

**Thinking Outside of the Box: Using Creative Interventions with Children, Youth,  
and Families in a Clinical Counselling Setting**

**A Field Practicum Report**  
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## **ABSTRACT**

This report discusses the counselling experiences and agency involvement of an MSW student at Ehrlo Counselling Services in Regina. Formal individual, family, and group counselling sessions are highlighted and demonstrate the use of theoretical approaches including cognitive-behavioural, solution-focused, narrative, and play therapy. An in-depth analysis of these experiences is offered based on the relevant literature as it pertains to the determinants of problems and effective interventions. Other learning opportunities in relation to the practicum are also shared including skill development and visions for the future. This student's personal framework for counselling is revealed with its strong emphasis on the use of creative interventions.

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## **Introduction**

For as long as I can remember, I have always had a keen interest in working with children. This interest has been furthered by my experiences working within the child welfare system. It is here that I encountered countless children who were exposed to unimaginable traumas. I was witness to how trauma impacted the lives of these children either positively or negatively. I was amazed by how some children were able to overcome these traumatic experiences to achieve positive outcomes. On more than one occasion I found myself advocating for children in care, asking foster parents or extended family caregivers to have patience with these children. I would explain that behaviour is the language of the child and when a child acts out behaviourally, it is the responsibility of everyone involved to determine the cause of such behaviours so the child can be supported in their development and learn more acceptable behaviour. Virginia Axline (1947) wrote: "There is a frankness, and honesty, and a vividness in the way children state themselves in a play situation" (p. v). Through the therapeutic use of play, children can be offered the same opportunities to 'play out' their feelings and problems, just as in therapy with adults, individuals speak about their difficulties.

As a goal in writing this paper, I undertake to identify my personal framework for counselling, with particular emphasis on the incorporation of play and other creative interventions in the counselling process. I will explore how my life experiences to this point have shaped my view of the personal psyche and human behaviour. I will review three theories that I believe offer a broad understanding around the determinants of problems in people's lives as well as discuss four interventions that I have had most experience with throughout my practicum as well as my career. I will then undertake to review four separate theoretical approaches and discuss how play or other creative interventions can be incorporated into each

theory. This will be followed up with a discussion on some specific skills that support the therapeutic process in a clinical setting and challenges that I faced throughout my practicum. Finally, I hope to share the vision for my future endeavours within the field of social work that I hold for not only myself, but also for the profession as a whole.

## **Personal Background**

Before being able to articulate what I see as my personal framework for counselling, I think it is imperative to begin with sharing some of my personal experiences that have shaped the woman I am today. Born in June of 1978, I am the youngest of three girls. Our parents were German immigrants who came to Regina, Saskatchewan with my two sisters, paternal grandparents, and paternal uncle in 1977. Growing up, both parents worked outside of the home on alternating schedules to be able to make ends meet and provide us with the life that they envisioned for my sisters and me. Our parents wanted us to have opportunities they did not have themselves and so emphasized the importance of a good education and participation in various activities that connected us to the community. We were blessed when growing up to not only have connection with our paternal family in Canada, but also to maintain connection with maternal family in Germany through multiple visits there. Our parents were also very protective. Out of a desire to shield us from the negative influence of substance abuse and crime that was becoming more prominent in our neighbourhood, they decided to relocate our family to a new area of the city in the summer of 1985. Despite their best efforts however our family still faced some difficult times. Family was of the utmost importance to both of my parents. So despite some of the traumas my family has endured, my parents have always been available to provide support and encouragement as well as find solutions to achieve positive change.

I have faced two losses that have significantly impacted my life. The first was my separation and divorce from my first husband. Having met in high school, we were together for ten years before making the decision to marry. The relationship dissolved following the marriage and we separated only three years later. Following a period of grief around this loss, I began to acknowledge that I had allowed this relationship to define my whole self rather than maintain my individuality as a person. I began to expand my interests, find what makes me happy, and approach life with more confidence. The second loss that has greatly impacted me is the sudden and unexpected passing of my father in February 2013. While this is a loss my family continues to mourn, we support one another through our recollections of memories and times we were able to share with him. We are comforted in the belief that he continues to watch over us and the knowledge that he will forever remain in our hearts.

As mentioned earlier, my parents have always emphasized the importance of education. This is something that I have taken to heart and have taken steps to make education a priority in my life. I had the fortunate experience of being able to move onto post secondary education at the University of Regina following high school graduation. I achieved a Bachelor of Arts with Honours in Psychology in 2001 and went on to complete a Bachelor of Social Work in 2003. Throughout this time my interest in working with children grew and I first started to consider the goal of becoming a therapist specializing in play therapy and other creative interventions. I strongly identified with the idea that play is a symbolic expression of a child's view of the world and how play can be used to evoke the expression of the feelings they experience in their lives.

My first work and volunteer experiences while working on my undergraduate degrees included: a service provider at Child and Youth Services, a service provider at the Autism Resource Centre, and a big sister with the YWCA's Big Sister Program. The time during which I

first identified play therapy as an interest was when I was working for SCEP Centre Early Intervention and Training Services (SCEP). This is a socialization, communication, and education program for preschool children who struggle to fit into mainstream programming. SCEP's founder, Dr. Elisabeth P. Brandt, specialized in communication problems in young children. This program supports the philosophy that places emphasis on reciprocal and honest communication between children and adults where adults act as models for responsibility, dependability, planning, sincerity and affection ("SCEP CENTRE History", n.d.). Children in the program are encouraged to communicate their feelings through play and art while the staff verbally reflect these feelings back to the children. The goal is for children to learn to verbally communicate their emotions thus reducing their acting out behaviours which negatively impact their daily functioning.

I began my career with the Government of Saskatchewan in the Ministry of Social Services in August 2003. The majority of my social work career has been as a front-line child protection worker. I became aware of my naiveté when I first began in this field. I was emotionally overwhelmed to learn of how many children in our community are at high risk of harm each and every day and how perpetrators of abuse could target the most vulnerable members of the population. I quickly learned that my initial desire to completely protect all children from trauma was not possible. However, seeing children who demonstrated great resilience and seemed to overcome the trauma in their lives allowed me to change my focus to supporting children to succeed by promoting healthy adjustment despite their past traumatic experiences.

## **Placement Agency**

My practicum was undertaken at Ehrlo Counselling Services (ECS), a community outreach program that falls under the umbrella of Ranch Ehrlo Society (RES). RES was founded by Dr. Geoff Pawson in 1966. Originally an all male residential treatment facility with the vision of a "different approach to help young people with social, emotional, and behavioral problems" (2014, "Founder & History," para. 3), Dr. Pawson envisioned an organization that would provide a range of services based on an environment of nurturing and caring for troubled children so they could make positive changes for their future. Since this time, RES has expanded to become a multi-faced organization offering a variety of services aimed at improving the lives of children, youth, families and communities ("About Ehrlo Counselling Services", n.d.). The range of services include multiple residential facilities, each of which is designed to meet specific needs, educational and vocational programming and colleges, family programs, community sports programs, counselling, clinical assessment, Ehrlo Early Learning Centre, and Paper Crane Community Arts Centre.

Ehrlo Counselling Services (ECS) is a registered, not-for-profit, community-based program that is governed by a volunteer board of directors. ECS offers a variety of services including counselling, training, consultation, and assessment, all of which are intended to realize the goal of assisting children, adults, and families achieve their full potential. Services are founded on the notion of respect, caring, and nurturing for all individuals and families as achieved through "recognizing the dignity, value, and personal worth of all people". ECS's treatment philosophy assumes a developmental approach and includes a bio-psycho-social model of treatment with integration of various approaches. Treatment goals are based on standards for best practice and are collaboratively set with clients to ensure consideration of the unique needs

of each individual. The treatment modalities offered at ECS include individual, family, couples, or group counselling, as well as consultations, training, workshop, and conference events. Services are offered in response to individual requests so as to have a more meaningful and personal impact on the individuals it aims to serve ("Counselling Methods", n.d.).

Ehrlo Counselling Services has a number of referral sources including self-referrals, parents or guardians phoning to refer a dependent child or youth, or the Ministry of Social Services, as well as internal referrals from the residential services program. When a referral is first received, the intake worker will phone to gather some initial information in order to complete a risk assessment to determine the urgency of services for the identified client. While every effort is made to offer services as quickly as possible, there are times when a waitlist cannot be avoided. One unique aspect of the services offered by ECS, which is not a part of practice in most other agencies, includes regular weekly contact by the intake worker with the referral source to provide ongoing assessment of risk and need. This effort to check in with the referring individual demonstrates a concern for the client's well-being and provides help to reduce any concerns and to reassure them that the referral has been forgotten. ECS aims to provide short term interventions in order to ensure the ongoing availability of counselling services to the community at large. Where necessary however, longer term services will be offered and follow up support can also be made available when deemed appropriate to do so.

ECS has a total of ten full time staff: six registered psychologists, two registered social workers, one certified counsellor, and a Master of Arts graduate majoring in psychology. The primary role of the majority of staff is to provide counselling services to clients, however, some staff also offer clinical assessments, training, and two staff are considered behavioural specialists who are closely connected with the Cognitive Disability Strategy. In combination with their

diverse qualifications, everyone brings a unique approach to counselling to their work as well as comfort in the use of various treatment modalities. The client population being served is also extremely diverse. The clientele range from preschool to adulthood, have a wide range of developmental capabilities, and are coping with a variety of presenting issues. Some of the more common issues that are addressed include: grief and bereavement, adjustment difficulties, bullying, peer pressure issues, relationship issues, parent/child communication problems, disruptive behaviour problems in children, anxiety and depression problems, self-harm behaviour, suicidal ideation, and trauma related issues. A significant number of referrals are initiated for children and youth who are in the care of the Ministry of Social Services or are part of Ranch Ehrlo Society's residential program. These referrals are generally aimed at supporting children and youth to learn coping skills because of issues related to early childhood trauma as well as address presenting mental health concerns often associated with anxiety and/or depression. Another significant portion of referrals fall under the realm of self-referrals. This can include individuals phoning to request services for themselves, or family members phoning on the behalf of another family member, such as a parent phoning for a child. The remainder of referrals tend to come from other community agencies, including employee benefit programs.

My decision to pursue a practicum placement at ECS was based upon my personal interest of pursuing clinical work with children and teens in a setting that supports the incorporation of creative interventions in the provision of these services. During my initial consultation with the director of ECS, I learned that ECS offers flexibility in the use of various therapeutic approaches and models of treatment as long as these are proven to be supported by research and determined to be in the best interest of clients. I felt that ECS would be the ideal setting for me to experiment with the use of different theories and approaches as well as learn the

appropriate use of various techniques. The emphasis on such flexibility was important for me so that I would have the best opportunity to develop my own personal framework for counselling.

