# An Emancipation of the Client and the Clinician: The Integrative Social Work Experience of a Second-Year MSW Student

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*This narrative explores the author's learning experience as a second-year master of social work student in field practicum. In the setting of an adult partial hospitalization program, the author applied knowledge learned in her masters courses and began to develop her personal therapy style. This is a narrative account of her exploratory use of different therapy styles with a young client diagnosed with bipolar disorder and her family.*

When social work master's students begin their second year, they enter a critical period in their career. During the second-year field placement, students begin to develop their own therapeutic style and apply the theories and techniques that they have learned in their courses to their practice. This year can be a time of trial and error until students determine what works best for them. It also can be a time of frustration and insecurity in personal knowledge and skill as a social worker. This paper describes my experience as a second-year master's student in my field placement at an adult partial hospitalization program. More specifically, the paper analyzes my emerging therapy style and application of theoretical techniques with a specific patient and family. To begin the paper, background information on myself, the treatment program, and the patient are provided. Following this are a description and analysis of my cognitive-behavioral and integrative work with this patient.

This social work student is a second-year master's student at a Midwestern university with a clinical concentration and a mental health focus. I am a twenty-three year old Asian American female and would consider myself as growing up in an upper middle class family. My bachelor's degree was in sociology and psychology; therefore, I had little experience in social work before starting the master's program. The experiences of close friends and family struggling with addiction and mental illness led me to the field of social work. Despite my interest in mental health, my second-year placement at the adult partial hospital program is my first work with the mental health system and cognitive-behavioral therapy. Even though it did not have a mental health focus, my first-year placement was a strong, generalist experience at a small non-profit agency. It provided me with valuable exposure to group work, case management, and working with an interdisciplinary team. This first-year field placement helped me to develop a strong foundation for my second-year clinical placement.

The adult partial hospitalization program where I had my internship consists of two tracks, a partial hospital program and an intensive outpatient program. When patients begin the program, they are placed in the partial hospital program, which meets daily from nine to four. Once patients understand the basic concepts introduced in the partial program and present as more stable, they are generally moved to the intensive outpatient program, which meets from nine to twelve. This program is more intensive and teaches in-depth cognitive-behavioral concepts. In both tracks, the modality of treatment is group therapy and education, but patients also receive individual therapy with their case

manager a minimum of once a week. The general length of stay for most patients in the whole program is three to five weeks. The program uses cognitive, behavioral, and social learning perspectives to explain human functioning as a product of interaction between individual and environmental variables (Regehr, 2001). A strong emphasis is placed on the interaction between three spheres: behavior, cognition, and physiology. With behavior, specific techniques such as daily structure, social skills training, and assertiveness training are used to improve behavioral deficits that contribute to symptoms (McGinn, 2000). In the cognitive sphere, restructuring techniques are learned to change negatively distorted thoughts to clearer thinking. Finally, in the physiological sphere, patients are taught skills such as imagery and relaxation techniques to calm their bodies.

As a student intern, my role in the program encompassed several areas. First, I had my own small caseload of patients. My duties in regard to case management included weekly individual sessions, insurance reviews, disability paperwork, and discharge planning. Second, I was a co-facilitator for the daily group therapy process group. Finally, I often led the cognitive-behavioral education groups. These groups focus on topics such as symptom management, relapse prevention, medication management, and diagnosis education. At times all of these duties could be overwhelming, but they helped me to learn about all aspects of the program and gain a more in-depth understanding of cognitive-behavioral therapy.

### Case Study of Mary Jones

In this narrative I analyze my work with Mary Jones, whose name has been changed for this article, and her family. Mary was one of the first clients that I worked with on my own while at the agency. Also, it was with her family that I conducted my first family therapy session. For me, the work I did with Mary was a defining moment in my career. Working with her helped me to discover what styles and techniques work for me and gave me confidence in my ability as a social worker. I used an integrative approach combining the cognitive-behavioral framework of the program with techniques from other models that I found effective.

