.

Complex Trauma. Adverse Childhood Experiences (ACE) are characteristically intense, persistent, or uncontrollable situations of threat or distress. ACE in a child's attachment bond are described as complex trauma (Van der Kolk, 2009). Complex trauma has a dual effect of creating heightened emotion while reducing one's ability to

self-regulate and be secure in the world (Maté, 2008). Heightened emotions, combined with a decreased ability to self regulate, can lead to maladaptive behaviours such as substance abuse (Maté, 2008), mental health (Van der Kolk, 2001, 2006, 2009), and antisocial behaviours, including violence (Courtois, 2008; Mikulincer & Shaver, 2008). Heuser and Hinrich-Lammers (2003) find that the perception of threat can cause a stress reaction that leads to a heightened internal experience. Tafet and Bernardini (2003) find a strong correlation between experiences of chronic stress, anxiety disorders, and major depression.

A longitudinal primate study of three groups of mother-infant pairs illustrates the intergenerational effects of chronic stress. Each group of mother-infant pairs lived with different abilities to acquire food. One environment had consistently easy foraging, another consistently difficult foraging, and a third, unpredictable food supplies. The stress experienced by mothers in the unpredictable situation exhibited inconsistent, dismissive, and erratic rearing behaviours (Maté, 2008). The infants of these mothers grew up to be anxious, less social, and highly reactive adults while the infants in the consistently easy and difficult environments matured into healthy adults. The environmental conditions became emotional experiences of disrupted attachment, which increases the likelihood of further emotional distance in the next generation.

Experiences over time shape the ways our brains develop and function. Chronic stress affects the limbic system and the Hypothalamo-Pituitary-Adrenal (HPA) system. The limbic system is the emotional center. Real, or perceived, experiences of chronic stress over stimulate the system causing emotional dysregulation (Tafet & Bernadini, 2003; Van der Kolk, 2006). This leads to compromised rational functioning and a

decreased ability to appraise social situations, evaluate coping strategies, implement appropriate responses, or retrieve information (Taffet & Bernardini, 2003).

Similar to the way that mature oak trees are able to access enough sunlight, moisture, nutrients and withstand environmental adversity, people withstand adversity through various coping mechanisms that may include spiritual practices, substance use, community support, or isolation. Experiences of complex trauma are akin to damage suffered by a sapling that alter the pattern of growth and compromise the structure of the plant later in life. Children account for psychological damage and are able to survive, and thrive, in adverse situations. Certain measures of psychological protection are condoned by society. These include workaholism, drinking alcohol to excess, and indulgence of television and movies. Other measures that include aggressive behaviour, intravenous drug use, and sexual promiscuity are viewed as personal character flaws (Maté, 2008). All of these behaviours make sense in the context of each person's life. Limiting pathology and engaging with people curiously is the first step to becoming helpful.

A controlled study of the impacts of prenatal stress and fetal alcohol exposure of primate infants found that these early stressors contribute to altered biological substrates, gene expression, and brain functioning that significantly alters an individual's development trajectory (Schneider, Moore, Kraemer, Roberts, & DeJesus, 2002). The effects of these developmental disturbances present as decreased attention spans, reduced mobility and exploration, increased irritability, and altered stress responses. The prenatally stressed monkeys were less resilient under social and environmental stress as they showed disturbance behaviours of clinging to peers, decreased exploration, and decreased time used for play. Two hours after stressful experiences the chronically

stressed group had elevated cortisol levels while the control group did not. (Schneider et al., 2002).

The Paraventricular Hypothalamus (PVA) is responsible for releasing cortisol into the body. This natural stress response is mediated by natural feedback loops that help a person relax after a stressful event (Heuser & Hinrich Lammers, 2003). Chronic stress disables this natural system that aids self-regulation, causing hyper arousal and an inability to self-regulate (Maté, 2008). Mood altering behaviours and substance use engages the dopamine system to relieve the anxious experience of hyperarousal (Weinschenk, 2012). This can develop into a need to maintain a 'high'.

Family Systems. Attachment patterns can be understood within the family as an emotional system (Brown, 1999, 2008; Dattilio, 2006; Farmer & Geller, 2005). Functional families are characterized by emotionally differentiated members able to experience and resolve emotions and conflict. Platt and Skowron (2012) describe differentiation as the "intrapsychic… ability to separate thoughts from feelings, and the ability on an interpersonal level to balance intimacy and autonomy with others" (p. 37).

Dysfunctional family systems create chronic stress or anxiety in the undifferentiated persons (Bartle-Haring, Rosen, & Stith, 2002). This anxiety is generally expressed in three ways, including emotional reactivity, emotional cutoff, and emotional fusion with other (Hooper & DePuy, 2010).

The most basic family structure is a triangle. Triangulation is a key concept that describes a process by which a dyad, typically a couple, will include a third person, typically a child, as an emotional reference point. This is normal human functioning, however the third member of the triad risks becoming involved in unhealthy ways by

becoming enmeshed, losing a differentiated sense of self, or receiving projections (Farmer & Geller, 2005). Any change in the system will cause further change with the eventual goal of healthy differentiation (Brown, 1999).

This systems approach may expand our frame of reference from the well-being of a single tree to that of an ecological system. In this way we can see salmon in the trees. Interventions address relational patterns within the system to foster healthy development. It is not necessary to work with the 'problem' member of the family to help the system change to achieve symptom relief. Healthy emotional differentiation between family members is the goal of therapy. This is marked by less reactivity, self-responsibility, and emotional freedom (Brown, 1999).

Schwartz (1995) applies this family system understanding to make sense of personal psychology as the inner systems and outer systems tend to mirror each other. In an interview with Pedigo (1996) Schwartz describes how a person's internal functioning naturally reflects their family system, which is a reflection of larger social structures. Just as a family is composed of numerous people, individuals are an aggregate of parts rather than a cohesive whole. Working with an individual requires working with each part of the person as one would work with a member of a family.

A fictitious example to illustrate this approach may be a man named Jason who attends counselling at the request of his girlfriend. She describes Jason as emotionally closed, silly, and unable to engage in conversation. Jason grew up with a father addicted to alcohol. Jason develops a keen awareness of social cues that led to difficulty creating trusting friendships. Jason's withdrawn nature was adaptive within his family, but contributed to hardship later in his life. There is a part of Jason that hesitates being

vulnerable. There is another part that seeks intimacy and wants to belong and be accepted.

Each part is imbued with its own knowledge, aspirations, reactions, and intentions. Schwartz believes that helping a client reorganize and differentiate these internal relationships brings relief and clarity (Pedigo, 1996). To improve the boundary around a subsystem improves the function of that subsystem. From an IFS understanding the goal is to locate the parts of a client in order to differentiate the self by reorganizing their internal system of parts and to help release parts from extreme positions (Schwartz, 1995). The internal system of parts are understood to play one of three roles; managers, exiles, and firefighters.

Managers keep the person safe. This is the part of our internal system that make sure that the system (self) remains balanced and functioning. In Jason's case, the manager is the part that keeps people at arm's length to ensure that he would not be vulnerable. This is the funny part of Jason. Jason uses humour to ensure that exiled parts do not disrupt the self. Exiles are perceived as dangerous so managers control the outside world as best they can to ensure that exiles are controlled. Managers don't take risks.

There is a part of Jason that needs to make jokes, which help him feel at ease. Another internal part wishes that he could simply relax and get to know his friends rather than horse around all the time. Jason's exiled part may be the boy who wants to be accepted and safe. There are parts of Jason that perceive that he will be judged and firefighters come to put out the danger. This may be the part of Jason that gives up and runs away. Real or perceived danger of the exiled part being activated is responded to by

the part that is too cool. "Forget this, see you later" may be the way Jason makes sure he isn't hurt by the world.