### **Goal and Objectives**

The goal for my practicum was to gain graduate level social work knowledge and experience in counselling children and their families. This goal was supported by five separate learning objectives including: to gain in-depth theoretical understanding of commonly used social work and counselling theories and how these are effectively applied in a clinical counselling setting, to learn about and use creative counselling strategies, to learn how to effectively work with diverse clientele dealing with any number of personal problems, to increase my skills in cross-cultural competency, and finally, to enhance my clinical social work skills through the use of multiple theoretical practice methods and develop my own personal framework for counselling. All of these objectives were successfully achieved. Throughout the duration of my practicum I had numerous experiences that supported me in attaining my objectives. I observed and jointly participated in numerous individual sessions with clients of various ages and backgrounds; I helped facilitate a parent education group at the Family Treatment Program; I helped to create an outline of activities and co-facilitated a therapy group for a foster family consisting of one caregiver and six children between the ages of 10 and 13; and I sat in on an art group at the Paper Crane for the parents of the Family Treatment Program. I worked with six clients under the supervision of my professional associate. The clients I worked with included: nine and six year old sisters who were having difficulty with their parents' separation; a ten year old female with low self-esteem and struggling to cope with past traumas; a seventeen year old female with significant cognitive impairments who resides in a residential program and was referred by staff to address personal boundary issues, a nineteen year old male

who resides in a residential program and was referred as a result of anger issues in the home; and finally a 24 year old female with Asperger's Syndrome wanting to enhance her social skills.

My first objective was to gain a more in-depth theoretical understanding of commonly used social work and counselling theories and how these are effectively applied within a clinical counselling setting. Through training, review of resources, observation of client sessions, discussion, and direct practice I attained this goal. I was able to gain valuable information on the following: psychosocial/developmental theory, family systems theory, attachment theory, the strengths perspective, cognitive behavioural therapy (including exposure therapy), solution focused therapy, and narrative therapy. Throughout my practicum placement, I developed the ability to critically review theories that were pertinent when considering the presenting issue as well as offer a rationale for the use of one particular treatment approach over others.

My second objective was to learn about and use creative counselling strategies. Through self-directed research as well as discussion with my supervisor, I was able to compile an initial resource list of activities and materials that can be used in individual and group counselling sessions. While engaged in direct practice with clients, some of the creative strategies that I relied upon included role plays, storytelling, drawing, music, and activities identified in the multiple publications by Liana Lowenstein (1999, 2002, 2006) of creative interventions for use with children and youth. While I did not engage in traditional play therapy during the practicum, I was able to receive constructive feedback from my professional associate on the techniques I used. Towards the end of my practicum, I was successful in spontaneously pulling from the repertoire of activities and resources that I became familiar with to use in sessions with clients. It was extremely rewarding to witness how the use of any number of creative strategies

encouraged clients in the expression of their feelings as well as supported them in gaining mastery over problem situations.

My third objective was to learn how to effectively work with diverse clientele who could potentially be dealing with any number of personal problems. This particular objective resulted in the greatest personal and professional growth for me. At the onset of the practicum, it was evident that I avoided open discussion of sensitive issues such as self-harm and suicidal ideation. Through self-reflection, it became apparent to me that this behaviour was caused by my worries of creating discomfort for clients. Through reviewing various resources, being presented information on motivational interviewing, and discussion with my professional associate, I came to realize that clients already live with the discomfort of these issues.

Furthermore, it is the responsibility of practitioners to demonstrate comfort in addressing these issues so clients are free to share their thoughts and feelings without fear of judgement. My direct practice with clients offered me experience in working with individuals ranging in age from ten years to mid-adulthood and addressing the following issues: anxiety, depression, separation and divorce, bullying, past trauma, developmental delays, and social difficulties.

My fourth objective was to increase my skills in cross-cultural competency. My practicum experience allowed me to see that my original idea of what constitutes cultural diversity was much too narrow. Originally, I identified cultural diversity as being solely related to one's race and ethnicity. The reality is that becoming aware of the similarities and differences between world views of people from various racial and ethnic backgrounds only accounts for a portion of what is required for demonstrating cultural competence in social work practice. Culture also pertains to person in environment. My practicum expanded my ideas of cross-cultural competency to include the communities individuals reside in, the supports that they have

available to them, as well as the barriers they face including things such as discrimination based on race, age, ability, and gender (Kirst-Ashman & Hull, 2002).

My fifth and final objective was to enhance my clinical social work skills through the use of multiple theoretical practice methods and to develop my own personal framework for counselling. While I did possess academic knowledge about various theoretical models, practice methods, and skills, it became apparent that I lacked the confidence to successfully use these approaches in a clinical setting. At the onset of my practicum, I was too concerned about saying the right thing that I failed to relate to the emotional state of clients because I was not actively listening to what they said. As outlined earlier, I avoided discussion of difficult issues and rushed to creating solutions for clients in order to minimize any feelings of discomfort. This interfered with my ability to build rapport with clients as well as their parents and/or guardian. Towards the end of the practicum however, there was noticeable improvement in my work with clients. I gained the confidence necessary to follow my own approach in working with clients rather than trying to imitate the approach of the other counselors. I also improved upon my engagement skills, thus allowing for better therapeutic relationships with clients. What I learned about my personal framework for counselling is that I am very much influenced by feminist principles including acknowledgement and appropriate disclosure of the therapist's values, viewing the client as competent, maintaining respect for an egalitarian relationship with the client, and practicing informed consent so that clients are empowered to make decisions that are in their best interests (Enns, 2004). I do not see myself as a supporter of only one method of counselling but prefer to approach counselling in a manner that allows for consideration of various models, theories, and techniques as well as differing levels of intervention (Sheafor & Horejsi, 2003). Regardless of the model, theory, or technique I used, I strongly support the use

of creative interventions as a means of engaging clients and allowing for the expression of feelings.

### **Ideology**

The ideology that a therapist identifies with influences not only how they view the world and human behaviour, but also, how they approach their work with clients. As Howard Goldstein (1997) explains, "the language of the theories, concepts, philosophies, and other perspectives we choose to use to describe, explain, or classify our clients has something to do with the nature, direction, and style of the helping experience" (p. 23). As outlined in the previous section, I find myself influenced by the feminist perspective as well as subscribe to a Rogerian style of working with clients. I very much support the goals of feminist counselling as outlined by Enns (2004): (1) valuing and affirming diversity, (2) counselling for change and not adjustment, (3) equality, (4) balancing instrumental and relational strengths, (5) empowerment and social change, and (6) self-nurturance. While I believe in the importance of being aware of the ideology that guides a therapist's own values in the work they do, I believe it is equally important to be sensitive to the views of the individuals with whom we work. Maintaining a 'person-centred approach' as defined by Rogers (1980) we must take care to not impose our values and beliefs upon the clients with whom we work as we should recognize that individuals have within themselves the resources to achieve self-actualization. The goal of therapists is to create an atmosphere of acceptance and understanding. When conditions of genuineness, unconditional positive regard, and empathic understanding are met, clients are enabled to adopt a more caring attitude toward themselves as well as alter their basic attitudes and self-directed behaviour in order to move closer to a state of self-actualization (Rogers, 1980).

My professional education has allowed me to study a number of theories around the human condition as well as various approaches and techniques that can be used to intervene with individuals. Many of these theories have influenced my overall view of human behaviour and how a client can be supported to overcome the problems they face in their lives. I will now discuss three theories that I believe are relevant in understanding the determinants of problems. These theories are developmental, attachment, and family systems theory. Following this, I will move into a discussion of three possible approaches to intervention: development of the therapeutic relationship, focus on the strengths perspective, and the use of creative interventions. I will offer some background information and an explanation of each theory and approach as well as provide examples of their use as it relates to my experiences throughout my practicum placement.

### **Determinants of Problems**

Weick and Chamberlain (1997) present a progression in social work practice where the emphasis on the determinants of problems has increased significantly since the 1920's. Prior to this time, social workers primarily viewed problems as being caused by every day troubles. In the 1920's however, the field of social work was heavily influenced by the fields of psychology and psychiatry and followed a medical model that was common in this era. The psychoanalytic influences shifted the view of the causes of problems to be as the result of deeply seated and complex interpsychic and behavioural patterns that required professional intervention to understand and address. I agree with the words of Weick and Chamberlain (1997) who urge therapists to remember that "a person is always more than his or her problems" (p. 45). They agree that problems do signal a need for something to change, however, they also point out that no prescriptive directions for change exist. I agree that an overemphasis on the identification and

understanding of problems results in less attention being available for developing creative solutions to reduce/resolve problems and thus ameliorating their negative effects.

My practicum has strengthened my belief that regardless of the beliefs held by a clinician in relation to problem orientation, it is imperative for problems to be accurately identified in order to develop a successful intervention plan. Sheafor and Horejsi (2003) suggest that adhering to a generalist perspective in the beginning phases of the helping process helps clinicians to be successful in the task of accurate problem identification. To correctly identify areas of change and the approach(es) most effective in achieving change, a clinician must consider a variety of factors that contribute to an individual's social functioning. A comprehensive assessment that gathers information related to the individual's development, family history, available supports, and self identification of strengths and stressors puts clinicians in a position to see not only the functioning of their client, but how their client is impacted by the world in which they live.

### **Developmental theory.**

Developmental theory encompasses a vast set of theories that offer perspectives on multiple areas of development including physical, cognitive, social, and emotional. Developmental concerns are often the basis of professional judgements about the problems people face and the existing literature not only helps counselors focus their attention on the needs of clients within the clinical setting, but also at different points in their lives (Miazga, 2000). Four of the theorists whose work that has influenced classical developmental literature and continues to be referenced in contemporary developmental literature include: Arnold Gesell's (1945) theory of maturational development, Jean Piaget's (1962) theory of cognitive development, Erick Erikson's (1963) theory of psychosocial development, and John Bowlby's

(1970) work on attachment theory. Regardless of the theory being considered, three common themes exist when considering how developmental concerns impact the functioning of individuals: continuity versus discontinuity, nature versus nurture, and activity versus passivity (Kail, 1998). The first theme, continuity versus discontinuity, explores how aspects of our early development are related to later developmental stages. The second theme, nature versus nurture, explores whether an individual's biology or their experiences within the environment are more influential in development. And lastly, activity versus passivity, looks at whether individual characteristics influence development or if we are at the mercy of our environments.

Arnold Gesell (1945) was extremely influential in the scientific observation of infants and children that ultimately led to his development of maturational theory. According to Gesell (1945), maturation is defined as "a child [who] comes into his biological endowment through the innate processes of growth" (p. 20). Gesell believes that all development follows a natural sequence that is biologically based, but also unique to every individual. He believed there are biologically based stages of development. Within each stage, there is room for variance of development based on environmental factors, but thresholds exist that prevent advancement until one's biological make-up cues movement to the next stage in the sequence (Thelen & Adolph, 1992). Miazga (2001) explains this by outlining that every person has their own schedule of development and "develops potential when the environment is in tune with developmental processes" (p. 4). While no longer widely recognized in developmental literature, Thelen and Adolph (1992) argue that Gesell's work does continue to influence contemporary developmental study because it relates to what can be considered developmental norms for infants and children.

