Treatment Plan 3.0

Date: 4/22/23 Case/Client #: 02828
Clinician Name: Jennifer Matelski Theory: Solution Focused Family Therapy

Modalities planned: ☐ Individual Adult ☐ Individual Child ☐ Couple ☒Family ☐ Group: _____
Recommended session frequency: ☒Weekly ☐ Every two weeks ☐ Other: _____
Expected length of treatment: 5 months

Treatment Plan with Goals and Interventions

Early Phase Client Goal: Manage crisis; reduce distressing symptoms.

1. Increase AF1s social interaction and attendance at church events to reduce anxiety and loneliness.
   Measure: Able to sustain regular attendance at church/social events (2x per week) for a period of 1 month.
   Interventions:
   a. Interact with friends at women's prayer group and share about her struggles.
   b. Participate in art classes hosted by the church.

Working Phase Client Goals: Target individual and relational dynamics using theoretical concepts.

1. Increase AF1's communication with children to reduce AF1s lonliness and isolation and CF1, CM1, and CM2's worry about their mother's wellbeing.
   Measure: Able to sustain regular facetime calls/zoom sessions with family (1x per week) for a period of 2 months.
   Interventions:
   a. Discuss each person's high and low points of the week in order to gain a closeness.
   b. Share one thing each person is looking forward to for the week ahead.

2. Increase AF1's participation in bereavement group to reduce depression.
   Measure: Able to sustain attending a bi-monthly bereavement group for a period of 3 months.
   Interventions:
   a. AF1 will introduce herself to the group and share that her husband died.
   b. AF1 will share about some symptoms of her grief that she is experiencing.

3. Increase AF1's ability to be open and vulnerable with CF1, CM1, and CM2 to reduce feelings of isolation.
   Measure: Able to sustain individual conversations with each child (1x every 2 weeks) for a period of 2 months.
   Interventions:
   a. AF1 and each child will share and discuss what each person does for self-care each week.
   b. AF1 and each child will share their favorite thing or what they miss about their husband/dad.

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Closing Phase Client Goals: Long term goals or goals set by theory's definition of health.

1. Increase CF1, CM1, and CM2's visits with AF1 to reduce AF1's symptoms of loneliness and CF1, CM1, and CM2's frustration with the lack of closeness with their mother.
   Measure: Able to sustain visits every 4 weeks for a period of 3 months.
   Interventions:
   a. During visits, AF1 and her children will choose an activity to all participate in together.
   b. AF1 and children will go to eat at the late husband/father's favorite restaurant in order to honor him together and gain a sense of closeness.
2. Increase AF1s time doing shared interests with CF1, CM1, and CM2 to reduce depression.
   Measure: Able to sustain regularly schedule activities (1x per month) for a period of 4 months.
   Interventions:
   a. Each family member will make a list of activities they would like to do together. Then all members will narrow these down to decide which 4 activities they will focus on for the next 4 months.
   b. While doing activities together, AF1 and children will ask open ended questions about how they are all coping since the loss of their husband/father.

Treatment Tasks

1. Develop working therapeutic relationship using theory of choice:
   Relationship building approach/intervention:
   During the engagement stage, it is important for the social worker to build a collaborative alliance with the family members. The social worker will listen to the perspectives of the family members to get an idea of what the presenting problem is, in the client's words. It is important to collaborate with the client and let the family know that they are the most valuable contributors to this therapeutic process. It is also important for the social worker to use future-focused language. It is very easy for clients to focus on the problem or the issue that brought them to therapy. However, with Solution focused family therapy, it is important to shift the focus to the future in order to bring out change.

   There are key questions that can be asked in order to help the family members stay positive and future focused. For example, the social worker can ask a client a miracle question or some form of it. "What would be different in your life if 6 weeks from now, you felt this therapy was successful?" This helps the client and social worker have a more concrete perspective of what the client wants to change.

   In Solution focused family therapy, the therapist should remain positive, hopeful, and respectful when working with clients. They should utilize solution-focused questions that do not focus on the negative or the problem, but rather the solution. At some point, the social worker will likely use a conversational shift in order to move the conversation from problem-focused to solution focused. Since the clients are the experts in this theoretical approach, it is important to remain respectful of the client's pace and comfortability in making this shift.

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The social worker should also encourage the clients to ask for what they want from one another, rather than discussing what they do not want. This will help keep the session positive and avoid certain family members feeling attacked or blamed.

2. Case conceptualization of individual, relational, and community dynamics using theory of choice.

Strategies and techniques:

a. The first strategy is to identify the positive elements. This is also known as compliments. In solution focused family therapy, the social worker should utilize a strengths-based approach in order to focus on the existing strengths and assets of the family. Identifying these strengths can help motivate transformations within the family. According to DeJong and Berg, there are three types of compliments in solution focused family therapy. These include direct, observing something useful in clients and bringing that to the attention of all family members, and indirect. Indirect compliments include asking questions from the perspective of other individuals who are familiar with the family, and self. This would include asking questions that cause the family members to describe and recognize strengths (Hook, 2014).