Approaching clients as a cumulative of parts can facilitate an exploration of internal ambivalence, conflict, or discord. This takes the form of interviewing and exploring the numerous parts of a person rather than the individual as a concrete whole. The relation between parts is the aggregate experience of the person. Interviewing the parts of a person can help resolve discord between parts.

To recognize and differentiate their "parts" helps the client reorganize their internal system to function appropriate to situations (Pedigo, 1996). Just as strengthening boundaries in a family's subsystem facilitates improved functioning of that subsystem, helping an individual differentiate internal conflict between parts of themselves brings relief and new possibilities for change and growth.

Exploring the different parts of a person normalizes ambivalence and accepts internal contradictions. It is important to prioritize safety and connection it is thought that parts will emerge through conversation. Parts can also be named and invited into session. For example a counsellor may make a reflection such as

> "it seems that a part of you really needs me to know how hard you've worked in the past to succeed. Can we talk to that part of you that is fighting so hard to be heard, your confident part, and give her space to talk?"

The conversation may continue to explore when this confident part comes out. When does the confident part get to speak? With whom? Psychological parts can be humanized and given characteristics such as knowledge, intuition, decisiveness, intention, and reaction.

"What does the confident part want for you?"

"When does the fighting part of you know when to speak up?"

"When does your confident part get smaller?"

These questions personify traits and characteristics as parts giving focus to differentiate parts of one's self. Just as a differentiated family is able to find resolve a differentiated individual can find clarity and relief by acknowledging and understanding their parts.

I have noticed the normalizing effect of interviewing the parts of a person. For example, speaking with a client:

Counsellor: "so there's a part of you that seems to be frustrated and angry with your boss that makes it tempting to work from home, and there's another part that wants to be in the office because he really cares about your staff."

Client: "yeah, this might sound contradictory, but there's a part of me that want's nothing to do with those two people, but another part that cares about my staff."

We continued to explore these contradicting parts. Being able to normalize the client's internal conflict creates space for him to increase insight and approach resolve. This client attributed his strengthened relationship with his son to the resolve he made with this professional dilemma.

My thoughts about IFS remind me of the novel Life of Pi (Martel, 2001). The story follows the journey of a boy and a tiger that coexist in a life raft for a number of weeks. Despite the animosity and danger of this pairing they find ways to coexist. In the final chapter the main character suggests that the story is a psychological metaphor of surviving himself while being at sea. The tiger represents a violent, angry, and conflicted

part of himself. Although this part is dangerous, to kill a part of his self is to kill his whole self. The boy credits the intense animosity to his survival. This story reminds me the importance of normalizing and expecting multiple parts of a clients as a source for identifying and nurturing client's motivation.

Chapter Five

Model 1: Clinical Geography

In order to hold the client in the center of the therapeutic process I conceptualize the counselling process as a walk through a forest. This allows me to conceptualize the course of therapy in relation to the client while drawing from relevant theory within the context of the therapeutic alliance. This includes the client's frame of reference, perception of the problem, resources, and motivation. The landscape, plants, and animals of their geography represent the factors and dynamics that constitute the client's situation. These may include the client's perceptions, resources, relationships, and psyche. I visualize the client in their geography both in session and while writing case notes to inform the course of therapy.

The client's desired outcome is the destination of the hike, which is the top of the mountain. The client's theory of change is the route they choose to get there. By walking this path together the client and I have opportunity to learn about the obstacles and opportunities of their psychological landscape. Together we explore opportunities and setbacks involved in each path. Again I want to note that I help the client lead this process, and that I follow in a spirit of curiosity.

Figure 1.

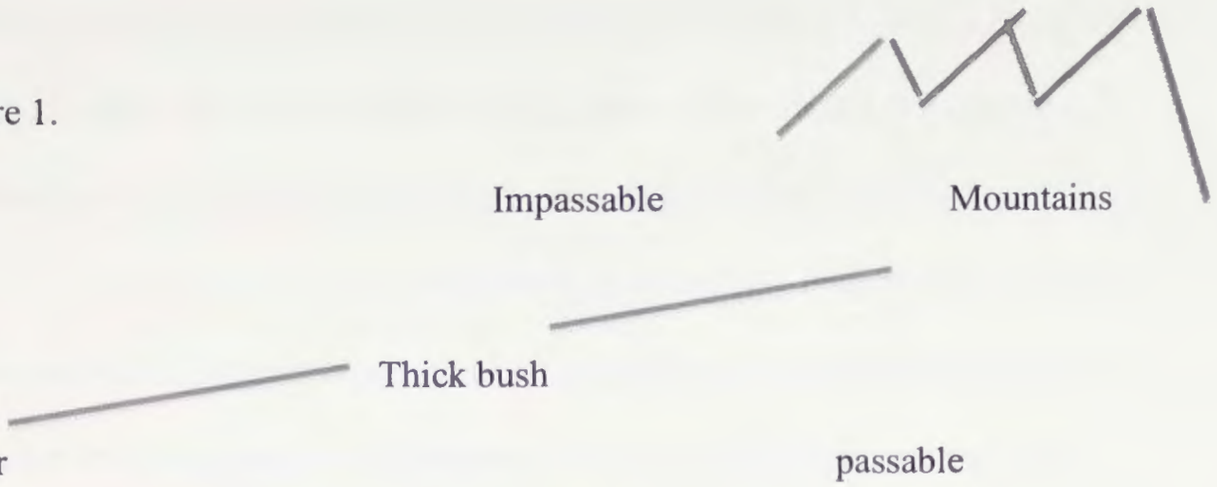

Figure 1. represents the clinical geography in which the client and counsellor work towards desired outcomes represented by a mountain peak. There are obstacles and difficulties to achieve goals. This conceptual model helps frame the process of therapy.

The way a person behaves in their geography is a rich source for curiosity. Reflecting, questioning, or exploring these can shape the process towards the client's goals. A client, for example, was pointing out numerous examples of how her son had misbehaved in the previous week. I perceived this to be similar to her examining numerous plants despite stating that she wants to hike to the mountaintop. I questioned how naming numerous examples helped us work towards her goal and she realized a pattern of thinking that contributed to part of the reason that she felt overwhelmed with her son. We chose one example to work with and refocused our work.

The client's theory of change may not result in their desired outcome, or perpetuate the situation they are trying to change. This creates opportunity to select a new route. There is a trust and safety built through the therapeutic process whereby a number of clients have asked me for advice. Others come to alternative approaches on their own, and with others the process of exploring informs multiple small changes that can result in desired outcomes.

There is part of me that wants to have a map of what to do and where to go with the clients I work with, like a GPS unit in a car, to guide and track the therapeutic process. A theory driven approach can be precarious if they cease to function or an unanticipated event happens. A number of years ago, when GPS units became available for outdoor enthusiasts, I heard a report on CBC radio of a group of snowmobilers who became lost after travelling over 100 kilometers. The group had been tracking their journey on a single GPS device and had not been using common sense by noticing landmarks or using intuition. Their device stopped working and the group became lost for a considerable amount of time.

Tools can be useful, but they must be used within a wider set of skills. Duncan and Sparks (2002) conclude that good rapport is insufficient to achieve positive results. Similarly, skills without rapport are ineffective. Technical skills embedded within a good therapeutic alliance make for effective therapy. This is akin to using mountaineering sensibilities in combination with GPS technology.