Jean Piaget's (1962) theory of cognitive development identifies "four principal stages of the development of intelligence...[in which children] progress from one stage to the other by the

construction of new operational structures, and these structures constitute the fundamental instrument of the intelligence of the adult" (p.128). The first of these four stages is the sensorimotor stage and spans from birth to two years. This stage reflects the progression from simple reflex actions to symbolic processing. The preoperational stage spans the ages of two through seven years and is marked by a child's use of symbols to represent objects and events. Miazga (2000) states that children in the pre-operational stage are very egocentric which, prevents the ability for them to see the world from the perspective of others, and thus leading them to interact differently than older children and adults. The concrete operational stage spans the ages of seven through eleven years and demonstrates a child's first use of mental operations to solve problems. In this stage, children learn by doing, making the abstract concrete, and using the environment to stimulate their thinking (Miazga, 2000). The final stage, formal operations, spans the ages of eleven years into adulthood. During this stage, children develop the ability to apply mental operations to abstract entities, thus allowing for the existence of hypothetical thought and deductive reasoning skills (Piaget, 1962). According to Piaget (1962), children use schemas, psychological structures that organize our experiences, to understand the world around them. Through the processes of assimilation and accommodation, these schemes are constantly being shaped by our experiences. However, he identified that simple accommodation of experiences does not suffice at the four distinct stages of cognitive development, thus necessitating the creation of new schemas at these junctures.

Erik Erikson (1963), who elaborated on the earlier work of Sigmund Freud's psychosexual development, proposed eight distinct stages of psychosocial development. Each of Erikson's eight stages of development defined a unique crisis or challenge to be addressed. According to Erickson, the resolution of earlier stages would provide the foundation for later

stages of development. The identified crises to be addressed at each stage of development are as follows: basic trust versus mistrust (birth to one year), autonomy versus shame and doubt (ages one through three years), initiative versus guilt (ages three through six years), industry versus inferiority (six years through adolescence), identity versus identity confusion (early through late adolescence), intimacy versus isolation (young adulthood), generativity versus stagnation (middle adulthood), and integrity versus despair (old age).

Awareness of these developmental theories can assist professionals in their assessments as well as guide the creation of interventions that are well-suited to the clients they serve.

Developmental theories help to better understand the strengths and needs that clients present with. They also encourage consideration of client problems that can be a reflection of unmet needs they have previously experienced in their life (Hepworth, Rooney, & Larsen, 2002).

Webb (2011) outlines developmental factors play a critical role in how children respond to life events, whether favourable or stressful because these factors are influential in the ability of individuals to cope with problems they face. She also identifies that children are not only impacted by their environments, but can also be seen as active agents in influencing the environment around them. Delays in development, in combination with other environmental factors, have the potential to produce disturbances in a child's behaviour and functioning.

For example, one individual whom I worked with throughout my practicum was a seventeen year old female youth referred for counselling by a Ranch Ehrlo residential program caseworker to address personal boundary issues. Staff expressed concern regarding behaviours that included: intrusion in the physical space of others, acting like a cat as a means of engaging in physical contact with others by rubbing against them, and making unwanted advances as well as demonstrating obsessive tendencies towards women to whom she was attracted. These

behaviours caused extreme discomfort in peers and staff alike and were negatively impacting her social relationships with others.

During the initial assessment, which included consultation with her caseworker and teaching staff, an interview with the youth, and a review of some file information, I learned that this youth grew up in foster care from an early age due to parental addictions and physical neglect. She was diagnosed with Fetal Alcohol Spectrum Disorder (FASD) as a child and her cognitive testing revealed significant impairment of her intellectual abilities. Initially residing in homes considered to be a part of regular foster care resources, the youth spent many of her childhood years in a long term placement with her biological brother. She was eventually moved to a group home setting when the foster parent was unable to meet her exceptional needs. It was clear that this youth's prenatal exposure to drugs and alcohol as well as placement and relationship disruptions throughout her life were at least partially responsible for her current struggles with social functioning. Obvious delays were noted in both her cognitive and psychosocial development. Her cognitive functioning was in large part at the preoperational stage of development as observed through her inability to consider abstract concepts and strong egocentric tendencies. Based on this stage of cognitive development as well as her diagnosis of FASD, she had extreme difficulties in her ability to consider the perspective of others. She also had not successfully resolved many of Erickson's proposed stages of psychosocial development including basic trust versus mistrust.

These developmental delays helped to explain her inability to understand how her physically intrusive behaviour caused others to feel uncomfortable, resulting in social rejection. She was unable to identify how her overt behaviour toward others negatively impacted her relationships, yet at times she did express remorse for her actions towards others. My

intervention was initially focused on trying to build a strong therapeutic relationship with her built on mutual respect and trust. We spent much of our first session playing games and discussing things of interest to her. An opportunity to model and verbalize appropriate personal boundaries arose while playing "Jenga". After a block had fallen on the floor, the youth was asked to pick it up. When she initially declined, I explained to her that because we do not know each other well, I would feel uncomfortable entering her personal space. While she did not respond verbally, at this point she did pick up the block. During our second session, as I attempted to use pictorial representations of the differences between soft, rigid, and flexible boundaries, I noticed that she became disengaged. This taught me that she would benefit much more from the continuous use of games and discussion in areas of interest to her and where possible, tying this into her problems with personal boundaries.

### **Attachment theory.**

John Bowlby has been credited with creating the dominant view of early human relationships. Bowlby (1970, 1982) notes that his work on attachment theory was heavily influenced by ethologists, particularly Lorenz's studies regarding instinctual behaviours of ducklings and goslings as well as Harlow's studies of the effects of maternal deprivation on rhesus monkeys. Bowlby (1982) defines attachment behaviour "as any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world" (p. 668). Attachment, or affectional bonds, are seen as basic components of human nature with the biological function of survival (Bowlby, 1958). In infancy, this can be observed in behaviours including clinging, sucking, crying, and smiling, all of which elicit responses from caregivers that encourage interaction and lead to the development of attachment relationships. Bowlby (1970 & 1982) identified that

attachment is not only embedded in the neurobiology of a child, as seen in the existence of a child's innate temperament, but is also highly influenced by early childhood care giving. It is the early relationship between an infant and their caregiver(s) that provides children with the relational context where the earliest models of self, others, and self in relation to others are developed (Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B., 2003).

Mary Ainsworth expanded on the work of Bowlby by pioneering the study of the quality of attachment relationships (Kail, 1998). The creation of the "strange situation" allowed for observation of infants reactions to their separation from and eventual reunion with their caregivers. Four primary attachment styles were identified: secure, avoidant, resistant and disorganized. Secure attachments are characterized by children who may or may not become upset when separated from their caregiver, but upon reunion are happy to have the caregiver return and can quickly be consoled if upset. Avoidant, resistant, and disorganized styles of attachment are considered to be insecure attachment styles. Avoidant attachment is characterized by infants who tend not to become upset when separated from their caregiver, and upon reunion may actually ignore the caregiver. This reaction is thought to occur because the infant has learned that they are unable to consistently rely on their caregiver to meet their needs. Resistant attachment is characterized by infants who become upset when separated from their caregiver and remain upset or even become angry after reunion. These children are difficult to console when upset. Disorganized attachment is generally characterized by confusion - on the part of the infant - upon separation and reunion. They present as though they do not understand what is happening.

Consideration of attachment theory is essential as part of initial assessments in working with clients in a clinical setting because as outlined by Kail (1998) and McKenzie (2008),

attachment relationships developed in the first year of life have been shown to lay the foundation for all future social relationships. Remkus (1991), using the ideas of some of the leading attachment theorists, noted that "failure to establish a secure attachment relationship limits the emotional, cognitive, and social development of the child" (p. 144). Limited development in some or all of the aforementioned areas, can have a lasting impact on an individual's ability to build and maintain positive social relationships with others.

Attachment theory is something that I always kept at the forefront of my mind when meeting with clients throughout my practicum. One example of a client whose present difficulties could in part be understood through the lens of attachment theory was a woman in her early 20's who self-referred for counselling because she was interested in improving her social skills. This client explained that growing up, she always had the sense that she was somehow different from her peers, but never understood why. Much to her relief, she was diagnosed with Asperger's Syndrome two years ago. This diagnosis provided her with validation of her feelings growing up and helped her to understand her difficulties in socialization were associated with Asperger's Syndrome. This woman's goal in counselling was to improve her ability in identifying complex emotions and improve her social skills. She identified these as skills that would be necessary to increase her success in making and maintaining friendships as well as opening the door for possible romantic relationships. I was very mindful of attachment theory in this situation because early attachment problems would not be uncommon for a person with a diagnosis on the autism spectrum of disorders. These infants and young children tend not to respond to the efforts of parents in providing care and love, thus, there is an increased risk of the development of insecure attachments or for no attachment to develop at all. I spoke at length with this client about her current and previous relationships with family and friends. During this

discussion, I learned several strengths she already possessed, including her acknowledgement that she has little interest in social interactions, but has gone to great effort to find common interests with others as a means of connecting with others. Her strengths were highlighted and role plays were used to increase her confidence in different social situations.

### **Family systems theory.**

Social work practitioners endeavour to promote positive outcomes for individuals through identifying and influencing interactions of various systems and subsystems of a person's life including individuals, families, groups, organizations, and communities (Kirst-Ashman & Hull, 2002). Murray Bowen (1966), a pioneer in the development of family systems therapy, proposed a theoretical model offering a comprehensive view of human behaviour as it relates to family therapy. Bowen (1966) identified families as systems whose functioning is dependent upon the functioning of the larger ecosystem where they are embedded as well as its subsystems. Therefore, a change in one part of the system results in compensatory change in other parts of the system. Bowen's (1966) theory outlines six concepts that help explain the emotional forces that regulate how we relate to those around us and are based on the need for balance between individuality and togetherness: differentiation of self, triangles, nuclear family emotional process, multigenerational transmission process, emotional cut-off, and societal emotional process.

According to Nichols (2009) differentiation of self refers to one's ability to balance their capacity for thinking and feeling. A person who successfully achieves differentiation of self is capable of strong emotion and spontaneity, but is also capable of self-restraint in the face of emotional impulses. Triangles pertain to the involvement of third parties in relationships of duos where each person is driven by the reactive forms of behaviour of the others (Nichols, 2009).

Anxiety is a major influence in one's need for emotional closeness or distance to others and can create unhealthy triangulations that act as diversions which undermine relationships. Nichols writes that nuclear family emotional process refers to the emotional forces in families that operate in recurrent patterns over the years. The multigenerational transmission process describes how anxiety is transmitted from one generation to the next, with children moving either higher or lower on the scale of differentiation of self, depending on their level of involvement in the family's emotional reactivity (Nichols). He identifies emotional cut-offs as describing the physical or emotional distance that individuals seek as a way to manage the anxiety between generations. Lastly, societal emotional process refers to how social influences (ex. sexism, class, and ethnicity) affect the functioning of families. According to Bowen (1966) the underlying factor in the origin of psychological problems is emotional fusion among members of a family that is passed down from previous generations. The primary mechanism for change in Bowenian family therapy is the opportunity for individuals to learn about themselves and their relationships so they are in a better position to focus on the role they play in interpersonal processes.

Systems also have identifiable boundaries that help to distinguish between those who belong and those who do not (Sheafor & Horejsi, 2003). Boundaries are invisible barriers that regulate the amount of contact that an individual has with others and there are three distinct types: rigid, diffuse, and flexible (Nichols, 2009). Rigid boundaries tend to result in disengagement because little contact is permitted with outside systems. Diffuse boundaries on the other hand result in enmeshment, losing one's independence and autonomy for heightened feelings of support. Lastly, flexible boundaries can be considered the healthy control between boundaries that are either too rigid or too diffuse and encourages balance between dependence

and independence. Take for example, a family system that consists of a mother, father, and two children. Several subsystems exist within the larger system of this family: the couple subsystem, the sibling subsystem, the parent-child dyad, etc.. Kirst-Ashman and Hull (2002) state that it is the work of a generalist social work practitioner to conduct a thorough assessment in order to make a determination of what system is best targeted to pursue positive change for their identified client.