### Background about Mary

The patient Mary Jones was a nineteen-year-old Caucasian female of middle class background who had just been diagnosed with bipolar disorder, type I. She had a previous diagnosis of ADHD from childhood. Halfway through her sophomore year of college, the severity of her symptoms forced her to withdraw from school. Mary reported both manic and depressive symptoms during the last year, including impulsivity, racing thoughts, hyper-verbal speech, increased sleep, irritability, and aggressiveness. She was referred to the adult partial program upon her discharge from the inpatient psychiatric unit. Mary had admitted herself to the inpatient unit following heightened irritability, impulsivity, and aggressiveness towards her parents. At admission, a drug screen was positive for cannabis, but Mary denied cannabis abuse.

Since her withdrawal from school, Mary had been living with her parents, and there was a great deal of tension in the home. Miscommunication, misunderstanding, arguments, and lack of trust and respect characterized the relationship between Mary and her parents. Since learning of Mary's impulsive behaviors and drug and alcohol use, the parents had suspended all of Mary's privileges including use of the phone and car. They required her to be in their supervision at all times. In addition to these family conflicts, all of the family required education about Mary's new diagnosis of bipolar disorder.

**Initial Session with Mary**

In my first session with Mary, I wanted to develop a therapeutic relationship and specify treatment plan goals. Establishing a strong therapeutic relationship is extremely important because research shows that effective helping cannot occur without the existence of a significant relationship between the helper and the help seeker (Garvin & Seabury, 1997). Like all approaches, cognitive-behavioral therapy, the framework of this agency, requires a sound therapeutic alliance before patients are willing to follow through behaviorally (Beck, 1995). Before the session, I was extremely nervous about meeting with Mary. I was insecure about my ability to work with someone so close to my age and to appear competent and knowledgeable to her and her parents. Despite my misgivings, the first session went extremely well, and we began to develop a close therapeutic bond. The closeness in age allowed us to connect almost instantly. We both had recent college experience and the same generational language and interests. Having an instant bond allowed Mary to trust me and express and share openly from the start.

I was concerned about the immediate connection, though, because I thought that it might lead to transference or countertransference. These concepts are not usually linked with a cognitive behavioral approach, but they are concepts that I learned about in my social work basic skills course. I think these concepts are important to any therapeutic relationship regardless of therapy approach. Mary could start to view me as a friend or ally against her parents rather than as her case manager. As for countertransference, I was concerned that my work with Mary would become entangled with past experiences I have had with friends who had struggled with similar experiences. This could mistakenly have led me to befriend Mary rather than keep a client-therapist relationship. To prevent this from occurring, I tried to be particularly attuned to my "conscious use of self" or self-awareness while working with Mary. This means keeping a conscious balance between the head and heart or distance and closeness (Garvin & Seabury, 1997). To actively accomplish this, I always had a plan for our sessions, I frequently consulted with my supervisor about the case, and I tried not to allow myself to participate in chatty, friendship-like conversations. Overall though, I think that our strong therapeutic bond enriched the therapy experience by allowing Mary to trust my opinions and suggestions and be willing to make changes.

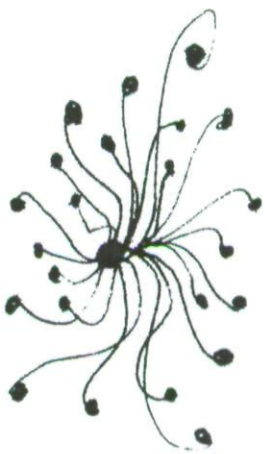
My other objective for the initial session with Mary was to develop treatment plan goals based on her outlook of the presenting problem. When using cognitive-behavioral therapy, the client rather than the social worker describes the problem situation, emotional consequences, and surrounding thoughts (Regehr, 2001). In addition, the social worker should identify client strengths and successes on which to base reframing and behavioral interventions in future sessions. As Mary described her present situation, I focused not only on the words but also on the patterns, underlying meanings, and body language. By listening to Mary, I identified the themes of independence, emancipation, control, communication, lack of knowledge, and responsibility. Independence, emancipation, and control related to having the freedom from her parents to make her own choices and actions. Communication referred to the lack of communication occurring between Mary and her parents. Lack of knowledge related to the information that Mary and her parents needed about her new diagnosis and medications. Responsibility referred to taking responsibility for her own actions. All of these themes were connected and seemed to be at the core of the problem that Mary described along with her diagnosis