A GPS, map, plant identification book, hiking boots, and a snack are useful in their own ways. Using these resources with common mountaineering principles creates a safe, enjoyable experience that will lead to a view. Mountaineering principles are learned and intuitive ways of knowing how to move across the land. By understanding the way water shapes a landscape, one will have a sense of where impassable or dangerous areas may be. It will also be evident where the bush will be too thick for easy travel.

The SRS measures the alliance of the hikers, giving opportunity to communicate if the relationship needs to be attended to (Appendix A). The ORS facilitates a conversation about the direction of travel (Appendix B). An Individualized Service Plan

(ISP) is created with each client early in the therapeutic process at TFA to guide the course of therapy. The ISP consists of two or three goals with a brief plan for each. This becomes the individualized map for each client. The plans and specific goals chart our route to the desired outcome.

I have found that client's goals must be used as invaluable tools to focus the clinical work in ways that hold the client responsible. For example a client struggling with being overwhelmed by numerous events in her life would present numerous tangential thoughts as she spoke in session. By reflecting this behavior within her goal to sleep better we were able to focus on addressing her perseverating thought patterns in session as they related to one of the main reasons she attributed to her poor sleep, her thoughts.

Despite having difficulty creating change on their own, the client is the best person to introduce me to their perspectives, experiences, and knowledge. Curious inquiry can deepen the work as the client's way of being in session communicates the ways they are in their life. Attending to the meta-communication contributes to both building the therapeutic alliance and becoming comfortable with the client's unique geography. It is through multiple strains and vulnerabilities that intimacy is created between client and counselor. As the client shares past experiences of change, obstacles to growth, and precipitating factors, I gain valuable insight into their geography. This collaborative route finding process is the heart of a CDOI approach.

The client is in the best position to be the expert, and learning how to access this knowledge increases the efficacy of therapy. For example a client wanted to improve communication with his son. During the fourth session the client began talking about

stress at work. This seemed to me that we were heading away from his goal. I inquired how work place stress is related to our work together. The client identified perseverating thoughts contribute to his irritability and relationship with his son. This deep belief in equality and fairness underpinned his dissatisfaction at work and ran through his head in the form of stressful conversations at home for the previous three months.

As we continued working together the heart of the workplace stress revolved around competition with a colleague about a promotion. He didn't really want the job as it required more managerial work, but he also didn't want to see his colleague receive a promotion. By forcing his ambivalence the client came to realize that he did not wish to pursue the promotion. The next week the client rated a higher ORS score, which he attributed to reduced workplace anxiety and an experience of having fun and joking around with his son.

Previous to this session we had been exploring communication techniques and parenting styles without significant changes in the ORS. The right kind of change required me to step back and listen to the client's own understanding of what was in the way of achieving his goal and moving from where he was stuck, not where I perceived he was stuck. By trusting the client in his own geography we were able to move towards his goal in a way that worked for him.

By exploring the tangential nature of work place stress in relation to his expressed parenting goals we located a significant source of stress that contributed to his short fuse at home. Working from a motivational interviewing frame of reference empowered him to make a decision that freed up emotional space to pursue positive family interactions. By stepping out of the way of directing therapy and holding him accountable to his goals

I witnessed movement and growth. By orienting the process towards his goal, he intuitively knew what needed to change. Honouring the client as guide helped us access the appropriate path towards his goal.

Effective goals can drive the therapeutic process in ways that access the problem solving capabilities of a client to explore and achieve change otherwise unknown to the clinician. Paterson, Alden, and Koch (2006) outline an effective way of creating successful goals using the client's theory of change. This training is offered across British Columbia and a copy of the audio lecture and course package was made available to me.

Goal Setting. Paterson et al. (2006) frame change as an intentional goal oriented process to change thoughts and actions. Problems can be seen as ultimate goals. Complaints contain goals. 'I'm totally out of shape' can be reframed by saying 'I want to feel fit'. This outcome to feel fit is the mountain destination of model 1. A number of immediate goals will lead to achieving this. Immediate goals sensitize the person to the actual changes that they are making that will coalesce into meeting their desired outcome. The acronym SMART is used to frame appropriate goals. SMART stands for; specific, my own, action oriented, realistic, and time defined.

Specific goals require a single step to achieve. The example of going for a bike ride is used in the lecture as an example of a big goal. This goal is made into an immediate goal by specifying a new goal of pumping the tires of the bike.

Successful goals are 'my own'. This has two parts. The goal needs to be made by the person who is going bike riding. Second, the goal must be possible to accomplish without the involvement of others. For example, to ride bikes with Gertrude, requires Gertrude's participation. A 'my own' goal would be, to invite Gertrude on a bike ride.

Action oriented goals require doing, which is different than feeling, or thinking. Goals will likely not feel enjoyable or exciting. Paterson et al. (2006) emphasize this point and suggest giving oneself permission to accept one's feelings as they arise as the goal is to do. This is exemplified by a goal of taking a relaxing bath. The goal needs to be to take a bath.

Realistic goals have clear and achievable finish lines. Without clear behavioural achievements any goal could be considered a failure. Defining a clear finish line in behavioural terms creates an end point for a goal. Once the bicycle tires are pumped and it may be realistic to go for a bike ride. A realistic goal may be to ride my bicycle for 5 minutes.

Time defined goals are particularly useful to contain vague goals. If the bicycle required more maintenance than the pumping up of the tires a SMART goal may be to spend twenty minutes to check bike and make a list of tasks. Time defined goals invite particular time frames to make goals more specific such as, I will ask Gertrude to go for a bike ride on Tuesday.

This acronym may seem simple as presented here in the examples of Gertrude and Reggie, however, it is the simplicity that contributes to its effectiveness. SMART goals are realistic because they require action from the person who makes the goal. People become powerful when able to exercise abilities within their locus of control.

Reflections. Early in the practicum I spoke with a TFA counsellor about how I enjoy using the ORS with clients. I described how it helped me remain goal specific. He asked a question that disarmed me. "So how did you work with clients before?"

As I write this report I cannot imagine working without clear goals. I have come to appreciate the way collaborating with clients to make effective goals creates space to explore and shape a person's theory of change. This is of particular importance because this theory of change can contribute to the presenting problem. Take, for example, a person who wants to communicate better with his son. This is a great goal. However if their expectation is that the son needs to get their act together, stop using drugs, and receive a haircut to show some respect, then the parent has an unhelpful theory of change that will likely not assist with communication.

Goal-oriented conversation can create space to explore the client's assumed theory of change.

Counsellor: So your goal is to communicate with your son in a calm way?

Client: Yes, the arguing isn't good, and we often end up yelling at each other.

Counsellor: how do you imagine getting from yelling to communicating?

Client: well, I'm not sure, I guess I need help thinking about how to communicate without blaming him, because he always says I don't understand what he's going through. I also have so much anger at his dad, and he just needs to calm down.

Counsellor: so learning some communication skills and working through some anger are two ways that you imagine moving you towards better communication with your son?

Client: yeah…

Counsellor: I'm going to write these ideas down as part of our plan to realize your goal to communicate with your son. As we're thinking of ways to do this we need to remember that our plans need to be within your control. I get the sense that

your son can contribute to the reason that the arguments happen and are so intense, but if we wait for him to change, who knows how long it'll be before things change at home.

Client: yeah, I do want him to change, but I guess it's important for me to learn how to not get triggered by his anger and disrespect when we're talking.

Counsellor: certainly. Parenting is like a thermostat not a thermometer. You will be more effective if you're able to set and stabilize the emotional climate in the house, rather than react and match your son's 'temperature'.

Slowing down the process to create a collaborative plan represents an invaluable learning that I am taking from this experience. I am grateful for these experiences and I feel more effective in my work. These conversations frame the therapeutic process and non-confrontational approaches described as beneficial by Norcross and Wampold (2011).