How does systems theory help to explain the determinants of problems that individuals present with? As quoted by Nichols (2009) "Experience teaches us that what shows up as one person's behaviour may be a product of relationship." (p. 64). Even when only one person in a system is singled out as having a "problem" that needs to be addressed, practitioners must take the initiative to look beyond this one individual to be able to fully understand the source of the problem and how best to focus one's helping efforts (Webb, 2011). There must also be consideration of how the proposed interventions will affect not only the identified client or family in the case of family therapy, but how others involved with the client or family might change as well.

During my practicum placement, I had the opportunity to work with two young girls who were seven and nine years of age. They were referred for counselling services by their father who was concerned about their adjustment to the parents' separation. The parents shared parenting of the girls with them generally spending a week at a time with each of their parents. Of greatest concern for both parents was the strained relationship between the eldest daughter and her mother that was observed through the anger she directed toward her mother while in her mother's care. Without consideration of family systems theory and how each of the separate sub systems impact one another, I might have targeted the ten year olds aggression as the issue to be

addressed and offered her anger management strategies as a possible intervention. Instead, exploration was done with the children and both parents separately to learn how the change in the parental subsystem was impacting everyone. I learned that everyone had fears and insecurities which were not being communicated and/or addressed. These tensions contributed to an increase of behavioural reactions between family members. In a session with the parents and children we identified some of these fears and developed of strategies to improve communication (including time set aside at to talk together at the end of the day and using a journal to share feelings that are difficult to speak about in person), the relationship between the mother and eldest child improved significantly.

### **Interventions**

Prior to my practicum placement at Ehrlo Counselling Services, I believed that I was relatively successful in my efforts as a front-line child welfare worker. I believed myself to have the skills needed to develop strong therapeutic relationships with clients. I considered myself a strong supporter of the strengths perspective, incorporating strength identification in my assessments. I also thought that I was quite successful in refraining from the use of a standard or 'cookie cutter' approaches for problem resolution without considering how the approach would be helpful to the client. However, after starting my practicum, it became apparent to me that my many years as a child welfare worker resulted in the development of some poor habits. While I was successful in developing positive working relationships with clients predicated on mutual respect and trust, I can see now that I was not as successful in establishing a relationship of therapeutic benefit. I attribute this to being distracted by the overt safety threats to the children that I failed to relate to the state of mind of parents, therefore I did not understand their perspective of problems. In each and every assessment I completed, I was extremely careful in

identifying client strengths and existing supports, but these strengths were not always successfully tied to how they could be utilized in creating solutions. I always took great effort to view each client and family as unique and provided them an opportunity to be involved in a treatment plan that they thought would be effective. However, the longer that I remained in the role of a child protection worker, the more I saw that treatment plans I implemented lacked consideration as to how the plan would benefit the family both now and in the future.

My previous experiences of working with clients does not meet the expectations that I want to include in my personal framework for counselling. Ideally, I want to be a clinician who is able to support and empower clients to view their current circumstances and identify areas of change that will have a positive influence in their lives. I want to support clients in developing creative solutions to their problems; solutions that are meaningful in their lives and that have the potential for long lasting change.

### **The therapeutic relationship.**

When I was taking my undergraduate coursework in social work, great emphasis was placed on relationship building skills that assist practitioners to develop therapeutic relationships with their clients. Hepworth, Rooney, and Larsen (2002) argue that communication skills are used as building blocks to assist in the development of a therapeutic relationship. Carl Rogers (1980) summarized the central hypothesis of his 'person-centred approach' to therapy as follows: "Individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behaviour; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided" (p. 115). The conditions that Rogers argues must be present to facilitate such a climate are congruence, unconditional positive regard, and empathic understanding.

Rogers (1980) defines the condition of congruence as the clinician's ability to provide genuine care and concern that is transparent to the client, without hindering the client's self-determination. He goes on to define unconditional positive regard as a clinician's ability to maintain a positive and accepting attitude toward the client, regardless of whether the client is in a positive or negative emotional space. Lastly, Rogers defines empathic understanding as the clinician's ability to accurately sense the feelings and personal meanings being experienced by the client and to be able to communicate this information back to them. Rogers found that the effective use of congruence, unconditional positive regard, and empathic understanding created an environment where clients are free to experience emotions without fear of judgement. He goes on to note that a strong therapeutic relationship provides professionals with the opportunity to communicate both conscious and unconscious feelings back to clients thus facilitating the greatest likelihood of constructive change. I agree with Roger's statement that clients who feel truly accepted and "prized" are more able to develop a more caring attitude toward themselves. This very process encourages greater alignment between one's self and one's experiences, thus resulting in "greater freedom to be the true, whole person" (Rogers, 1980, p. 117). My personal and professional experiences lead me to believe that this type of sensitive and active listening is rarely experienced in one's life, yet is one of the most powerful forces of change.

One of the most rewarding examples from my practicum was to truly and successfully engage with the mother and father of the two girls whom I met with to help resolve their feelings regarding the separation of their parents. While the focus of most sessions was on working with the girls, I also took time at each session to meet with each of the parents. At the conclusion of each session, time was also taken to meet together as a family. The purpose of the family meetings was to review, with agreement from the girls, those things they were comfortable in

sharing with their parents. Initially I had difficulty connecting with the parents. I believe that my insecurities about transferring my skills to a clinical setting were unconsciously communicated to the parents through the tone of my voice and my body language. This reduced their confidence in whether I would be able to successfully support their children as well as help them. During the first two sessions, the parents directed questions and concerns to my supervisor, seeking her feedback. However, through consistent use of congruence, unconditional positive regard, and empathic understanding, I was able to gain the confidence of the parents. They became much more comfortable in opening up to me without fear of judgement and felt secure that I was able to support them in achieving positive change in their own lives as well as in their children's lives.

### **Strengths perspective.**

As a profession that is focused on helping others, it seems counter intuitive that social work has developed and maintained a strong emphasis on the identification and treatment of deficits, disease, and dysfunction (Cowger, 1997; Weick and Chamberlain, 1997). However, the influence of psychoanalytic theory, which suggests a need to know about past traumas in order to treat present problems, on the field of social work has led to problems being emphasized when working with clients toward positive change. In fact, society in general has an overwhelming emphasis on pathology that results in a number of assumptions that paint vivid and unflattering pictures of individuals who seek the help of professionals to address their problems (Saleebey, 1997). When they set out to edit a text on resilience, Anthony and Cohler (1987) were surprised to learn of the limited literature available on this topic:

One would have thought that the picture of children triumphing over despairing, degrading, depressing, depriving, and deficient circumstances would have caught the

immediate attention of both clinicians and researchers, but the survivors and thrivers appear to pass almost unnoticed amidst the holocaust of disadvantage and the tragedies of those who succumbed to it. (p. 28)

The introduction of a strengths perspective in social work practice in the mid-1990's helped to denounce the idea that people who have endured hurt, trauma, or neglect are somehow flawed or weak because of their experiences and destined to face barriers in meeting their full potential in life (Saleebey, 1997). Saleebey advocates for professionals to turn their focus to a lexicon of strengths because "any approach to practice speaks a language that, in the end, may have a pronounced effect on the way that clients think of themselves and how they act" (p. 8). According to Saleebey, six ideals exist within the strengths perspective. The first ideal is that individuals need to be empowered to discover and expand the resources and tools around them. Membership, the second ideal, refers to promoting a sense of membership and belonging that affords individuals the benefits of dignity, respect, and responsibility that comes with such membership. Third, this perspective also believes that people need to be seen as having the capacity for resilience in order to rise above in spite of traumatic life experiences. The fourth ideal is that there should be an emphasis on healing and wholeness. The fifth ideal is that the helping process needs to use dialogue and collaboration so clients can be supported to trust in their innate wisdom about what is right for them and what they should do when faced with challenges. The final ideal is that professional social workers need to suspend any disbelief, particularly when faced with skepticism of information presented by clients (Saleebey, pp. 8-11).

The strengths perspective is intended to be much more than merely identifying client strengths. According to Dennis Saleebey (1997), everything that a social worker does is based "on helping to discover and embellish, explore and exploit client strengths and resources in the

service of assisting them to achieve their goals, realize their dreams, and shed the irons of their inhibitions and misgivings" (p. 3). Saleebey offers five principles intended to guide the work clinicians do when using a strengths perspective. The first is acknowledgement that every individual, group, family, and community has strengths. Second, the presence of trauma, abuse, illness, or other struggle should be seen as a source of challenge and opportunity for individuals to rise above. Third, helpers are discouraged from assuming they know the upper limits of clients' capacity to grow and change, therefore needing to always take seriously a client's aspiration for change. The fourth principle is that clients are always best served through collaboration and thus, social workers have as much to learn from the clients as the clients have to learn from them. And finally, one must never forget that every environment has a full range of resources that can be accessed to support growth and change, we simply need to find and utilize them (Saleebey, pp. 12-15).

One example from my practicum that demonstrates the benefits of using a strengths perspective are the sessions with a previously mentioned female client in her early 20's who came to counselling because she was interested in improving her social skills following a diagnosis of Asperger's Syndrome. This client's goal for counselling was to increase the skills necessary to identify with others as she believed that this would increase her success in making and maintaining personal relationships. During the initial assessment I learned that this client demonstrated significant strengths in regards to making and maintaining a few core relationships throughout her life. Together we reviewed how she was able to accomplish this in spite of her difficulties with social skills. She identified that finding common interests proved effective in the past. However, she felt that since she moved from a large urban centre to a smaller rural community, this has created barriers for her in finding others who share similar interests with

her. Together we explored whether or not expanding her own areas of interest might result in more success in making new friends. This young woman was extremely motivated and so identified two areas of interest that she believed to be most common to residents of her current community: health and fitness and sports. From this point, we role played different scenarios she might encounter in starting conversations with someone she was meeting for the first time. This exercise provided her with the opportunity to practice reading not only facial expressions, but body language as well. While it was assessed that she already had skills in this area, it was observed that she would sometimes get caught up in assessing a situation, missing social cues as a result of not being mindful. Practicing these skills helped to increase her confidence and allowed her to focus more on the present moment.

**Importance of creative interventions.** Children naturally use creativity and play as a way to grown and learn. Hall, Kaduson, and Schaeffer (2002) write that play tends to be a useful approach in working with children because "they have not yet developed the abstract reasoning abilities and verbal skills needed to adequately articulate their feelings, thoughts, and behaviours. For children, toys are their words, and play is their conversation." (p. 515). . Children are naturally drawn to creative interventions such as music, art, stories, and play and it these interventions that are best suited to facilitate the expression and exploration of children's emotional worlds in a non-threatening way (Axline, 1947; Landreth, 2002). Axline (1947) and Landreth (2002) speak to the fact that children's defenses are reduced as a result of involvement in activity that is comfortable and second nature to them, an environment is created in which children feel secure in connecting with their feelings that they might otherwise avoid due to threats to their sense of self. Play [and other creative interventions] offer children the opportunity to use fantasy as a way of mastering the skills needed to effectively deal with

situations that threatened their safety and security (Axline, 1947; Hansen & Saxe, 2009; Landreth, 2002; Terr, 2009).