of bipolar disorder. At this point, I took a client-centered approach by introducing these themes to Mary, and allowing her the opportunity to explore these themes and develop her own goals and plans (Rothery & Tutty, 2001). To me, this action was important for the empowerment of the client even though it is not particularly linked with cognitive behavioral therapy. Unfortunately, Mary's manic thought process prevented her from accomplishing this synthesis without assistance, and so together, we developed treatment goals, outcome criteria, and treatment plans.

Four treatment goals were developed for Mary's treatment plan in the program. At this adult partial hospital program, goals one and two are the same for all of the patients. Goal one is taking medications as prescribed by the psychiatrist. Mary reported accomplishing this goal most of the time at the time of this first session. Goal two is discharge planning. Mary already had a therapist in the community but did not have a psychiatrist. She would need a referral before discharge. Goal three was developed in relation to the themes of control, responsibility, and lack of knowledge identified from Mary's story. Mary's goal three was to learn cognitive-behavioral skills and techniques to manage and decrease her symptoms. The outcome criteria for this goal were a decrease in impulsive behaviors, decrease in irritability, decrease in aggressiveness, and ability to list and use symptom-management techniques. The plan for meeting this goal was to attend the program every day, participate in groups, and apply what was learned in the program to daily living. Mary reported hardly ever accomplishing this goal at the time of goal formation. The fourth goal addressed the identified themes of communication, independence, emancipation, and lack of mental health knowledge. For goal four, Mary wanted to increase family communication and understanding of her diagnosis. The outcome criteria for this goal would be less arguing in the family, return of her privileges, and family understanding of bipolar disorder. The plan for this goal was to have some family therapy sessions and to read literature on mental illness and bipolar disorder. According to Mary, this goal was hardly ever being met at the time of goal formation. After setting these goals, Mary and I reviewed them to ensure that they were realistic. To encourage her, I emphasized the strengths that she had that would help her to reach her goals. These strengths included intelligence, courage, genuineness, and a desire to get better.

**Individual Work with Mary**

My work with Mary was divided into two areas: individual work and family work. Individually, I worked on reinforcing the cognitive-behavioral skills that Mary was learning in the groups. Particularly with bipolar disorder, the psychoeducational nature of cognitive-behavioral therapy can be an effective treatment because it promotes monitoring and self-regulation (Patelis-Siotis, 2001). The cognitive-behavioral approach to bipolar disorder can be divided into three phases. The first phase focuses on educating the patient on medications, the cause of illness, and symptoms (Patelis-Siotis). For this phase, I worked in conjunction with the psychiatrist and nurse. During our first individual session, I provided Mary with numerous handouts on bipolar disorder since this was the first time she had received the diagnosis. I spent a great deal of time describing the symptoms of mania and depression and the difference between all of the mood disorders. Once she had the list of symptoms, we worked together to identify which symptoms she struggled with or had experienced in the past. By identifying possible symptoms, Mary and her family had a list of possible indicators of relapse. Briefly, I talked about mood stabilizers, but I referred specific medication questions and concerns to the nurse and psychiatrist. Both the psychiatrist and I emphasized the importance



of taking medications even when feeling better. Educating both Mary and her family was important for the treatment process.