The client is at home in their psychological geography and as a curious visitor the counsellor can gain insight into the client's frame of reference. Just as I would ask somebody about a plant in their garden I inquire about people's experiences. "what was that like moving to Canada by yourself?" "What's there for you when you see your son struggling?" Curious questions may be self-explanatory, however the point is not to know, but to give opportunity for the client to name and process their experience.

Trust is built and maintained through genuine curiosity. Approaching therapy as a series of opportunities to explore with the client can be a process that builds intimacy and connection. The whole idea of talk therapy is to be able to talk through change. This process often reveals possible incongruencies between emotions and cognitions, which may contribute to the presenting problem. Understanding the desired outcomes from the

client's frame of reference and theory of change unearth rich opportunities to create change. Effective goals mobilize a client's perceptions, resources, and opportunities to culminate in genuine change.

Through my work at TFA I have had opportunities to learn how to use tools such as MI, CPS, and IFS to help people navigate their psychological ecologies. Technique and theory enhance my confidence and ability to remain focused while working with clients. I'm not expected to know all of the answers or be an expert. I don't need to know all of the plants to reach the destination of a hike. It is through the process of therapy that I have learned to work with the client to access the necessary information and detail within the goal driven process. I have gained skills, but more importantly I have learned how and when to use them while working with people.

Chapter Six

Resource Analysis

Below are a number of resources that I have explored over the duration of the time that I've spent at TFA. It is important to note that theory and technique are used in relationship with each client. I find an increased potency by adapting these resources within the context of each client rather than using the pure form in a psychoeducational manner. The principles are adopted for each person in the language, metaphor, and therapeutic alliance. I have drawn on these resources while working with clients.

Child Parent Relationship Therapy. Bratton, Landreth, Kellam, and Blackard, (2006) author a child parent relationship resource called Child Parent Relationship Therapy (CPRT). This ten-week series of groups' help parents relate with their children

in developmentally supportive ways. The parent is an emotional thermostat, not a thermometer. Through structured playtimes the parent learns how to respond to their child instead of reacting to the child. Working within the attachment relationship empowers the child to discover their passions and develop into their own, unique, differentiated self.

A structured weekly 30-minute playtime is the environment to empower the child to be at the center of his or her life (Appendix C). The physical and emotional environment is critical for a child and parent to realize an emotionally stable environment. Bratton et al. (2006) describe that "when a child is drowning, don't try to teach her to swim" (p. 21). The structured playtime is the opportunity to 'learn how to swim' in a predictable, regulated space.

Parents are guided to create a safe, uninterrupted space to play on a blanket with special toys. Parents are supported through the training program to join with their child as a follower and use basic reflecting skills to verbally track the child's play. Parents describe what they see their child do, feel, and think. It is important to recognize the child's power and effort. Limits are firm and consistent, including the time limit regardless if the child wishes to continue playing.

Limits are presented as "if – then" choices. This helps the child learn consequences to certain behaviours. Bratton et al. (2006) give the example that "if you choose to use the play dough on the floor then you choose not to play with the play dough for the rest of the day". Inappropriate behaviour is addressed through the acronym ACT, which stands for acknowledge, communicate, and target. For example, 'Simon, (A) I see you want to swim in the puddle, but (C) I'm concerned that you may hurt yourself, (T)

let's play on the grass with the ball instead'. As a rule each part of this communication should be ten words or less, specific, and behavioural in order, for communication to be effective.

Bratton et al. (2006) describe the absence of limits as an insecure experience. The special playtime is an environment in which children experience safety through consistent, predictable, limits so that everyday coping behaviours become unnecessary. Children may act out to achieve the stability and safety they need to feel safe. Competitive or disruptive behaviours seldom lead to security, or safety for others, and can perpetuate unsafe and unpredictable environments.

Developmentally appropriate choices are given to create opportunities for a child to exercise their agency. "Big choices for big kids, little choices for little kids" (Bratton et al., 2006, p. 39). An example may be, 'do you want to wear green or turquoise to school today' rather than 'what do you want to wear'. Age appropriate choices empower children to facilitate a measure of control over their circumstances. "Children who feel more empowered and 'in control' are more capable of regulating their own behaviour, a prerequisite for self-control" (Bratton et al., 2006, p. 41). Choice giving also facilitates the development of the child's conscience, as children have opportunities to learn from their mistakes, they learn to weigh decisions based on possible consequences" (p. 41).

The importance of honouring a child's choice is paramount. "Never do for a child that which he can do for himself" (Bratton et al., 2006, p. 51). Parents must ensure that they are willing to live by their child's choice. Choices must not be given in ways that manipulate the child to choose the will of the parent. Creating opportunities for the child

to make choices creates opportunities for the child to develop feelings of positive self-esteem, competence, and usefulness.

Through play the parent learns about their child's competencies and personality. The goal is for the child to experience and engage with the world as an autonomous person. Play helps children experience curiosity through this process of discovery and problem solving facilitated by the parent. Play is an opportunity to catch and nurture the spark of a child's interest to develop passion for life. Praise is given to encourage the child's effort and process rather than the product.

Parents similarly learn about themselves through the process of containing the play experience. This is described as being an emotional thermostat instead of a thermometer. Rather than matching the child's emotions, the parent learns to accept, reflect, and contain the child in their experience. A child's experience of hearing their parent's emotional reflections fosters emotional insight foundational for developing self-concept and emotional regulation.

Collaborative Problem Solving. I had the opportunity to attend a one-day training with Ross Greene. I had already been influenced by Greene's Collaborative Problem Solving (CPS) approach as I had read three articles (Greene, Ablon, & Goring, 2003; Greene et al., 2004; Wolff, Greene, & Ollendick, 2008) and accessed online lectures through Greene's non-profit organization: livesinthebalance.org.

The opportunity to engage with Ross was an illuminating experience that helped organize my thoughts around disruptive and maladaptive behaviours and how to engage in effective change making processes. The effectiveness of this approach is evidenced by a study conducted with children diagnosed with oppositional defiant disorder (Greene et

al., 2004). Two parent child groups were used to compare CPS with parent training. Better outcomes were reported for CPS at end of treatment and four-month post treatment, which points to the benefit of addressing behaviour relationally.

Collaborative Problem Solving (CPS) understands problematic behaviours as symptoms of a person's unsolved problems and lagging skills. Behaviour-based interventions are ineffective because behaviours are symptoms, not causes. Greene assumes people succeed when they have the skills to meet the demands of their environment. Maladaptive behaviours result from an environment that demands more skills than an individual has. This difference between demands and skills is describes as an unsolved problem.

Understanding a person's perspective of the unsolved problem is the first step to understanding how to solve the problem. Problems are defined in specific behavioural terms. We will use the example of an eager student that regularly disrupts her social studies class. The teacher sets a time and place to meet with the student that allows for privacy and genuine communication. This first step requires naming the student's behaviour in order to explore their experience. The question may be framed like this; "Jane, you seem to have difficulty raising your hand in social studies, what's up?" Notice that the observation is framed in terms of the expected behaviour of raising one's hand before speaking. This is different than "Jane, you are calling out answers, what's up?" where the undesirable behaviour is named without the specific context of social studies. Worse yet, would be to confuse Jane with her behavior by saying, "Jane, you are an impulsive student, what's up?" A statement like this will likely lead to a defensive reaction and lead away from collaboration.