Play has been identified by some writers to be the sole work of children. Landreth (2002) identifies that many adults fail to acknowledge play as an intrinsically complete activity. Nearly all activities that adults engage in are dependent upon external rewards (Landreth). As a result, adults tend to feel uncomfortable, self-conscious, and even embarrassed about engaging in playful activities, thus hampering the spontaneous and creative impulses associated with play (Landreth, 2002; Lowenstein and Sprunk, 2010). However, when clients are open to being involved in play therapy or the use of other creative interventions, these interventions have shown to be effective in use with adolescents (Bruneau, 2012; McKenzie, 2008), adults (Landreth, 2002; Malchiodi, 2003), as well as in family therapy approaches (Hall, Schaefer, & Kaduson, 2002). Eliana Gil (1994), a pioneer of family play therapy, argued that play techniques should be considered a viable and pivotal aspect in therapy because they "can engage parents and children in enhanced communication, understanding, and emotional relatedness" (p. 42). The therapeutic benefits of play in family therapy sessions include: overcoming resistance, improving communication, developing competency through mastery, thinking creatively, achieving catharsis, visualizing through fantasy, learning through metaphoric teaching or role plays, forming attachments, enhancing relationships, improving overall development, and improving socialization (Gil, 1998, p. 12).

The use of creative interventions has also proven to be useful when working with individuals who have experienced trauma in their lives (Hansen & Saxe, 2009; Levine, 1997; Terr, 2009). According to Levine (1997), trauma is the result of an excess of built up energy that is stored in our bodies during times of crisis. Friedburg and Wilt (2010), identify that creativity

is an inherent aspect of change and by incorporating the use of creative interventions such as music, art, or stories and metaphors can help clients to reduce anxiety, increase memory retrieval, organize narrative accounts, as well as prompt clients for learning more information about their presenting problems.

Debates within the fields of study including musicology, cultural studies, and aesthetics exist around the role and function of music in society and how the use of music in everyday life impacts emotional regulation and behaviour (Ruud, 2008). Consider the use of music in cinema to create a certain mood, or how songwriters convey their thoughts and feelings within the lyrics they create, or even how people are drawn to or respond to different genres of music dependent upon their mood. Using music in therapy provides a means of improving, regulating, and restoring physical and mental health (Ruud, 2008). He outlines a number of ways that music is able to influence people. First, listening to music can trigger memories of important events and people in our lives. Music also allows us to dissociate from difficult emotions or thoughts, thereby reducing our anxiety. Music can be an exercise in social bonding and inclusion, thus improving outcomes for those people who might otherwise experience social isolation. And lastly, because individuals learn to relate to music beginning in early childhood, musical communication can be successful where other forms of communication have failed. Activities including song writing, listening rituals, improvisation, performances, and recreational music activities can provide clients with a new context, freedom, or strength that allows them to bypass their vulnerability and take steps toward positive change (Ruud, 2008).

Art is another creative venue that can provide clients with an alternative means of expression. Malchiodi (2003) identifies that there is debate around two common definitions of the term 'art therapy' and which of these is correct. One is that art is seen as an extension of

psychotherapy whereby clients are supported in communication of their thoughts, feelings, beliefs, problems and world views. The other is that the creative process of making art is seen as inherently therapeutic and can ultimately lead to physical and emotional healing. Being creative encourages personal growth, increases self-awareness, and assists with emotional self-regulation. According to Malchiodi, most therapists subscribe to both of these definitions. Vick (2003) provides a history of art therapy that suggests its origins lie in the medical field. Art therapists have been successful in working with patients being treated for a variety of medical conditions including AIDS, asthma, burns, cancer, chemical dependency, and trauma to name a few (Malchiodi, 1999a, 1999b). The success of using art therapy to help improve the lives of individuals treated with various medical conditions suggests that art has a role to play in exploring the connections between our bodies and our minds (Vick, 2003). For art therapy to be effectively used in a clinical setting, professionals must always remember that the client must always maintain the role of interpreter regarding their own work (Vick, 2003), and client's art representations are reflective of present functioning only (Kaplan, 2003).

In their research, Friedburg and Wilt (2010) showed that to increase our ability in coming up with solutions to the problems, we must first learn to see things in a new way. They suggest that the use of metaphors and stories is one way to achieve new insight. Friedburg and Wilt identify metaphors and stories as having the potential to enliven traditional therapeutic approaches by presenting information in a new way that is potentially more meaningful to the individuals with whom we work. The transformational power of metaphors and stories comes from the client's identification with the characters and events portrayed within the metaphor and/or story used (Heston, 1997). The benefits of using metaphors and stories in the therapeutic process include: fostering developmental sensitivity; helping with the recall of information;

increasing an understanding of complex ideas with simple representations; fueling learning and objectivity; teaching skills in an engaging way; promoting collaboration; having the ability to challenge existing beliefs with minimal defensiveness; and allowing individuals to express prohibited thoughts and feelings with relative safety (Friedburg & Wilt, 2010, p. 101-103).

I was presented with several opportunities throughout my practicum to incorporate creative interventions into the work that I did with both individual clients and in groups. In each of the sessions conducted with children, I included hands on activities that were based on the issues we discussed. For example, when meeting with the two children referred for counselling because of their parents separation, the use of stories proved to be effective. Together we read a story about a boy whose parents had separated and he wished for nothing more than his parents to reunite. In the story the boy learned that as upsetting as the truth was, whether or not his parents got back together was something that he could not control. However, he also learned that one thing that was in his power to control was to think of those things in his life that make him happy. This story provided the girls with security in knowing that the feelings they were experiencing were natural. Following the story we spent time involved in a writing/drawing activity where the girls were asked to think about things in their life that are positive and made them feel happy. By being occupied with the hands-on aspect of this task, the girls were openly able to share a number of positive changes that have resulted from their parents' separation including less arguing between mom and dad.

Another example of a creative intervention I used with one of the young adults was the use of music. The young man whom I was meeting with had been referred by the staff of his residential program due to problems he experienced in relation to depression as well as verbal and physical outbursts of anger in response to direction by staff. During the initial session, this

young man shared with me that he loves music and at times when he has been upset, he will sometimes write out the lyrics to songs he identifies with. In a future session, we discussed and explored the possibility of how his mood can be impacted by listening to different genres of music. He agreed that listening to upbeat music containing positive messages could improve his mood. As a way of encouraging further exploration of this idea, he was asked to identify a song that inspires him in some way. In the next week, whenever he was experiencing a depressed mood, he was encouraged to listen to this song and even write out its lyrics as a way to see if it improved his mood. Unfortunately, I did not have an opportunity to meet with him again following this session and so cannot say how the exercise may have impacted him. Throughout the duration of this session the focus on music opened up various avenues of discussion and empowered this young man to more openly share his thoughts and feelings without fear of judgement.

### **Theoretical Approaches**

In their efforts of compiling a text addressing the use of cognitive-behavioural therapy with children, Reinecke, Dattilio, and Freeman (2003) discovered the literature pertaining to clinical work with children was sparse in comparison to clinical work with adults. The existing literature on interventions with adults fails to consider developmental and family systems theoretical perspectives that are essential in clinical work with children (Reinecke, Dattilio, & Freeman). The lifespan of children and adolescents is characterized by dramatic changes in their social, cognitive, behaviour, affective, and physical abilities. The competencies developed in each of these areas serves as a foundation for effective functioning in adulthood (Kail, 1998). As such, developmental delays in these areas place children at risk of developing emotional and behavioural difficulties in their lives (Reinecke, Dattilio, & Freeman). When considering the

benefits of therapeutic approaches to be used with children, Reinecke, Dattilio, and Freeman suggest that children who have not yet developed the ability for abstract thought and reasoning are better served with therapy that is directive and focused on problem resolution. Virginia Axline (1947) on the other hand, who was involved in developing non-directive play therapy, believed that when children are left to naturally play out their feelings and emotions it would result in children having a better understanding of themselves and others. Mash and Dozois (2003) identify that emotional and behavioural development of children is influenced by a range of factors that cut across multiple systems, both internal and external to the child. A very influential method of learning for children is modelling which is learning that occurs by observing the behaviour of others and the consequences of that behaviour (Bandura, 1969). It therefore stands to reason that behavioural and emotional development of children is influenced not only by biological factors, but also by the role modeling from their families, peers, schools, and communities. Creative interventions used with children and families support a child's increased understanding of abstract concepts while at the same time support families and communities to make the changes necessary to alleviate any unnecessary stress in the child's life (Reinecke, Dattilio, & Freeman, 2003). The end result is children who have increased adaptive functioning that will help them cope with life's struggles.

Reinecke, Dattilio, and Freeman argue that despite the theoretical approach used with a particular client or family, there are a number of common characteristics between the different theoretical perspectives. Some of these similarities include interventions that are active and focused on problem resolution, aimed to provide the shortest and least intrusive treatment as possible, encourage action on the part of children and families, focus on the generalization of treatment, and take steps to prevent future recurrence of problems (Reinecke, Dattilio, &

Freeman). These authors also note that when there is a shared understanding of the problems between the therapist and families, the families and children will have a sense that they have been heard and understood and thus be left with increased feelings of hopefulness that problems will be resolved.

### **Cognitive-Behavioural Therapy**

Cognitive-Behavioural Therapy (CBT) is founded on the assumption that behaviour is adaptive and its purpose is to organize and regulate our responses to life events (Reinecke, Dattilio, & Freeman, 2003). This means that how we think and feel about events in our lives will influence our behavioural responses to these events. Cognitive processes are viewed as a skill set that is developed over the lifespan and cognitive development is influenced by our social context. (Reinecke, Dattilio, & Freeman). According to Dattilio and Hanna (2012) CBT is aimed at correcting thinking errors and altering negative automatic thoughts into more positive and productive representations of reality. Therapists using CBT work cooperatively with their clients, helping them to identify their current cognitive patterns (Reinecke, Dattilio, & Freeman). Once client thoughts and beliefs are identified, there needs to be an assessment about the helpfulness of the existing patterns when addressing a client's emotional and behavioural concerns. This process includes identifying a client's core beliefs and assumptions, the automatic thoughts they have about themselves, and the often unpleasant thinking errors that are present and interfere with their opinion about what they are capable of and want to do in their lives (Reinecke, Dattilio, & Freeman).

Paul Stallard's (2002) publication "Think Good - Feel Good" is a CBT workbook for children. Stallard created three characters that are intended to help children explore and understand the link between thinking, feeling, and behaviour. The 'thought tracker' is the

character that helps children explore their thinking patterns including the existence of core beliefs, assumptions, and automatic thoughts. The 'feeling finder' is the character responsible for how the way we think influences whether we experience pleasant or unpleasant feelings. Lastly, the 'go getter' is the character that encourages children to explore that strong and persistent feelings that directly impact on our actions, but that we have the power to "STOP" unhelpful cycles by learning to have balanced thinking that challenges our negative thoughts (Stallard, p.37-44). Stallard also uses metaphorical representations that children can relate to and that help them better understand complex ideas. An example is comparing automatic thoughts to a tape playing over and over in a child's head.