This ties into the key aspect of focusing on the exception to the problems the family is experiencing. When a family seeks help from a therapist, it is natural to want to focus on the problem that brought them in. However, staying in this mindset can be unmotivating and stressful. This mindset des not lend itself to positive change. When we gently shift the focus to the solution, through our thoughtful questions posed to members of the family, we can help them become future focused and construct their own solutions to the presenting problem.

b. Another technique in solution focused family therapy is that the family members are the expert in their situation. The social worker can help the clients construct solutions and begin thinking about what goals can be introduced in order to get them to where they want to be. One technique is to ask the “miracle question” to all members of the family, one by one. This question can help the family start to formulate solutions to what they perceive the problem to be. The miracle question can take the form of “Pretend you went to be tonight and woke up in the morning and the problem here was solved. What would be different?”, This allows the family members the opportunity to address the problem while focusing on the positive aspects that are different. It is designed to help clients look past the immediate issue and

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begin to visualize the future they want (Hook, 2014). From here, the family members can begin formulating the steps that it takes to get to that place. The focus here is shifted from the problem to the solution.

"DeJong and Berg reminded therapists that asking the client to imagine how life will be changed when the problem is solved can be difficult. Use of the miracle question represents a major shift in the client's thinking. They suggested several techniques that can be helpful to make this transition in using the miracle question with families" (Hook, 2014, p. 231).

These techniques include being mindful of our tone as the therapist. A therapist can speak softly and slowly to help the client shift from problem-focused to solution-focused. Also, using future-directed terms can help the client get into that mindset. These include questions like "what are the signs that a miracle has happened?" or "what changed for you?". Helping the client to refocus on what will be different can help them to pinpoint what they are looking for in a solution.

> "This is an action-oriented therapy model which utilizes sensitive listening in the language of the client. All client verbalizations are accepted and refrained into behavior and action solutions. Attitudes and feeling states or moods are translated into behavioral actions or expected interpersonal interactions. Client activity outside the therapy hour is urged." (Kobos, 1993).

It is critical that the therapist portray that the client is the expert in this situation. They know problem at hand better than anyone, and because of that, they can construct the best solution for them. In this approach, the therapist should utilize the same terms regarding the problem. This is likely a difficult subject to discuss, and it is hard for a family to welcome a therapist into their personal lives. In order to help build the therapeutic alliance, validation and rephrasing of the family members feelings and ideas is important. This helps the client to know that you are listening and hearing them. This helps build their confidence because they know you care about what they have to say. It also helps a trusting relationship form between each family member and the social worker. That trust is crucial for the clients to open up and allow themselves to be vulnerable with you. It helps them feel less judged by the presenting problem and more likely to start constructing solutions in the therapy space.

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3. Identify needed referrals, crisis issues, collateral contacts, and other client needs.
   a. *Crisis assessment intervention(s):* N/A. Risks assessment was performed. No family members are a danger to themselves or others.

   b. *Referral(s)*:referral for AF1 to bereavement group

Diversity Considerations

Describe how treatment plan, goals, and interventions were adapted to address each area of diversity:

Age: *Include developmental tasks, cognitive ability, family life cycle, generational differences, etc.:*

AF1 : Female Age: 66

AF1 has high cognitive functioning. She lost her husband and is now a widow. All children are adults and live outside the home. Some children live farther away and out of state. AF1 was raised to not complain or bring up issues she is facing. Her parents never shared any hardships they faced with their children, and she feels that she should maintain the same protocol with her children. This is a significant generational difference. Her children learned from an early age in school that it is important to reach out for help and prioritize your mental health. This is not something that AF1 was raised with.

CF1 : Female Age: 32

CF1 has high cognitive functioning. She is living in a different state than AF1 and her siblings. She is currently living with her significant other and working a high stress job. CF1 was taught in school the importance of reaching out for help. CF1 also took a psychology course in college that helped her develop self-care habits to support her mental health. CF1 differs from AF1 generationally because CF1 was raised in a time when sharing your thoughts and feelings was more encouraged. AF1 grew up in a time when people, especially girls and women, were told to not complain or share their feelings with others.

CM1 : Male Age: 37

CM1 has high cognitive functioning. He is living in a different state than AF1 and his siblings. He has a family of his own, and also works full time.

CM2 : Male Age: 34

CM2 has high cognitive functioning. He lives the closest to AF1 out of his siblings.

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CM1, CM2, and CF1 are in a different generation than their mother (AF1). AF1 has expressed that she was taught that when you have a loss, you keep your head down and just move forward. Her children were open to bereavement counseling and support after the loss of their father. The adult children are more open to mental health support than their mother. AF1 reports that this is from her upbringing. When she was a child, her mother had many family members die, but they never discussed it in the household. She shared that discussing negative emotions was looked down upon.