Greene describes this process of exploring the person's concerns as 'drilling'. Without a clear idea of Jane's perception a mutually agreeable solution is not possible. Drilling is important to get Jane's concerns and perceptions of the unsolved problem on the table. Jane may identify a need to succeed as the cause for her behaviour by saying "well I don't usually understand my other courses, and I just get so excited to prove that I understand social studies and I want a good mark". Deepening the conversation may result by reflecting the ineffectiveness of the behaviour. "Well, judging by the amount of time you spend in the principal's office doesn't make it seem like shouting out the answers is helping your marks". The conversation continues until a lagging skill is identified.

Once Jane's concerns are expressed the teacher's concerns are presented in specific behavioural terms. The teacher may say "while I appreciate your eagerness in class Jane, I am concerned that other students have difficulty focusing when you speak before it is your turn". This statement is void of blaming, or making Jane wrong. The goal is for both parties to be able to talk about the behaviour in curious ways to eliminate the need for the behaviour in the first place. Durable change is the result of both people cooperating in solutions.

Both versions combine to define the unsolved problem. With both Jane and the teacher's problems on the table they are now able to generate a plan to help her succeed. The teacher may start this part of the conversation by saying "I wonder if there is a way …" This is the time to brainstorm solutions that are mutually agreeable and reflect both people's needs.

A new range of possibilities emerge from this collaborative approach to solving problems rather than simply addressing the negative behaviours. Jane may suggest that sitting closer to the teacher during social studies may help her maintain focus and have less of a need to seek the teacher's attention by blurting out answers. This is significantly different then the teacher unilaterally deciding to move Jane to the front that may contribute to animosity, or resentment, towards the teacher. By being part of the solution Jane is better able to work towards her own goals that mutually benefit the teacher and the class.

They may try this solution and it may not work, however the trust and empathy established through the collaborative process better positions them to succeed. This contributes to a stronger relationship and creates a foundation to discuss new solutions. Engaging in the process is a success and movement towards positive change.

Durable solutions emerge by addressing the skills required for Jane to succeed in the social studies classroom. In addition to strengthening the relationship between teacher and student, Jane experiences opportunities to grow and learn the skills she is lacking through the process. In concert with strategies to help Jane succeed, the strengthened relationships and skills will mitigate or eliminate further situations of inappropriate behaviours. This won't happen overnight, however through the process of solving problems Jane and the teacher will develop approaches that work for the class, for the teacher, and for Jane.

Jane's principle lagging skill is difficulty considering the consequences of her actions. She also has difficulty interpreting social cues and classroom rules. Social studies

may be one of a number of places that Jane struggles. Learning the skills to handle social studies will affect her ability to self-regulate in other areas of her life.

I am inspired by this approach that transforms a hierarchal relationship of parent/child, counsellor/client, or teacher/student into a cooperative relationship of shared responsibilities and rights. Each person has the responsibility to succeed and the right to be involved in planning for success. Establishing a respect for both people's autonomy creates the opportunity to help a struggling person succeed, it strengthens the relationship, and affirms independent self-concepts.

I perceive CPS as a maturation process whereby people become autonomous, communicative, problem-solving individuals operating from their own agency and unique place in the world. Through this process people may become aware of where one's self ends and the other begins. This may be part of a foundational understanding of empathy that underpins personal interdependent autonomy.

More extreme behaviours such as swearing, blackmail, or assault, are more severe, than the example of Jane. CPS may not always be appropriate, but healing and negotiation are possible when conflicting needs and lagging skills are addressed. Built on principles of sovereignty, interdependence, and self-responsibility, experiences of CPS may inform the next generation to become healthy members of society.

Duluth Model. A series of wheels developed by the domestic abuse intervention program in Duluth, Minnesota. These psycho-educational tools are accessible online and are useful in naming the ways power is exerted through the ways people relate. Identifying coercion and power is presented as a critical component of changing

manipulative or abusive behaviour. An equal number of wheels address healthy and abusive characteristics of relationship.

The wheels suggest that perpetrators engage intentional patterns that maintain power and control in relationships. Use of force and the threat of force characterize the power and control wheel. These include coercion, intimidation, isolation, minimizing, denying, blaming, withholding finances, and cultural norms of masculine domination. Each of these behaviours denies an implied independence, or sovereignty, of the partner to exist as his or her own unique person in the world.

The equality wheel presents approaches to relationship that honour difference and demand responsibility, which respects the other person's right to be their own person. This includes behaviours such as negotiation, listening, creating safety, support, accepting responsibility for self, sharing parental responsibility, mutual agreement, and making decisions together. It is important for both partners to engage in simultaneous change from a confrontational 'power over' way of being to a 'power with' way of being.

Two wheels focus on abuse and nurturing relationships with children. Threats, intimidation, isolation, put downs, using adult privilege, and withholding basic needs are all inappropriate ways to control a child's behaviour. Manipulative interactions with children disrespect a child's inherent right to be their individual person. The nurturing children wheel explicitly names the right for children to have their own feelings, friends, activities, and opinions. The caregiver is held responsible to contribute to create genuine physical and emotional safety for the child.

Power permeates all relationships. The Duluth model is a psychoeducational approach to challenging unhealthy behaviour. Dutton and Corvo (2007) thoroughly

critique the Duluth model as an ineffective and clinically unsound approach to interpersonal violence (IPV). As a psychoeducational approach the model assumes IPV results from gender norms and the rational actions of men against women to maintain power and control. "Evidence that patriarchal beliefs cause violence has very little empirical support" (Dutton & Corvo, 2007, p. 662). Personality disturbance is a better predictor of IPV than gender. This is evidenced by the recently released Shoenborn report following the murder of three children by their mentally unstable father in 2008 (RCY, 2012).

Dutton and Corvo (2007) are also critical of the implicit assumption that IPV is a unilateral flow of violence from a perpetrator to a victim. This simplistic view of IPV does not represent the relational nature of IPV. Dutton and Corvo suggest IPV is better understood as mutual violence as evidenced by a national survey conducted by stets and Straus (1992). Behaviours are not entirely rational. The things a person does reflects cultural norms, neurobiological development, interpersonal and intimate relationships, and destructive behaviours that result from early trauma experiences (Courtois, 2008). Van der Kolk (2009) sites a study that reports 75% of perpetrators of child sexual abuse report to have been sexually abused in their own childhood (p. 3). These characteristics are considered comorbid conditions rather than part of a comprehensive exploration of the antecedents of IPV to inform effective interventions. This is not to excuse behavior, but to challenge simplistic understandings of IPV that inform ineffective interventions.

I appreciate the way that the Duluth model present abuse as the transgression of a person's autonomy to be an independent life force. Framing power in terms of the responsibility to nurture, support and create safety for those in one's care is an excellent

starting point for an intervention. However therapeutic interventions require more than content based conversations. If IPV results from more entrenched personal and interpersonal patterns of escalation then psycho education will remain ineffective. I agree that it is important to critically address the normative power that men hold in Canadian society, however Dutton and Corvo's (2007) suggestion that the Duluth model lacks a therapeutic process to change the perpetrators intrapersonal reality and the interpersonal reality of the couple.

Psychoeducation is insufficient to alter the relational patterns of IPV and the etiology of emotional dysregulation that perpetuate instances of abuse. Despite the useful content of the Duluth model, psychoeducation is inadequate to create meaningful change. Dutton and Corvo (2007) suggest that the 50% recidivism rate by one such group is unacceptable. They cite a CBT approach to working with perpetrators of IPV that achieved a 16% recidivism rate based on wives reports at 2.5 years post treatment. A 21% recidivism rate 11 years prior to completion based on police reports (Dutton and Corvo, 2007).