Resources, like the one developed by Stallard (2002), are intended to be used based on the client's needs. Clinicians are encouraged to use only those activities that are relevant to a specific client in order to help them gain mastery in their ability to accurately identify their thoughts and feelings as well as to encourage developing more positive thoughts that can be substituted for those that are causing difficulties.

Cognitive-behavioural therapy is the most commonly used therapeutic approach by staff at Ehrlo Counselling Services. I had the opportunity to use this approach with some of the clients I worked with during my practicum. One example is the sessions I had with a young man who had been referred by staff of the residential program because of adjustment difficulties. He presented with a depressed mood and staff were concerned about outbursts of anger he displayed when being given direction. In the initial session, this client attributed all of his problems to the break-up of a romantic relationship. By exploring his thoughts and feelings about this, I learned that he viewed this relationship as perfect in every way, yet he chose to end it. He made the decision to end the relationship because he was not comfortable with his former girlfriend's

desire to become more physically intimate. He believed his decision to end the relationship was cowardly. His negative interpretation about himself seemed to cast a negative light on other areas of his life as well. Together we explored alternative interpretations of the event. For example, we explored an alternative perception of him and his awareness of his own limits and respect for his boundaries, despite outside pressures, as being courageous rather than cowardly. Provided with an alternative interpretation of the break-up, this client was able to identify more positive emotions. He did not reach a position of being able to consistently maintain a positive interpretation of this particular event. He was however introduced to the concepts of CBT, including the need to challenge his thinking errors. He experienced that positive interpretations of events can improve his mood as well as have a positive impact on his behaviour.

### **Solution-Focused Therapy**

Solution-focused therapy is a strengths based approach where the history of problems is not considered necessary in order for therapy to be effective. Nichols (2009) explains that solution-focused therapy assumes that clients are the experts on their situations and the therapist takes on a supportive role, helping clients to "see that their problems have exceptions - times when they don't occur - and that these exceptions are solutions...available to them" (p. 262). There are three assumptions that form the basic model for solution-focused therapy (Nichols). First, effective therapy must look to the future where problems can be solved rather than search the past to discover what caused them. Second, clients are considered to be the experts of their own situations. Therapists should routinely check in with clients if there is anything that should have been asked or something they want to share as part of the process in helping clients construct solutions that are able to enhance their lives. Lastly, attempts must be made by the therapist to not categorize clients by labelling their behaviour. To do so suggests that individuals

act a certain way all of the time. Instead, therapists must acknowledge that individuals will adapt their behaviour based on changes in their environment.

Solution-focused therapy emphasizes that interactions we have with clients convey messages and impressions to the client that have a powerful impact on the professional relationship (Berg, 1994). There are four basic types of questions that are used when conducting a solution-focused session with clients. These are exception finding questions, miracle questions, scaling questions, and coping questions (Berg). Exception finding questions allow clients to think back to a times when the problem might have existed but did not. This encourages the identification of how patterns around the problem were different or changed. Miracle questions encourage clients to disregard their current problems and imagine what life would be like in a successful future. This type of question creates a vivid picture of what the client's life would look like if the problem is solved and creates hope that things can be different. One example of the miracle question is this: "Suppose one night there is a miracle while you are sleeping and the problem that brought you ...[here] is solved. Since you are sleeping, you don't know that a miracle has happened or that your problem is solved. What do you suppose you will notice different the next morning that will tell you that the problem is solved?" (Berg, p. 97). Scaling questions are useful to help clients identify a continuum of concrete behavioural changes in relation to abstract concepts such as self-esteem, investment in change, perceptions of hopefulness, etc. This type of questions generally uses a ten point likert scale with 1 denoting the complete lack of some identified concept and 10 denoting the opposite. Once a concept has been quantified, clients are able to see where they want to be, what they are doing now that helps, what else they might need to do, how others around them might respond differently to the changes. This puts clients in a better position to make an informed decision about what steps

they need to take next. Coping questions explore with clients the resources and strengths they have of which they are unaware. By finding out from a client about what they have done to cope with their present problem, clients can begin to recognize their self-worth and build confidence in their abilities.

Solution-focused therapy also has a number of techniques that are unique to this approach. One technique involves looking at past successes of clients. Insoo Kim Berg (1994) explains that the exploration of past successes empowers clients, reminding them of their past abilities to solve problems. Another technique, the exploration of pre-session change, amplifies a client's self-initiated movement toward change from the time of booking to the actual appointment. Recognition of their efforts will generally result in the continuity of this behaviour (Berg). Nichols (2009) identifies the use of compliments as a technique of solution-focused therapy. While compliments are also used in other forms of therapy, those used in solution-focused therapy are often conveyed to clients in questions as well as highlight effective strategies in order to keep clients focused. The final technique used in this approach is ending a session by taking a short break in order to prepare a thoughtful summary of the session and feedback to the client (Berg, 1994; Nichols, 2009). Summary messages should include a review of what the therapist heard the client say, a statement reflecting the therapist's reaction, as well as suggestions that can be used before the next appointment to build on positives (Nichols, 2009).

Selekman (1997) argues that traditional solution-focused therapy has a number of limitations when used with children. He identifies that a solution-focused approach is a form of 'talk therapy', which is in direct contrast to children's natural means of self-expression. Secondly, the use of abstract concepts such as goals and miracles can be too difficult for young children to understand since they have not developed the cognitive ability of abstract thought and

reasoning. And lastly, solution focused therapy fails to consider the concept of 'wholism' as defined in family systems theory. Just as altering parental beliefs and interactions with children has the ability to change children, so too can children serve as the catalyst for change in relation to family interactions.

An example where a solution-focused approach was used in my practicum was in the work I did with the siblings who were referred because of their parents' separation. The parents were concerned about the children's ability to adjust and cope. A common theme emerged when I met with the girls. Both girls expressed concern because their mother was easily upset and would often raise her voice to them. The girls worried that their mother was angry with them and avoided sharing their feelings and concerns with her because of fear that she would become upset with them. In one session, the girls were asked to identify activities they enjoyed participating in with each of their parents. The eldest of the girls who was nine chose to write a list, while her younger six year old sister was given the option of creating a drawing. When they finished, we spoke about their list and drawing and what in particular they enjoyed about the activities. Our discussion included some brainstorming about what could be done to encourage these feelings in the future. The parents were advised ahead of time about this activity and were asked to make a similar list for each of the girls. When the parents and children were brought together at the end of the session, everyone shared what they had come up with. This proved to be quite powerful for the family. The mother was able to reflect on how her responsibilities as a newly single working parent left little time to engage in quality time with her daughters. The mother and daughters were able to brainstorm how they could ensure some time is set aside each day to have much needed quality time. For the mother and eldest daughter, this meant making a point at the end of each day to sit and talk while getting ready for bed. Following this session,

the mother and children reported more enjoyable interactions between each other and in turn the mother reported fewer behavioural concerns with her eldest daughter.

### **Narrative Therapy**

The narrative approach to therapy focuses on the personal stories of individuals, communities, and cultures and the ways that people construct meaning of the experiences in their lives (Nichols, 2009; Sheafor & Horejsi, 2003). Therapists who practice narrative therapy listen to the stories of clients with the goal of helping them identify the unproductive story lines they have about themselves and their problems. The focus is then on helping them find alternative and more productive stories (Nichols, 2009). There is a strong emphasis with this approach on the power of language in shaping our perceptions. A question and answer dialogue is used to elicit the existing world of the client as well as to encourage the construction of stories that will result in new behavioural patterns (Freeman, Epston, & Lobovits, 1997; Sheafor & Horejsi, 2003). Externalization of problems is a technique used to help clients view themselves as struggling against a problem instead of the problem being a part of who they are (Freeman, Epston, & Lobovits, 1997; Nichols, 2009). Once individuals are able to view the problem as outside of them, they are better able to deconstruct unproductive stories by questioning their assumptions and then reconstructing new and more optimistic accounts of their experience (Nichols). "Children and families are invited to share [their] accounts of past events and to speculate about the future within the context of a new story in the making" (Freeman, Epston, & Lobovits, 1997, pg. 19).

Freeman, Epston, and Lobovits (1997) have explored how narrative therapy could be modified in order to increase its effectiveness and appeal to children. They argue that the central focus in using a narrative approach with children is to connect with their imaginations. As noted

by Lenore Terr (2009), narrative approaches can be used to help children develop context around traumatic experiences because children often need support to process material that they might otherwise not think to discuss with anyone. Freeman, Epston, and Lobovits (1997) encourage playfulness be incorporated in the externalization of problems as this sets the stage to deal with serious issues in lighthearted way, making it more appealing for children. For young children who do not have the developmental ability to verbalize their narratives, pictures and play can also be used to elicit their stories. I believe that the process of externalization gives children and families a greater sense of control over the problem. And when a person feels in control, they are better able to develop solutions to deal with their problems in a way that is most meaningful and effective for them.

Throughout my practicum, I did not use a true narrative approach in any of my sessions. While I used various questions to elicit stories about the current circumstances of clients, externalization was not used to help clients separate themselves from their problems. What I did do, was use therapeutic stories with children that offered them an alternative way of viewing a particular problem. After reading stories, we would discuss the stories so the children could process the ideas being shared in them. Despite not having gone further with the narrative approach in my own sessions, I did have the opportunity to observe this approach being used by my professional associate. I sat in on a session where she was meeting with a young girl around nine years of age who struggled with anxiety. During the session, this girl discussed an anxiety provoking situation at her school when they were having a routine fire drill. This was very upsetting to her as she did not know what was expected of her. The professional associate and the young girl spent much of this session creating a story based on a fictional character that the child created in a previous session. In this story, the character was faced with an anxiety

provoking situation and the young girl was asked to help the character resolve it by considering what she thought the character might do that would be helpful. Because of the emotional distance that was created through the use of a character, this young girl was able to create a number of creative solutions that she believed would be helpful. These solutions included the character asking their mother for support, taking deep breaths, and asking for information from others as stress is reduced when you eliminate the unknown. At the conclusion of the exercise, the young girl read the story aloud and was able to consider how some of these solutions might be effective in her own life.

### **Play Therapy**

Play Therapy Canada (2006) defines play as a therapeutic intervention that "uses a variety of play and creative arts techniques ... to alleviate chronic, mild and moderate psychological and emotional conditions in children that are causing behavioural problems and/or are preventing children from realising their potential" ("A Definition of Play Therapy", para.1). Children view the world in concrete realities and it is through play that a child communicates their experiences to others (Landreth, 2002). Play is an activity of childhood that is universal to all children. In its true form, play is spontaneous, enjoyable, voluntary, and non goal directed (Landreth, 2002). Arnold (2000) writes that "it is a beautiful thing to see a child thoroughly absorbed in his play; in fact, it is hard to think of a purer, more spiritual activity. Play brings joy, contentment, and detachment from the troubles of the day..." (p. 35). Play therapy is seen by many as a medium for use with only children, however, play therapy has also been shown to be effective with adolescents and adults as well (Webb, 2011). I would suggest that while play can be seen as a therapeutic approach in its own right, it is also a tool that can be used alongside other therapeutic approaches (including family therapies and CBT) to engage children,

adolescents, and adults alike. Gil (1998) outlines the benefits of play in therapy include: overcoming resistance, enhancing communication, developing competence through mastery, and creative thinking. She also notes that play therapy can produce catharsis (abreaction) and be used in role playing. Play therapy uses visualization or fantasy, learning through metaphoric teaching, and can help in attachment formations, enhancing relationships, developing positive emotions, mastering developmental fears, and improving socialization (Gil, 1998, p. 12).