The second phase of cognitive-behavioral therapy for bipolar disorder is the skill-training phase. In many of our sessions, Mary and I reviewed the skills that she was learning in the cognitive-behavioral groups. Self-monitoring and use of structure were especially important in Mary's treatment. The use of self-monitoring can be especially suited to the manic phase of bipolar disorder by teaching the client to recognize early symptoms and implement pharmacological treatment and behavioral interventions to minimize the impact of the mania (Patelis-Siotis, 2001). As previously stated, Mary and I developed a list of symptoms that she experienced when feeling depressed or manic. I encouraged Mary to share this list with her parents so that they all were aware of the early warning signs of an episode. Equally important as identifying the symptoms is identifying the triggers that lead to symptoms. Mary really struggled with identifying her triggers, and was able to come up with only one: disagreement with her parents. Together, Mary and I brainstormed several interventions she could implement in these triggering situations. First, she could remove herself from the situation before it became too explosive and then come back to the discussion once everyone was clear headed and calm. Second, Mary had to set clear boundaries or limitations in relation to her needs. An example would be that there can be no intense discussions, criticisms, or arguing in Mary's room because that is her safe, private area. These types of discussions must occur in another neutral area of the house. By developing these skills, Mary would have better control of her bipolar disorder.

For Mary, structure was another essential aspect of cognitive-behavioral intervention. Lack of daily structure can lead to an increase in negative thoughts and impulsive behaviors. Every session, Mary and I would work on structuring her whole week and ensuring that she did not have too much time to dwell on the negative. We made sure to schedule time for all of the basic needs, including self-care, personal time, and socialization. Scheduling helped Mary and also reassured her parents of her safety. I encouraged Mary to continue structuring her time to some degree even after discharge. Being knowledgeable and prepared for these types of situations may help Mary better manage her symptoms in the future.

The final stage of cognitive-behavioral therapy is using cognitive restructuring interventions to address core beliefs (Patelis-Siotis, 2001). Mary did not make as much progress in this area as I would have liked, and I think that part of the reason for this was my lack of experience with cognitive-behavioral therapy. In work with clients, patterns often emerge that represent underlying themes or beliefs. When this occurs, the social worker needs to explore the origin of these beliefs with the client and determine whether the assumptions are still valid (Regehr, 2001). Mary had a pattern of thoughts and behaviors that could be traced to the core belief that everyone must like me or I am not a lovable person. This belief often led Mary to irresponsible, impulsive behavior while searching for acceptance or love. A lot of uncomfortable group work and individual work was done to uncover this core belief. Once this belief was revealed, Mary began to challenge the accuracy of this belief with the three cognitive-behavioral criteria she had learned in the treatment group. These questions are: (1) What is the evidence that supports or refutes this belief? (2) Is there an alternative explanation for this belief? (3) What are the real implications if the belief is true? (Regehr, 2001). Upon discharge, Mary was actively using these challenging questions whenever she had negative thoughts about being unlovable or worthless. Unfortunately, during her time in the program, she was not

able to completely remove this negative core belief or reframe it or discover its origin.

**Family Work with Mary**

The work that I did with the family was from a more integrative approach. I used a combination of techniques from the cognitive-behavioral approach, structural family therapy, and solution-focused therapy. I had two, hour-long family sessions attended by the father, mother, and Mary. My goals for the sessions were to provide information on bipolar disorder, to increase communication, and to have the family start to develop a long-term goal or plan for Mary's independence. During the first family session, I addressed the subject of bipolar disorder. Mary's parents were having a difficult time understanding that Mary had a mental illness and that many of her behaviors were actually symptoms of the illness. I provided handouts of the diagnostic criteria for bipolar disorder, manic episodes, and major depressive episodes. I explained the difference between all of the mood disorders and touched upon ADHD and bipolar disorder. Mary's parents also had several mediation questions which I answered to the best of my knowledge and referred the rest to the psychiatrist. At the end of the session, the family all verbalized a better understanding of what Mary was dealing with and how it affected her. It was my hope that they would be able to apply this new knowledge to their daily living.