Aboriginal Approaches to Health. Cree social work scholar Michael Hart (2002) frames healing as a journey towards mino-pimatisiwin. This concept is described in numerous ways that capture a complex understanding of the good life. Mino-pimatisiwin is broadly characterized by non-interference, non-judgement, and self-determination. The colonial process is based on principles of greed, self-righteousness, and dominion over others. Health and healing happen in simultaneous ways emerging from individual and collective change that interacts to create social change within families and nations. The way towards health and wholeness is to change and resist the

colonial forces as Hart (2002) writes "they are forced upon us but as they exude from us" (p. 34). Health and healing are simultaneously directed by external and internal realms where each individual is at once autonomous and a part of family, community, and nation.

Collective responsibility is addressed throughout Hart's (2002) findings. "Self-gratification, envy and jealousy must be replaced with support and a commitment to one another" (p. 33). The way to transcend greed, self-righteousness, and dominion is to ensure that that "children must once again be placed in the centre of the family, community and nation" (p. 33). There is a deep sense of the communal nature of mino-pimatisiwin that is realized through each individual person's ability to live a good life based on interdependence, humility, and self-determination.

The good life is understood as social and ecological balance at national, community, family, and individual levels. Imbalance, disconnection, and disharmony are dynamic forces that require sustained interventions to create and maintain balance. Individuals are responsible to pursue health in their own lives and contribute to environments that sustain and perpetuate health. "When the cycles directly involving people are in harmony, people are utilizing their own volition – hence power – to help themselves heal, learn and grow" (Hart, 2002, p. 53). Over this time the healing journey contributes to greater power and support for others to engage in healing, learning, and growth. The inseparable nature of individual and collective well-being and the collective goal to realize a good life is unique to other approaches.

Eduardo Duran (2006) describes diagnosis as a naming ceremony in which patients become inflicted with a new identity of being sick that saturates their

psychological makeup. This differs from the purpose of traditional naming ceremonies that aim to "restore a relationship with the energy of the sickness instead of the fearful antagonistic purpose of diagnosis in Western healing" (Duran, 2006, p. 32).

Drawing from conversations and experiences with traditional healers, Hart (2002) defines healing as a movement from disconnection to connection. Connections within a person's thoughts and emotions describe individual health. Social well-being is realized when healthy individuals relate with others in non-interfering autonomous ways. In this way personal well-being is central to realizing collective harmony and health in traditional healing.

This relation between individual and collective health is a continuous process that occurs in cycles in response to development. As external cycles in a person's life are in harmony, a person becomes more effective in utilizing their own volition to engage in learning, growing, and healing. A good life describes this life long process of maturing in physical, emotional, spiritual, and mental aspects throughout a community. Well-being is understood from an inward focus of an individual through to interpersonal healing between people. Collective health is a function of individual health.

Particular healing interventions are communal in nature and take the form of circles. Four types of circles are described as talking circles, sharing circles, healing circles, and spiritual circles. This approach to healing and health is described as a cyclical system that creates an atmosphere of cooperation and equality. The mutuality and support within the circle is the environment in which everyone becomes able to make change in their own life. Acceptance, humility, autonomy, and self-determination provide the foundation for circle work. This principle of autonomy and self-determination is the

foundation of circles. Hart describes autonomy embodied in the principles of acceptance, humility, and autonomy.

Hart (2002) lists a sample list of parameters:

1) You belong here just because you are here and for no other reason.
2) What is true for you will be determined by what is within you, by what you directly feel and by what you find making sense within you. The way in which you live inside yourself is important.
3) Our first purpose is to make contact with each other.
4) We will try to be as honest as possible in expressing who we really are and what we really feel. We will attempt to express as much as we can
5) We will listen to the person inside of each of us, and we will take ownership of our feelings.
6) We will respect and listen to everyone.
7) Everything discussed in the circle is real, and we do not pretend that it isn't.
8) Any decisions made within the circle need everyone to take part in some way.
9) I am responsible for protecting each member's place within the circle.
10) I will ensure that everyone in the circle is provided with the opportunity to speak and will ensure that you are heard. (p. 79)

Good conduct involves non-interference and a non-judgemental relationship with the affairs of others and their self-determination. Elder Jim Canipitatao says "it is useless to confront each other, my relatives. It is better to ask for unity, to work together, to think of our grandchildren. This is the Cree way" (Hart, 2002, p. 48).

Motivational Interviewing. Motivational Interviewing (MI) perspectives of change complement a CDOI approach. Miller and Rollnick (2002) describe MI as a collaborative process that respects the autonomy of the client. From a compassionate spirit of curiosity the counsellor joins with the client to support and guide the client through their change process. The client's belief that change is possible buoys the potential for change. Expectancy is a powerful factor and is built through relationship. Moreover, by working from the client's perception of the problem, theory of change, and available resources increases their ability to create change.

MI prioritizes accessing the client's motivation to change. Change is understood as a natural process that is constantly occurring. Durable change is the result of a client acting from inner motivation. As Miller and Rollnick (2002) write, change is "not about more treatment, but more *voluntary* treatment. Something happens with continued motivation" (p. 5).

Resistance is understood as a natural experience of reluctance or ambivalence. Resistance is conceptualized as both an interpersonal and intrapersonal phenomena. In this way interpersonal resistance is not an impediment to therapy, but the place where genuine work begins. Just as a journey starts with the first step, the process of therapy is an ever-emerging site of exploration and potential change. Far from being judged as a negative client attribute, resistance is understood to be a normal, healthy behaviour. Resistance may play an important function in other contexts of a person's life. Resistant behaviours include interrupting, changing the topic, not answering, and arguing. These reluctant behaviours serve protective functions informed by prior experiences.

Experiences of resistance in session are not a roadblock to therapy, but are understood to be the site of therapy itself.

Tug-o-war was used as a metaphor throughout the two-day course to represent interpersonal resistance in the therapeutic alliance. An example might be,

Counsellor: you should really stop blaming people.

Client: yeah, but it doesn't really matter, they're never going to change anyways

Confrontation can strain and damage the therapeutic alliance and is known to be ineffective in realizing positive therapeutic outcomes (Norcross & Wampold, 2011).

MI suggests that the counsellor put down their end of the rope and curiously join the client by exploring their experience of pulling on the rope. MI is most often associated with substance misuse. For example, a client resisting pressure to quit smoking from his family will likely not benefit from a counsellor similarly arguing for change, and effectively picking up the rope. From an MI perspective the first step is to join with the client and explore their experience of being convinced.

Counsellor: it sounds like you face a lot of pressure in your life to quit smoking.

Client: yes, there isn't a day that I don't feel ashamed of the habit, and often I'll smoke to just calm down from the stress at home.

Counsellor: it sounds like smoking serves an important function right now, and quitting could leave you more stressed out than you are now.

Client: well yes, but I've been coughing a lot and want to start taking care of my health so that I can be a good dad for my kids, they're pretty young still.

In this example the counsellor joined with the client by metaphorically crossing over to the client's side of the tug-o-war to pull in the same direction by genuinely

suggesting that an attempt to outright quit doesn't sound like a good idea. The client then shifts from his characteristic defensive position and presents a deeper concern, to be healthy for his family. By relieving interpersonal resistance space is created to explore *intra*personal resistance as explored from an IFS approach presented in chapter four.

The trainer framed the curious spirit of MI in eight principles, described as the 8 c's, of counsellor curiosity, calmness, connectedness, creativity, compassion, clarity, confidence, and courage (Marshall, 2012). These professional touchstones resonate with me and are a reminder to maintain my own health including clear differentiation with clients. Clients can emotionally affect me and I find the 8 c's effective reminders as I prepare myself before each session.