Therapeutic play can be either directive, non-directive, or a combination of the two (Axline, 1989; Landreth 2002; Play Therapy Canada, 2006). Play therapy is considered especially effective with children who cannot or are unwilling to talk about the problems. Directive play therapy refers to situations where the therapist leads children in their play. Non-directed play therapy refers to those situations where children direct sessions within safe boundaries established by the therapist. Virginia Axline (1947) is considered the pioneer of non-directive play therapy. She outlined eight basic principles to guide therapists in their work with children (pg. 69-70):

- Development of a warm and friendly relationship with the child.
- Acceptance of the child exactly as they are.
- Establishment of a feeling of permissiveness within the relationship so the child feels free to express themselves.
- Being alert to recognizing the feelings of the child and reflecting these back to him/her in a way that encourages them to gain insight into their behaviour.
- Maintenance of a deep respect for the child's ability to solve their own problems given an opportunity to do so.
- Refrain from attempts to direct the child's actions or conversation in any way; the child should lead and therapist follows.

- Refrain from attempts to hurry therapy along; therapy is a gradual process and should be recognized as such.
- Establishment of only those limitations that are necessary to ground the therapy in reality and make the child aware of their responsibility in the relationship.

Play therapy sessions can incorporate a wide variety of mediums or materials such as creative visualization, art/drawing/painting, therapeutic storytelling, sand trays, music, puppets, clay, dance/movement, masks, miniatures/replicas, and games to simply name a few. Therapists work to create an environment in which children can use all of their senses in the manipulation of materials available to them. Play is meant to symbolically represent something that the child has experienced either directly or indirectly in their lives (Landreth, 2002). These connections are sometimes obvious, but other times they might be quite obscure. Play represents the child's attempts to organize their experiences and can often be one of the few times that they have a sense of control and mastery, thus increasing their feelings of security.

Play is an approach multiple therapists at Ehrlo Counselling Services used to engage children, using a more directive approach. Counselors used games, clay, and stories in their work with children, as well as with adolescents and adults with cognitive delays. Throughout my practicum, my supervisor provided me with resources that included various activities that were effective in a therapeutic setting with children and their families. These resources included: Fifteen Effective Play Therapy Techniques (Hall, Kaduson, & Schaefer, 2002), Creative Interventions for Troubled Child and Youth (Lowenstein, 1999), Creative Interventions for Child of Divorce (Lowenstein, 2006), and Creative Family Therapy Techniques: Play and Art-Based Activities to Assess and Treat Families (Lowenstein & Sprunk, 2010). Some activities in these resources are pertinent to different stages of the therapeutic process from assessment to

termination while others are more pertinent to specific presenting problems of the client. I believe that regardless of whether a therapist engages in directive or non-directive play therapy with clients, it is essential to build your 'tool kit' and have many different materials and activities available to you and your clients.

I used play therapy and creative interventions in most of the sessions I had with clients, but in all of these instances I used a directive versus non-directive approach. Before sessions I would prepare several activities that could be used to address specific issues faced by clients with whom I was working. For example, the nineteen year old woman who struggled with personal boundary issues responded well to play therapy techniques. At our introductory meeting in her residence, I observed that this young woman was introverted and found it difficult to express herself. To help put her at ease, I suggested that we play a game of "Jenga" that was slightly modified from the original version. Instead of only taking turns removing blocks from the existing tower and repositioning them on top, we had to answer one of four questions on cards from an ice breaker exercise before proceeding with your turn. The addition of these questions to this game encouraged this client to share more openly in the session. Because asking questions was part of the game, her defenses were lowered and I was able to learn a lot about her strengths including that she demonstrated a genuine concern for the welfare of others, she had a love for animals, a positive work ethic, enjoyed working to earn her own money, and she enjoyed movies that she could relate with in terms of her life or her dreams. Knowing these things about this client provided me with multiple directions for future sessions that would foster engagement while at the same time provide information on respecting the personal space of others.

## **Creative Techniques in Family Therapy**

Selekman (1997) suggests a number of activities that can be used in family therapy with young children. These activities include various mediums such as drawing, storytelling, visualization, and drama. In family sessions, these activities can result in family members viewing each other in a new and more positive light. With the use of these techniques, negative interactional patterns can be broken down allowing families to generate viable solutions in moving forward. When these activities are used in individual sessions, they help to create an emotional distance from the problem, allowing clients a greater sense of security in exploring solutions.

Some examples of activities suggested by Selekman (1997) include: The Family Squiggle Wiggle Game, Child as Director, Stuffed Animal Team, and Visualizing Movies of Success. In "The Family Squiggle Wiggle Game" children are either the therapist or a family member of the child's choosing will draw a squiggle on a sheet of paper and then the child is asked to create a picture from this squiggle and follow with sharing a story about what they have drawn. This activity is useful in helping family members better understand the child. In family therapy sessions, the child and other family members could switch roles with the child creating a squiggle out of which another family creates a picture and story. Most family members will create a picture or story that incorporates the identified child client in a positive light.

"The Child as Director" activity is described by Selekman (1997) as being particularly useful in situations where a child is placed in a family-scapegoat role or if the family lacks playfulness. In this activity, the child is put in charge of the therapy session to act as though they are directing a television show about his or her family. The child is responsible for directing the other family members how to behave and converse with one another. The videotapes are later

viewed and reviewed with the family with the child offering editorial comments. Selekman (1997) identifies three benefits of this activity. First, children's competencies shine through when put in a position of authority. Secondly, unfavourable beliefs about the child and unproductive family interactions are challenged. And finally, families experience relief from their problems when they are able to become more playful and spontaneous with one another.

Selekman (1997) describes another activity called the "Stuffed Animal Team". He identifies this activity as being useful for children around two to five years of age as they are at the peak of their abilities for imaginative play at this point in development. This activity encourages creative problem solving strategies by asking children to consider what their favourite stuffed animal characters would do if faced with the same problems that the child themselves face. The child achieves emotional distance from the problem by projecting it onto their stuffed animal team, thus reducing feelings of guilt and shame that can interfere with successful problem-solving.

Lastly, Selekman (1997) described an activity called "Visualizing Movies of Success" that encourages children to think back to a time where they achieved success. Engaging in all of their senses, children are encouraged to create an internal movie in their mind of this success. The movie children create should be discussed with them so that they can use their past success as a roadmap for success in dealing with their presenting issue.

### **Skill Development and Challenges**

The learning opportunities I was presented with throughout my practicum at Ehrlo Counselling Services resulted in skill development in not only areas where I have previous experience but also in areas new to me. Shortly after starting my practicum I realized that transferring the skills I had gained from my experience with the Ministry of Social Services to a

clinical setting would not be as straight forward as I had thought. With the encouragement of my professional associate and academic supervisor, I became involved with aspects of clinical work that encouraged me to move outside of my comfort zone, especially in the area of group work. While my practicum experience resulted in a range of emotions for me around the change I was facing, I successfully rose to the challenge. The end result is I have increased my confidence in how the skills and knowledge I gained will serve me well in whatever future endeavours I undertake in my career. Four of the areas that will be explored in relation to skill development and challenges are: sessions with individuals, group facilitation, social work roles, and ethical considerations.

### **Individual Sessions**

What I consider to be some of most important skills in working with individuals and as outlined by Carl Rogers (1980) are those that are needed for the development of a therapeutic relationship: congruence, unconditional positive regard, and empathic understanding . A career at Social Services is highly dependent upon one's ability to practice active listening skills and have empathy for clients. These skills are essential to successfully engaging involuntary clients. Because of my work experiences I entered my practicum believing that relationship building was an area where professional growth was not needed. On the contrary though, I developed new skills that were more relevant for use in a clinical setting with voluntary clients. What I realized is that the level of authority held as a practitioner in the child welfare system has a direct impact on the development of a therapeutic relationship with clients.

Two areas where I greatly built upon my existing skill set included active listening to clients and remaining with the client in the emotional space they were currently in (Rogers, 1980). During some of my initial sessions in the practicum, I became aware that I was

preoccupied with thoughts about what my next question to the client would be, how it fits into the approach that I intended to use, and if it will benefit the client or the session. Because I was trying to stay one step ahead and was concerned about asking or saying the wrong thing, I was not able remain in the emotional space of the client. This resulted in missing key things that clients were saying and creating frustration for them when they were not being heard or understood. After becoming more comfortable in a clinical setting and recognizing how my skills needed to be modified, I was able to overcome the obstacles I faced in building rapport and slowly developed the quality of therapeutic relationships necessary to successfully support clients in their change efforts.

Another challenge I faced was finding a healthy and therapeutic balance between allowing clients to process their emotions through focus on the identified problem and redirecting their focus to finding solutions. Because the purpose of social work is to help people improve their social functioning and create social conditions that will enhance well-being (Sheafor & Horejsi, 2003), I think it is safe to say that practitioners of social work do not like to see the people they are working with experience physical and emotional pain. Therefore I tended to shy away from discussions with clients that could evoke negative emotional reactions (i.e. suicidal ideation, self-harming tendencies, etc.). Instead, I rushed to offer solutions intended to provide relief. While a practitioner wants to ensure a healthy balance between problem-talk and finding solutions, an important aspect for the growth of clients is experiencing empathic understanding (Rogers, 1980). Clients often need the opportunity to speak about these issues and emotions in an environment where they experience being heard and accepted before they can identify the resources that can promote emotional healing.

## **Group Facilitation**

Because individuals do not live life in isolation, it is impossible to escape the interdependence between our lives with the lives of others (Wodarski & Feit, 2012). Group therapy has been identified as an effective treatment modality that allows members to help each other enhance their social functioning (McKenzie, 2008; Wodarski & Feit, 2012) as well as to effect social change (Weiner, 1964). Kirst-Asham and Hull (2002) state that groups can be divided into two general types: task groups (ex. committees, multidisciplinary teams, case conferences, and social action groups) and treatment groups (ex. therapy, support, educational, and socialization). Depending on the type of group, the role of a social worker can include that of broker, mediator, educator, or facilitator (Kirst-Asham & Hull, 2002). Kirst-Asham and Hull (2002) also point out that successful group work must take things such as group size, composition, culture, and duration into consideration. Each of these dynamics will impact the quality of interaction among group members.

While I have gained experience in group work throughout my career, group facilitation is one area where I had minimal experience. Throughout my practicum I had the opportunity to observe a voluntary art therapy group for parents who were involved with the Family Treatment Program operated by Ranch Ehrlo Society. I was able to see how creative art opens avenues for discussion and offers individuals a non-threatening means of communicating difficult emotions. I observed how parents who attended were able to develop an emotionally intimate and supportive relationship than with each other. Aside from being an observer of this group, I also co-facilitated two other groups.