Communication was a much more difficult issue to address with the family, and the issue seemed to be at the core of many of the conflicts. In my attempt to improve family communication, I used techniques from several different therapeutic approaches. The cognitive-behavioral approach states that family relationships, cognitions, emotions, and behaviors all exert mutual influence on one another (Nichols & Schwartz, 2001). Therefore, I encouraged the family to explore the relationship between these spheres, and I asked each member to discuss what was happening in each of these spheres for them. This task did not come naturally for the family, and so I had them practice communicating about these issues during the family session. The structural family therapy approach offered several techniques that I utilized.

During the first family session, I used enactment to observe the customary method of family interaction. The basic understanding of the family dynamics which enactment provided me with was important because I knew nothing about the family. In order to move forward with family therapy, I needed to learn about the issues within the family and what approach would work best. I had the family discuss together what the "problem" was. Mary sat between her parents with her back to her father. The father only spoke when directly spoken to, and the mother and Mary argued continually. Through the use of enactment, I observed a highly conflicted but enmeshed relationship between Mary and her mother, and a disengaged stance by the father. We discussed the problem with communication, and I asked the family to help me brainstorm ways to increase or improve communication. The family came up with several ideas. The ideas were to set aside a specific time each night to talk, to set a timer for each person to talk without being interrupted, and to post a dry erase board to communicate important messages. At the end of the first session, I used the structural technique of assigning a task by asking the family to follow through on at least one of their ideas for communication. Overall, I stressed the importance of communication in the family. To Mary, I pointed out the importance of her communicating her needs and progress to her parents, and to the parents, I stressed the importance of positive communication.

My second session with the family had a different focus. By this time, I had determined that there needed to be a specific plan or long-

term goal for all of the family to work towards. I believed that Mary was slow in making progress in her treatment plan because she did not have a specific goal or plan with her parents to regain privileges and trust, and because she was not receiving positive support from them. In this session, I primarily used solution-focused techniques. Before the session, I asked each member of the family to make a list of their top three concerns and bring them to the session. During the session, I had each member of the family read their concerns as I recorded them on a board. Once those concerns were on the board, we all studied them to determine how many were connected. We determined that three-fourths of the concerns were related to Mary's taking control of and responsibility for her life.

Next, I used the miracle question to further emphasize the similarity of concerns. The miracle question also activates a problem-solving mindset by creating a vision of the goal (Nichols & Schwartz, 2001). The version of the miracle question that I used was: "You go to sleep one night, and in the middle of the night, there is a miracle that changes everything to the way you want it to be. The problems are gone. When you wake up in the morning, what will be different?" Mary's answer to the miracle question was that she would have her car and cell phone privileges back, her parents would trust and believe in her, and she would not have to be in their supervision at all times. The mother's answer was that Mary would be a responsible, independent young woman. The father's answer was that Mary would not be acting impulsively and would be taking control of her life. I emphasized to the family that they were all describing the same scenario just with different language. This was extremely encouraging for them and me, because working towards one common goal is more manageable than working towards three.

Once they had a common goal, I asked the family how they were going to get there. The family seemed at a loss for ideas. At this point, I encouraged Mary to share with her parents what she needed in order to reach this goal. Mary mentioned support and incentive. Immediately, Mary's parents became upset and said that they were giving her lots of support by driving her around and taking care of financial issues. I continued to question Mary, though, about her conceptualization of support despite the parent's indignation. As I probed, we discovered that what Mary meant by support was positive encouragement and feedback from her parents. She felt that all they did was criticize her and point out all of the things that she did wrong. This revelation completely surprised the parents who had no idea that they were not giving Mary the positive support that she needed. At this point, I questioned the parents as to what their plan was for Mary to earn back privileges. They stated that they did not have one. I explained to both Mary and the parents that it was difficult to get better or even want to get better if there was nothing to look forward to. As homework, I encouraged the family to develop a plan together for Mary to start earning back privileges. I also encouraged them not only to discuss it, but also to put it in writing and post it somewhere in the house. A clear plan would provide Mary with positive incentive and the parents with a continued sense of security.