MI engages change as a natural phenomenon. Readiness, willingness, and ability are considered to be the three components necessary for change (Miller & Rollnick, 2002). It is important to understand where the client is in relation to these to work effectively. Prochaska, DiClemente, and Norcross (1994) conceptualize change as a 6-stage process, including; precontemplation, contemplation, preparation, action, maintenance, and termination. Change does not occur in a linear process, and people may find themselves moving through these stages in non-sequential ways. This model helps frame the nature of appropriate interventions.

Precontemplation describes a person who doesn't identify a problem. A common example is a person who suffers from addiction whose family members are concerned while the person denies that there is a problem. I imagine this precontemplative state to an unsprouted seed. For this reason it is important to come along side the client to explore their experiences and relationship with change. Just as a seed requires specific

environmental considerations before it will sprout, establishing a collaborative relationship is the first necessary step when working with somebody who is precontemplative.

Contemplation describes a person who sees both positive and negative aspects to change and remaining the same. This is similar to a newly sprouted seed that is beginning to grow, but has neither firm roots, nor fully developed leaves. Working with a person at this stage requires patience as the client explores the ambivalence within themselves between the options. Reflecting and validating the person's ambivalence supports the client to confront and resolve their internal resistance. Paraphrasing and open-ended questions are helpful at this point to explore each part of the person (Marshall, 2012).

Preparation describes the client as he moves towards a resolve. This is evident in the way the client talks about change. This change talk includes complaints, optimism, convictions, and necessity (Marshall, 2012). Recognizing and supporting change talk helps people move towards the action phase. Confidence, ability, and willingness are three components that are important to attend to. Often scaling questions can help the client prepare for a successful change strategy. When transferring a seedling from a greenhouse into a field, or garden, there is a process of 'hardening them off'. This describes exposing the plants to direct sunlight and wind during the day and protecting them at night in preparation for the unregulated climate of the field. Once the person is confident, willing, and able, then we move to the action phase.

Action requires continued support of change talk through reflection and exploration with the client. Marshall (2012) suggests a goal driven process based on future expectations, past experience, and wisdom. It is important to remember that this is

not a linear process and that change will ebb and flow. Continuing to engage in the process is measured as success.

Maintenance describes building change talk and monitoring goals and expectation. At this point the client is motivated and working towards change. Supporting the person by helping them access resources and recognize opportunities is the focus of the work. Thinking about the seeds motivated to grow, the plant is now firmly established and requires minimal care.

Change is a lifelong process of making decisions. Termination describes the ending of the counselling relationship.

Chapter Seven

Model 2: Psychological Ecology

I conceptualize intrapersonal change in a separate model I describe as a person's psychological ecology where I liken the client's process of change towards desired outcomes as the growth of a plant towards the sun. Framing psychological experiences in ecological terms sensitizes me to a number of nuances of therapeutic interventions. There are three main points of interventions when working with plants. A gardener can attend to the health of an individual plant by attending to the surrounding plants competing for sun, nutrients, and water. The gardener can also adjust the environmental variables of water and nutrients. All annual plant growth is predicated on seed germination. The physiology of the individual plant including genetic makeup and the viability of the seed that the plant germinated from.

People similarly exist within social contexts and relationships that influence the individual's well-being. These relationship are beyond the control of either the counsellor or the client unless police become involved for safety concerns. A counsellor is similar to a gardener as both are limited by the autonomy of the person and plant respectively. A gardener plants seeds with good germination and attends to the environment in which the plant lives. As a gardener adjusts the nutrients, exposure to sunlight, and irrigation. A counsellor explores the client's world through their frame of reference. This may include the client's resources, goals, motivations, abilities, experiences, and needs, helping the client assess, access, and move towards his or her goals.

However not all seeds germinate and not all people are able to find motivation, make goals, and access resources. In these instances I attend to the harmony, or disharmony, between the client's thoughts, emotions, and behaviours. I've found that people become more aware of opportunities for change as they make conections between these parts of themselves. At this point in my career it seems to me that the ways these three aspects of our psyche relate to each other reflects our ability to function and withstand stress.

Duran (2006) suggests adopting Jungian typology onto figure 2.2 below. The three axis' represent six directions and the point of intersection represents a seventh, inward direction. Figure 2.2 visually represents the surface of figure 2.1.

Figure 2.1

Figure 2.2

Figure 2.1 represents thoughts, emotions, and behaviours as a continuum on each axis. Imbalance between these capacites affects the whole. The spiritual self is represented by the seventh inward direction where the three axis' intersect.

Figure 2.2 represents the external shape of the model. The spherical shape reflects a balance between the three capacites of thought, emotion, and behaviour surrounding the spiritual core.

Each axis of figure 2.1 represents two mirror image points. The middle of each line represent low intensity, and the end of each line represents an extreme position. Vigerous exercise are represented by an outward movement towards each end of the physical axis. An experience of intense emotion and behaviour, without insight, are pictured below:

Figure 2.3

Figure 2.3 shows the shape of a heightened emotional experience, with intense behaviours, and limited reflection or insight. Notice the asymmetry between the axis'.

This three dimensional model helps me think about the client in a dynamic way. The flat shape depicted in figure 2.3 is less resilient to external events then the balanced shape depicted by figure 2.2. I imagine an appropriate response to an intense experience as an equal heightening of behavioral, emotional, and cognitive functions depicted of

figure 2.2. Descalation from an aroused experience can similarly be imagined visually in this way. Is the client able to engage these parts of themselve equally? Which parts cause problems? What is it like to think about things all of the time?

Balanced intensity on each axis creates the ball shape of figure 2.2, which represents a stable sense of self. A ball, or egg shape, are resistant to external forces. Large imbalance between the axis create a non-circular shape. These shapes are less resilient to external pressure and represent disharmony and disregulation. In my experience, the identified imbalance needs to be attended to in order to help a person take direction in their life. This model is dynamic and changing to reflect the ways people respond to experiences throughout their lives and represents strength and well-being as a dynamic state of being in both interpersonal and intrapersonal contexts.

Just as a seed germinates in certain conditions, effective counselling results from an alliance that creates a space for a person to sprout. In this way counselling can be considered to be a greenhouse where the environment is regulated to entice people to find, nurture, and shape the direction they decide to pursue. In my experiences of organic farming there comes a point where the plants need to be moved from the greenhouse and planted in the field. We must remember this, as our work with clients is to foster and support growth that will serve them to be autonomous, self regulating, and capable to continue to grow throughout their lives beyond the regulated spaces of an agency or office.

People are shaped by experiences over time. This is evidenced by the literature that attributes maladaptive behaviour, mental health, and substance abuse within the context of lived experience and coping strategies (Maté, 2008; Tafet & Bernardini, 2003;

Van der Kolk, 2009). A lack of self-regulation distorted thinking, anxiety, addiction, personality disorders, or OCD, may be functional barriers to achieving one's goals.

Thoughts. Thinking traps and unrealisitc goals can perpetuate the feeling of being stuck. CBT approaches address the cognitive axis of figure 2.1. Goals can effectively help shape intense, or extreme, thoughts into more moderate thoughts conducive to change. I liken the relationship between goals to the way the sun guides plants to grow. An effective goal can be used as an ordering principle to keep emotions and behaviours in check. Goal directed counselling can also bring opportunities for change into focus by seeing the relationship between parts of one's life. To understand the reasons why a branch grows from a certain part of a tree is best understood by looking at the neighbouring foliage and openings in the canopy where there is accessible sunlight. Similarly goal centered counselling may result in unexpected change for the client.

The counsellor has direct access to the client's goals, and must work collaboratively with the client, as only the client is able to access the resources in their life. If there is an absence of nutrients then it may be unrealistic to promote change or growth and the focus may shift to building resources. It is important to explore thoughts that obstruct a client's ability to realize their goal. It has been my experience that careful attention and genuine curiosity to unhelpful thoughts connect to unresolved events, or relationships, that obstruct a client's ability to think in clear ways.