The first group was a therapy group for a foster mother and six foster children who ranged in age from 10 through 14 years. The foster parent approached Ehrlo Counselling

Services to request group sessions as she had concerns for the children's lack of empathy for one another. She described the children as often trying to persuade each other that their histories of abuse and neglect were more severe than the others. She hoped they could be more supportive and accept that each individual's experiences were difficult. She explained that the children's present attitudes resulted in them engaging in bullying type behaviours with one another.

Various group activities were utilized to encourage cooperation, introduce coping strategies, and encourage the children to challenge their thinking as well as identify and express their emotions.

The foster mother and children expressed that the group therapy sessions resulted in fewer issues and disagreements in the home and helped to improve group cohesion between the children.

This change was attributed to greater understanding of personal differences and increased empathy for each other.

The second group I co-facilitated was a mandatory psycho-educational parenting group for parents who were part of the Family Treatment Program. This group consisted of 10-15 parents who were having their children return from foster care. Once weekly the parents would meet to discuss some aspect of parenting that was relevant for the majority of the participants. Discussion was encouraged around each topic presented. This allowed the parents to learn from the past challenges and successes of others in the group. Because the cognitive capabilities of the participants ranged, it was important that information presented was done in a manner that all would understand. Since the learning styles differed among individuals, attempts were made to find a balance between written summaries, videos, hands on activities, and open discussion.

One thing that I learned that was particularly valuable was the importance of being cognizant to group composition. Each of the two groups I co-facilitated consisted of members who shared similar life experiences such as children residing in foster care and parents working

towards reunification of their children. It was gratifying to observe how shared experiences allowed group members to more deeply empathize with one another and thus provide a level of support that would have otherwise not been available. I also came to appreciate the diligence required in preparing activities and information for presentation to the groups to ensure cognitive and emotional abilities of all members are being considered. To ensure that all members were able to benefit equally from their participation in the group, I found that it was extremely useful to present information geared to multiple learning styles. For example, in the psycho-educational group, information was not only provided verbally, but written material accompanied presentations to support those who are better able to follow a written outline. And to break up having to listen to only one person, participants were asked to provide examples from their experiences or video clips were shown that were pertinent.

### **Social Work Role**

Social workers both in private practice and those who work within community agencies take on a number of different functional roles in their work with clients (Siporin, 1961; Sheafor & Horejsi, 2003). Specific roles are often determined by the position held rather than the individual who occupies that position, but as a generalist practitioner, the ability to perform several different roles is necessary (Sheafor & Horejsi, 2003). Sheafor and Horejsi (2003) outline 10 professional roles performed by social workers: broker, advocate, teacher, counselor, case manager, workload manager, staff developer, administrator, social change agent, and professional.

My practicum provided me with the experience of moving from roles that I normally performed in my role as worker in the child welfare system to those roles that are more prominent when working in a clinical setting. Despite the fact that agency work and private

practice share the same societal functions of diagnosis, treatment, and prevention of social dysfunction, the authority relationships that exist in each of these modes of practice differs considerably (Siporin, 1961). Siporin identifies that private practice tends to have a greater emphasis on the therapeutic relationship that is essential for a reciprocal power balance to exist between social workers and the clients whom they work with. Social workers who work within mandated agencies are not always as successful in achieving a reciprocal power balance, putting these social workers in a position of authority which can be difficult to overcome.

The pressures that exist in working within the child welfare system often necessitates professionals in assuming the role of broker, advocate, and case manager. As a broker, professionals must identify client needs, assess their motivation and capacity to use resources, and help them to gain access to the most appropriate resources (Sheafor & Horejsi, 2003). As an advocate social workers assist clients in upholding their rights to access services or to support causes intended to change programs and policies that negatively impact client groups (Sheafor & Horejsi, 2003). Lastly, case management refers to efforts to achieve continuity of services through coordination of services in order to reduce duplication and ensure that utilized services adequately meet the client needs (Sheafor & Horejsi, 2003). I found that professional roles in a clinical setting were predominantly those of teacher and counselor. Work throughout my practicum was much more focused on providing clients with the knowledge and skills necessary to enhance their social functioning while at the same time helping clients to understand their feelings and modify their behaviours so they were better able to cope with problematic situations.

Research conducted by Nichols (1984) in relation to adjustment to role transitions at work support evidence of the theory that "individual differences in the characteristics of people

and the transitions they undergo mediate the relationships of change vs. stability and individual vs. situational adjustment" (p. 172). Moving from my work in child welfare to the clinical setting of Ehrlo Counselling Services, I found myself in what Nicholson (1984) calls the exploration mode of adjustment. Not only was I experiencing changes in the parameters of my role as a clinical social worker, but I was experiencing simultaneous changes in the personal qualities necessary to perform this type of work successfully. Over the course of the practicum I was provided with feedback that allowed me to focus my skills and build my confidence in how to effectively implement and enhance these skills for effective use in a clinical setting. I demonstrated significant growth at the conclusion of the practicum placement.

### **Ethical Considerations**

The Social Work Code of Ethics (Canadian Association of Social Workers [CASW], 2005) provides a list of the values and principles that are intended to guide the professional conduct of social workers. The establishment of a code of ethics is of great importance because social work professionals are often faced with ethical problems and dilemmas in their day to day work. The six core values intended to guide social workers in the decisions they make are: (1) respect for the inherent dignity and worth of persons, (2) pursuit of social justice, (3) service to humanity, (4) integrity of professional practice, (5) confidentiality in professional practice, and (6) competence in professional practice (CASW, 2005, pp. 4-8).

Some of the more common ethical considerations that I faced throughout my practicum related to weighing the best interest of the clients while considering methods of practice that would promote greater learning opportunities. In order to gain personal insight into the effectiveness of my clinical approach, my professional associate and I determined that it would be beneficial to videotape my sessions and watch them. This required obtaining informed

consent and so a form was drafted that I signed with clients outlining the use of, storage, and destruction of these recordings. In some situations however, I made the ethical decision to not approach clients to take part in the video recording of their sessions because it did not justify the discomfort that this would have caused the client. For example, a young girl whom I worked with regarding issues of low self-esteem presented as quite unsettled in our first session in the room containing a two-way mirror. This was the same room needed to record sessions. She shared an experience of being in a room similar to this when testifying in court regarding abuse she suffered when she was younger. Being in this room brought back memories of her testimony where she was not able to see the accused; however, they were able to see her. In order to ease her worries, I made a point to allow her to examine the other side of the room with the lights both on and off and assured her that nobody else was in the room. However, I let her know my professional associate would enter for the purpose of being able to give me feedback on my work with her. Given her previous experience, I determined that recording her sessions would likely result in unnecessary stress.

Another ethical decision that I was faced with was whether or not to continue services with a 17 year old female client who was referred by residential staff to address issues of personal boundaries when she herself did not identify this as a problem and preferred to not attend therapy sessions. Given this youth's cognitive delays, I attempted to engage her in therapy by focusing on areas of interest to her. When opportunities arose to tie information being discussed to issues related to personal space and boundaries, I would include this information, however, at those times she quickly became disengaged. As a result, I made the decision that her dignity and worth must be respected and advised staff that this young woman was not motivated to address the boundary concerns they outlined. I believed it would be in her best interest that

she not be pressured into attending counselling if this is not something she was interested in, particularly given the vast other supports she already had available to her. In order to preserve her sense of self-determination, I assessed that having her unwillingly remain involved in counselling would create a negative experience which could ultimately lead to her avoiding services at some point in the future.

### **Conclusion**

Being able to develop my own personal framework for counselling has been a great learning experience for me. It was a process that included being able to consolidate the knowledge and skills I have attained through my previous employment and educational experiences with the experiences that presented themselves throughout my practicum placement. The experiences offered by Ehrlo Counselling Services included training opportunities, preparation of reference material for families, participation in case conferences and in the intake process, attending professional development meetings, observation of counselors using a variety theoretical approaches and techniques in sessions with clients, as well as my own direct practice with individual clients and group facilitation. At the onset of the practicum, I felt tied to whatever approach was being used by those whom I observed and would try to replicate their approach with clients only to find that it was not a good fit for me. Over time, I became more comfortable in experimenting with techniques that were more congruent with who I am as a person and came across as much more genuine in my work with clients.

Three of the theories that have most influenced my view of working with clients include humanistic, feminist, and family systems theory. I support the ideas of Rogers (1980) as outlined in his person-centred approach. I support the empowerment of individuals to having the freedom and access to resources needed to produce the outcomes they envision for themselves (Nichols,

2009). I also acknowledge and support theories that suggest people are a product of their social contexts and striving to maintain balance between the life forces of individuality and togetherness (Nichols, 2009). These are the ideals that I strive to achieve in my practice regardless of the therapeutic approach and techniques being used.

I do not have a strong conviction towards any one theoretical approach to counselling being more beneficial than another. Instead, I believe that it is most important to conduct a thorough assessment at the onset of therapy and to use this information to determine which approach or combination of approaches would be best suited for the individual, family, or group. I believe that the flexibility afforded by an eclectic approach such as this is the most useful for clients with whom we work in order to best meet their unique needs. I believe that clients are best served by clinicians who are experienced in using a variety of approaches and techniques in a flexible, thoughtful, and effective manner. I believe that it is essential to remain educated on the current research as to best practice standards. And of course, I personally prefer to use creative approaches. Whether working with children, teens, adults, families, or groups, I am passionate about finding creative ways of engaging clients that goes beyond traditional talk therapy. I believe that clients achieve a deeper level of emotional healing when their feelings can be supported by means that can engage their unconscious expression of feelings, especially when they may not have the words for feelings that are too threatening to share aloud.

### **Visions for the Future**

When I first began my Master's level coursework, I had done so in anticipation that I would leave my work with the Ministry of Social Services for the purposes of pursuing a private clinical practice where I would specialize in play therapy. I considered my ideal target client population as being young children between the ages of four through fifteen years of age. Since

this time however, my goals have changed somewhat. While I continue to have a strong interest in pursuing clinical work with children and teens, I now see greater value in moving beyond a sole focus of individual therapy to incorporating a greater emphasis on a family therapy approach. Also, I no longer feel that it would be in the best interests of clients or me to pursue a private clinical practice. I believe that finding a community agency to work in is a better avenue to pursue because this setting provides greater opportunity for consultations with colleagues to ensure best practice.

I have also considered how having experience in clinical practice can be of benefit to me in my work at the Ministry of Social Services. The extreme pressure put upon workers as a result of caseload demands and frequent staff turnover results in emphasis falling away from therapeutic involvement with clients. The result is a standard 'cookie-cutter' approach used with clients without consideration for how the intervention will benefit or impact clients and families. Instead of leaving the Ministry because of frustrations in this regard, I have developed an interest in encouraging a work environment that allows workers to engage in more therapeutic work with their clients. I believe that by successfully engaging with clients in a more therapeutic manner will result in greater success of families being able to resolve the issues that placed their children at risk and thus will result in fewer children being removed from parental care. This type of work with families is obviously more time consuming, however, I truly believe that effort put in now will lead to successfully reducing the crises that families face in the future.

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