Gender/Sexual Orientation: *Include specific gender role identity (e.g, working mother, traditional male, male-female transsexual, etc.), sexual orientation, ethnically based gender roles, etc.:*

All individuals in the family are straight. AF1 reports that being a female has caused her to be more reserved and speak less. Due to this, she feels speaking up about her anxiety or grief will cause her to look like she is weak and complaining. CF1 reports that her mother would often tell her to mind her tongue when she was growing up if she was venting about something that bothered her. CF1 feels she needs to act more reserved and calmer around AF1 in order to make her proud. Both CM1 and CM2 feel comfortable speaking their mind and do not feel they need to act more reserved in front of AF1. AF1 admits that this is something that was passed on by her parents, the idea that women and girls should be seen but not heard. This sentiment makes it harder for AF1 to open up about her grief and anxiety. This also makes it difficult for CF1 to try to have vulnerable conversations with AF1.

Race/Ethnicity/Religion/Class/Region: *Include race, ethnicity (i.e., Italian American rather than White), immigration-status, religious beliefs, socio-economic status, and geographic region*:

All of the children and their mother are Caucasian and identify as Irish-American. AF1 grew up in a household where emotions were not discussed and they were encouraged to pray for comfort from God rather than seek outside support. CF1, CM1, and CM2 grew up Catholic as well, but were educated in school about the importance of mental health care and seeking the help that is needed. They are more comfortable sharing their emotions and reaching out for help when they experience symptoms of grief or mental health decline.

Other factors: *Identify any other significant diversity considerations, such as school, work, community etc.:*

N/A

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Evidence-Based Practice (Optional)

Summarize evidence for using this approach for this presenting concern and/or population:

> "The therapist's task is to assist the client in using available personal resources to generate and act on alternative solutions. The process of constructing solutions is articulated and modeled in the therapy. The model of constructing solutions is rooted in the Strategic Therapy Model of and, the Structural Model of, the Milan Model and the Brief Therapy Model." (Kobos, 1993).

Solution focused family therapy has been shown to be effective when utilized with grieving families and individuals. This strengths-based oriented approach helps to uplift and empower the clients to find solutions. As mentioned by Butler and Powers, a solution-focused approach is valuable when helping families cope with grief and loss. Validation plays a crucial role since the family is likely facing many subsequent losses stemming from the death of a loved one (Hook, 2014). Once the family members are feel heard and understood, the miracle question can be a helpful tool in allowing the family to picture their new life moving forward. This can be both upsetting and hopeful for the client because they are picturing a world where their family member is still no longer physically with them. However, it also allows the clients to envision a future where they are happy and have overcome some pain and issues.

Keeping in mind that the clients are the experts in this approach, the therapist can guide the family towards a more positive future focused perspective. This must be done at the pace of the client. This is vital when working with grieving individuals because they can often feel alone in their pain. It is key for the therapist to take the proper time to validate the client's feelings prior to making the shift to a solution-focused perspective.

> "SFBT possesses unique features that permit it to function well in a variety of settings. For example, it is flexible and culturally responsive and allows clinicians to work collaboratively with patients and families to uncover solutions. SFBT focuses on strengths and individual resources, rather than dwelling on the past or the problem. This model also encourages recognition of successes in the past and determine hopeful solutions in the future. Additionally, it is designed to be brief, create change within a few sessions." (Hall, 2020).

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Goals are also a key component of a solution focused approach. When working with a grieving family, the simple act of accomplishing tasks can help build confidence. “The family therapist assesses whether action-oriented, thinking, or observational tasks would be most appropriate for clients. Whatever the task, the message is designed around the basic acknowledgement-possibility paradigm” (Hook, 2014, p. 245).

Scaling questions utilized in this approach also help the family explore ways they are able to move in positive directions towards goals. “Because the approach is set within the coping resources and strategies of the family members, it enables family members to identify resources within their own framework. Butler and Powers (1996) discovered that families will often identify spiritual resources. (Hook, 2014, p. 245).

In this approach, finding client’s resources such as spirituality, will benefit the client and bring about the change process. Spirituality can help a person be more resilient and empowered to continue on after facing a tragedy in life.

Client Perspective (Optional)

Has treatment plan been reviewed with client: ☐ Yes ☐ No; If no, explain: _____
Describe areas of Client Agreement and Concern: _____

Jennifer Matelski, Social Work Intern 4/22/23 Kelly Renwick, MSW 4/22/2023
Therapist’s Signature, Intern Status Date Supervisor’s Signature, License Date

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Resources

Gehart, D. (2013). Mastering Competencies in family therapy: A practical approach to theory and clinical case documentation (3rd ed.). Pacific Grove, CA: Brooks/Cole.

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Hook, V. M. (2014). *Social Work Practice with families: A resiliency-based approach*. Oxford University Press.

Johnson, L. D., & Miller, S. D. (1994). Modification of depression risk factors: A solution-focused approach. *Psychotherapy: Theory, Research, Practice, Training*, *31*(2), 244–253. https://doi-org.ezproxy.nyack.edu/10.1037/h0090220

Kayrouz, R., & Hansen, S. (2020). I don't believe in miracles: Using the ecological validity model to adapt the miracle question to match the client's cultural preferences and characteristics. *Professional Psychology: Research and Practice*, *51*(3), 223–236. https://doi-org.ezproxy.nyack.edu/10.1037/pro0000283

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