Emotions. Emotions are important indicators. Feeling afraid during turbulance on a plane is an appropriate response to a situation outside of one's control. However, chronic anxiety throughout the duration of a flight despite the statistical safety of flying in Canada, is maladaptive. Experiences of chronic elevated emotions can result from an

inability to self-regulate for a number of reasons. Figure 2.2 symbolizes the ways our experiences and perceptions can shape our thoughts, emotions, and behaviours as the self contains an intrapersonal environment.

In my experience at TFA, relief can result from expressing intense emotions. It has been important for me to remember not to assume what an experience means for a person. For example, if a client's father died it may be easy for me to assume that this was a negative experience. However, by exploring that experience by asking "how was the funeral for you?" I may learn that this event brought great relief, or perhaps resentment, or sadness. The importance of genuine curiosity is to create opportunities for the client to lead me through their life in ways that they may recognize parts of themselves in new ways that regulate the relationship between thought, emotion, behaviour, and spirit.

Behaviours. Behaviours shape interpersonal reality and can be a concrete area for change. Paterson et al. (2006) suggest that behavioural change is necessary to create and maintain healthy thoughts and feelings. If a person waits until she feels like exercising it is likely she will never exercise. On the other hand if she decides to exercise for thirty minutes three times and accomplishes these three goals she may create positive feelings about exercising.

Collaborative problem solving illustrates the importance of behavioural change. Articulating a specific behaviour like 'raising your hand in social studies' contains the conversation to specific, observable instances. This respects the person's autonomy as they are given the space to be the expert of their experience of the event and their

response. Exploring the interaction between a person's behaviour, thought, and feeling can help people make change in any of these areas.

Figure 2.2 helps us conceptualize these 7 directions within the experience of self. The boundary of self represented in the ball shape can be understood as a container that holds memory, self-concept, and knowledge gained over time. Thoughts, emotions, and behaviours affect the way a person functions.

A Tree in the Forest

Talk therapy is one of the many sites of Social Work. As I reflect on some of the numerous ways of helping individuals and families create change, I also think about how to foster social and cultural change. Conceptualizing society as a forest, or garden, represent a historical-intergenerational psychology. This is beyond the scope of this paper and is mentioned here as a comment towards the adoption of CDOI approaches for social work in the realm of community development.

Prechtel (2012) describes nature as knowledge manifested by the ordering principles of the sun. Plant communities respond to the sun and the particular characteristics of their immediate environment. Cyclical processes result from the patterns of the seasons and foster diversity with the capacity to "absorb disturbance and reorganize while undergoing change so as to still retain essentially the same function, structure, identity, and feedbacks" (Bergamini et al., 2013, p. 10). Particular patterns emerge that facilitate complex self-organizing ecologies resilient to adversity.

Hart (2002) suggests the need for a collective purpose for health that transcends difference. Healing becomes possible through a shared motivation that begins within each individual. In this way we become responsible for our own health and to contribute to

collective health. There is tremendous potential for social change as individuals realize their personal responsibility for collective well-being (Hart, 2002).

The collective project of cultural change is not addressed while working with individuals or families despite the importance of understanding social and economic determinants of health. Does the Canadian cultural context promote health? It is time to expand the conversation to understand culture and community as part of the interventions we use in clinical contexts. As tempting as it may be to chip trees to make plywood, or use one theory to guide each therapeutic encounter, there is an elegance and strength to hand made furniture and client directed therapy. How do we conceptualize the forest for the trees? Is individual and family therapy the most effective way to attend to experiences of contemporary living? I believe that talk therapy is an important component within a larger process of cultural change and collective healing.

It may be helpful to conceptualize collective healing processes as environmental reclamation. Individual and collective health are important and interrelated. How can we better help individuals engage in systems that revitalize and maintain individual psychological ecologies? In my mind the goal is to create social communities capable of absorbing external shocks and adverse environments. Attention is paid to increase individual resiliency, yet there seems to me that there is a lack of congruency between agencies to create systems that foster individual and collective well-being appropriate to time and place.

Conclusion

I set out to improve my clinical skills and confidence through this practicum experience. I can say with confidence that this approach has been a success. I feel better able to conceptualize the work with each client and I am comfortable using the ORS and SRS with clients to guide the course of therapy.

I am grateful to have engaged in the creative project of articulating my practice framework and ecological psychology models to help guide my clinical work. I feel more confident and better able to join and work with clients. There are broad implications for social work practice. Is it possible to understand clinical work at a social level, as social and cultural realities are determinants of individual health (Haskell & Randall, 2009)? What could a Community Directed Outcome Informed approach to community development look like?

Client directed approaches to therapy are effective by working from the client's perception of the problem and theory of change. Working from the client's frame of reference creates space for the client to learn new skills by participating as the central figure in the process of change. What might this look like at a community, provincial, and national level? The ORS and SRS are two concrete tools that can empower clients to remain at the center of their care. How might population measures of well-being and satisfaction be measured? Currently GDP and economic growth are measurements assumed to reflect well-being. The nearest measurement of a social SRS may be voter turnout at elections, which communicates a clear disinterest to the political systems touted to serve our needs. The fractured nature of social relations is testament to the

necessary work to realizing associational community life described by Neufeld and Maté (2004) as the attachment village.

I see great potential for outcome research to explore the effectiveness of community-based interventions. From my experiences working with groups, and my personal interest in community work, I hypothesize that similar findings that community directed approaches to neighborhood and community development may be more effective than institutional responses. A community directed approach grounded in rigorous outcome research could bolster funding and attention to the importance of associations of people working to meet mutual needs, rather than system approaches whereby professionals help clients (McKnight, 1997). Whereas CDOI practice has emerged from the field of psychology, it is time for social work to explore similar principles at a social level.

Hart (2002) frames the interrelation between individual and collective well-being in the Cree concept of Mino-Pimatisiwin. CDOI approaches to therapy have deeply affected my clinical practice and approaches to helping people. The lack of community directed interventions and research are worthy of further research. Working with individual's and families can only become more effective in collaboration with community directed responses to community needs. It is my hope that my reflections and thought behind conceptualizing the therapeutic geography (figure 1) and the psychological ecology (figure 2.1; figure 2.2) influence the reader's thoughts to inspire creative responses to the forces that shape society today. I have matured through this practicum and am better able to work effectively with clients. I have been significantly shaped through my work at TFA and I am grateful for this opportunity.

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Appendix A
Session Rating Scale (SRS V.3.0)

Name _____ Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. I----------I **I felt heard, understood, and respected.**

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I----------I **We worked on and talked about what I wanted to work on and talk about.**

Approach or Method

The therapist's approach is not a good fit for me. I----------I **The therapist's approach is a good fit for me.**

Overall

There was something missing in the session today. I----------I **Overall, today's session was right for me.**

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Appendix B
Outcome Rating Scale (ORS)

Name _____ Age (Yrs):____ Sex: M / F
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

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Appendix C
Guidelines for Child Parent Relationship Therapy

1- Set the stage
2- Convey "be with" attitude
3- Allow child to lead
4- Follow child's lead
5- Reflective responding to child's
    a. Nonverbal play behavior
    b. Verbalizations
    c. Feelings/wants/wishes
    d. Match voice tone with child's intensity/affect
    e. Brief and interactive
    f. Match facial expressions w/ child's affect
6- Encourage (self-esteem responses)
7- Set limits (ACT)

(Bratton, Landreth, Kellam, & Blackard, 2006, p. 34)