Several days after our last family session, Mary told me that the environment at home was completely changed. There had not been any fighting for four days, and the communication had improved. In addition, Mary had regained car privileges and some freedom from her parents' supervision. Mary appeared happier and more self-confident. She made an insightful comment to me that I felt summed up the entire situation. She said, "I have respect for them now. Before, I did not respect them or their parenting methods, and so I didn't care if I broke their rules or made them angry or worried. Now we have

a mutual respect and trust, and I don't want to do anything to lose that."

**Treatment Progress**

Upon discharge, Mary had met all four of her goals and was noticeably more stable without mood symptoms. In regards to goal one, medication management, the psychiatrist had been able to find the appropriate level of a mood stabilizer to eliminate the manic symptoms. Mary reported medication compliance without side effects. She still had a lower level of concentration and focus but this may have been part of the ADHD diagnosis. At discharge, she was referred to her new psychiatrist for the possibility of restarting the medication she had previously been taking for the ADHD. For goal two, discharge planning, Mary returned to her previous therapist, and I referred her to a psychiatrist in the community for follow up.

Goals three and four were the goals that my work with Mary had focused on. On the day of discharge, Mary stated that she was meeting goal three, symptom management, almost all of the time. She reported meeting all of the outcome criteria. There was almost complete elimination of impulsive behaviors, a decrease in irritability, and a decrease in aggressiveness. Mary was also able to list numerous symptom management techniques during our final session. Her list included use of structure, reframing negative thoughts, and evaluating the accuracy of thoughts. The last goal was the family goal. On her final day of the program, Mary reported meeting this goal almost all of the time. There was less arguing, a return of car privileges, and a greater understanding of bipolar disorder. During Mary's time in this adult partial hospitalization program, she successfully completed all of her treatment goals.

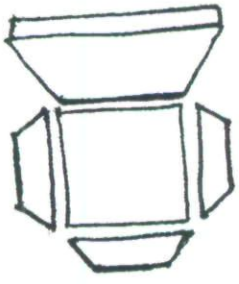
**Personal Reflection on the Process**

Overall, I was pleased with my work with Mary and her family, but there were several areas in which I could have improved or approached differently. First, I think that there was some transference and counter-transference despite my efforts to prevent it. Sometimes during our sessions, I found that our conversations were less than professional with discussion of shopping, fashion, and college life. To further avoid transference and counter-transference, I could have established clearer boundaries and ensured that both of us were clear about our expectations, conceptions, and purpose of the relationship (Garvin & Seabury, 1997). Another area I could have approached differently was my use of cognitive-behavioral therapy. I did not apply this framework as much as I would have liked, and I attribute this to my neophyte status as a user of cognitive-behavioral techniques. Mary was doing some insightful cognitive-behavioral work in the groups, and if I had focused on this more, she may have made even more progress in challenging her core beliefs. As my experience with cognitive-behavioral therapy increases, I think that this framework will become more natural to me as a clinician. Although I should have made more use of the cognitive-behavioral work, I also believe that the other approaches I used were essential to the process. If I had not used them, some of Mary's progress may not have occurred. For example, the use of client-centered techniques empowered Mary in developing her own goals and plans, which she had not been given the freedom to do within her family. The process allowed Mary to take ownership of her illness and behaviors. Within the family work, consensus and communication may have been lost without the use of the miracle question.

With the family, I also felt that there were several things that I could have done differently. In particular, there were two related dynamics that I wish I had addressed further. The first was the father's disengagement, and the second was the enmeshed relationship between the mother

and Mary. As structural family theory explains, once habitual family patterns are established, family members use only this small fraction of the full range of behaviors available to them, therefore reinforcing the troubled structure (Nichols & Schwartz, 2001). If I had been able to further challenge this structure and uncover alternative methods of function, then the family bond may have been strengthened even further. The last thing that I identified as something I would do differently was preparation. Before meeting Mary and her family, background research on ADHD, bipolar disorder, and the dynamics of families with only one child would have been beneficial. This information could have given me a better understanding of the situation, values, and interactions of the family. If addressed, all of these therapy issues could have led to additional changes and progress, but they are all deeper issues that can be further investigated in long-term therapy.

I am amazed by how work with just one client can teach so much. Mary reminded me of several close friends and family members, and, unfortunately, this reaction led me to want to be liked and accepted by her and her family. Awareness of these past feelings has made me more conscientious of myself within the therapeutic relationship. I more clearly understand that at times there will be clients who invoke certain emotions or memories. This response is normal, and now I strive to be proactive in monitoring my self-awareness. As previously mentioned, I was also very nervous about my young age and lack of experience while working with Mary. As I worked with the patient and her family, they never appeared skeptical or questioning of my ability or approach. I may have stumbled through some of the techniques that I experimented with, but I strived to do whatever I could to help my client. For me, this revealed that although age and experience are beneficial, a dedication to helping is the key to change. Most importantly, I think that my work with Mary proved to me that I could be a social worker. Sitting in the classroom memorizing diagnoses, interview skills, and theoretical approaches is very different from actually working with a client. Over and over again, I questioned my ability to successfully apply what I had learned in class with an actual client. Students ask themselves questions like: What if I make the client worse? What if I misdiagnose them? What if I say something that makes them mad? What if they won't talk to me? After having Mary as a client, I realized that I had retained a lot more than I had thought from my classes and that I can successfully use these skills in work with clients.



My experience with this client and her family also helped me to critically analyze my field placement agency and my master's social work program in a meaningful way. The adult partial hospitalization program effectively provides structure and intervention for clients who are at a level between inpatient hospitalization and outpatient services. I found the adult partial hospitalization program to be successful in helping many clients, but my work with Mary revealed several limitations in the program. The cognitive-behavioral framework of the adult partial hospitalization program can be somewhat limiting. By primarily using cognitive-behavioral therapy, I think that the program may be losing out on benefits from other theoretical approaches such as those that I used in my work with Mary. However, it may be that the time constraints of the program are better suited to a cognitive-behavioral approach rather than some of the other theoretical approaches. Additionally, I found that there was a disconnect between the group and individual work that the clients did. Group leaders should be aware of progress in individual sessions, and case managers should be aware of progress in groups. Increased awareness would potentially lead to even more success in treatment because concepts and progress

could be reinforced in these different settings. Lastly, there were times when as a student I felt unsupported or lacking in guidance at the adult partial hospitalization program. For example, I led the family session for Mary by myself with having only observed one other family session. In truth, I typically enjoyed the freedom I was given at the agency, but at times I would have liked more support.

Having real world social work practice also led me to analyze my master's social work program. I found that overall I was prepared to step out into an agency and practice the skills that I had learned in my coursework. I had a basic knowledge of several therapeutic approaches and skills, which I applied in my internship. However, professors tended to focus on the theoretical frameworks that they favored which means that students tended to learn more about those frameworks and less about others. The most significant critique I have of the program is that there was not a forum for students to discuss their field placements. In courses such as family therapy and crisis intervention, we definitely had opportunities to discuss our internships, but that was not the primary purpose of the course. I think it would have been valuable to have an internship seminar with the sole purpose of discussing and processing our field placement experiences. Such a course would have allowed students to reflect on personal experiences and emotions and to learn from each other's experiences.

Overall, my work with Mary was an irreplaceable learning experience for me. I learned a great deal about my therapy style and what I feel comfortable with. Real life application of interventions I have learned in courses provided me with important new experiences. I could have done several things differently or even better, but I learned from these mistakes and will know how to change next time. Most importantly, I gained more confidence in myself as a social worker. I strove to serve my client and help her make changes, and in the end, we saw positive results.

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