

**Walking the Journey Together:
An Analysis of a Clinical Social Work Practicum at
Ehrlo Counselling Services.**

**A Practicum Report
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By

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Abstract

This practicum report reflects on the experiences during my Master of Social Work field practicum at Ehrlo Counselling Services. My practicum took place over the Spring/Summer semester of 2016. Throughout the 12 week practicum, I strived to integrate theory into practice as I provided ethical, person-centred, holistic counselling services to people between the ages of 5 and 70. During this time, I studied various theories and therapy models including narrative therapy, cognitive behavioural therapy, and emotionally focused therapy in order to use in counselling with my clients. Additionally, my work was influenced by theories of attachment and trauma-informed care.

Throughout my practicum, I provided counselling in individual, couple, family, and group sessions. Furthermore, I engaged in professional development, team meetings, case consultations, intake calls and coordination, presentations, and projects. This practicum report is reflective of my experiences. The report provides personal and professional reflection of ideology, theory, therapy models, values, the counselling process, presenting issues, and ethics. Each section of this report illustrates how my six learning goals were achieved. Additionally, each section demonstrates some of the everyday realities I experienced while working with clients.

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Throughout my practicum, I was privileged and humbled by the clients who were willing to share their stories of triumph and tribulation with me. I learned so much from them, and I want to genuinely thank them for allowing me the opportunity to be their guide and confidant.

Lastly, I want to thank my friends, family, and partner, Jordan. My friends and family were incredibly motivating as I embarked on this journey. And to Jordan - you walked me through this journey with the loving, emotional support I needed, all the while encouraging me to pursue my dreams. Without your patience, support, and humorous nature, I would have never made it through. You kept me focused on my goals even on the days that I failed to see them myself. For this, I truly thank you.

Dedication

It is with a proud and happy heart that I dedicate this accomplishment to my Gramma Liz, as she was, and always will be, my eternal biggest fan.

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Introduction

Having people entrust their life stories with us during their most difficult times is a true honour. To delve into the emotional, mental, physical, and spiritual aspects of one's life involves empathy and patience, especially in the beginning of a healing journey. As a clinical social worker, I often saw people who were at their worst. These people were struggling to cope with the insurmountable odds that seemed to be stacked against them. Therefore, I believed it was my role to collaboratively and professionally work with individuals, couples, and families in order to build on their already existing strengths that they were struggling to see. In a perfect world, everyone would have the answers to their own problems. However, life is often not that generous. Therefore, it was my role to walk along side of others until they felt confident to walk on their own once again.

Throughout the Master of Social Work Program, the courses I studied advanced my knowledge in the areas of addictions and mental health, child and adolescent development, grief, separation and divorce, and the histories of First Nations and Métis people, to name a few. My education also shaped what I was looking for in my practicum experience. When I discovered Ehrlo Counselling Services (ECS) in Regina, I found that the agency epitomized what it means to work with individuals, couples, and families in a therapeutic, collaborative, and person-centred environment. In addition, they uphold the highest ethical standards as professionals and as an organization. The compassion and responsiveness of all staff who work there make it a trustworthy and reliable place for clients seeking healing. After my preliminary interview, I knew that it was the right place for me.

Ehrlo Counselling Services created a learning environment for me that fostered creativity, independence, and support. As a result, ECS allowed me to design a practicum based on my

professional goals and interests. I began my placement on May 2, 2016, working Monday to Thursday and the odd Friday morning. I completed my hours on August 31, 2016. Like many others who have pushed the limits of their comfort zone by trying something new, I was extremely nervous. This practicum was a new journey I was about to embark on; a journey that would challenge me both personally and professionally and put me on a path towards my future. Therefore, I have put significant thought and reflection into the creation of my learning goals in order to encompass my interests and allow me to grow.

My practicum experience exposed me to significant life events and issues that children, youth, and adults were faced with. Throughout my practicum at Ehrlo Counselling Services, I set collaborative goals with my clients in order to assist them with emotion identification and regulation, self-esteem, anxiety, depression, abuse, suicidal thoughts and ideations, parenting skills, and relationship difficulties, to name a few. As a clinical social worker, my role involved being a confidant, counsellor, advocate, and resource for people. I provided them with skills and tools that would assist them in keeping their mind, body, and spirit healthy in order to improve their overall well-being. I am grateful for all the clients I provided counselling to because they taught me about what it takes to work with others in a counselling capacity.

Learning Goals

Taking the time to prepare my learning goals provided me with ample reflection about what was important for my academic success and what would allow me to be successful in my future career. Based on my professional interests and goals, the following goals became the core focus of my practicum with Ehrlo Counselling Services:

1. To integrate theories of counselling into practice, specifically narrative therapy, cognitive behavioural therapy, and emotionally focused therapy.

2. To gain an understanding of the counselling methods used by Ehrlo Counselling Services and to utilize these approaches to complete initial assessments and collaboratively set goals.
3. To develop greater skills and competency when providing services to individuals, couples, and families. This includes providing a critical analysis of myself, and the skills and theoretical approaches being utilized in order to best meet the needs of clients.
4. To learn how to facilitate group therapy sessions that were offered during my practicum.
5. To learn and integrate different theories and approaches used by my Professional Associate and other counsellors into my practice.
6. To actively seek out supervision and debrief after sessions so that I can obtain feedback on how I conduct therapy sessions. Additionally, to take the time for personal reflection and insights based on what I have been learning.

Ranch Ehrlo Society

Origins

Founded by Dr. Geoff Pawson, Ranch Ehrlo first opened in 1966. Dr. Pawson had an unwavering dedication to children and a deep dedication to providing the appropriate treatment to them (Ranch Ehrlo Society, 2014, Reminiscing About The Past). Since its inception, Ranch Ehrlo has grown from being a small group home just for boys. Ranch Ehrlo is now a charitable organization responsible for forty residential programs, two schools, one college, and five community based programs located throughout Saskatchewan (Ranch Ehrlo Society, 2014, Founder and history). Ranch Ehrlo Campuses are located in Pilot Butte (outside of Regina), Corman Park (north of Saskatoon), and Buckland Centre (northwest of Prince Albert). Ranch Ehrlo strives to provide an environment that nurtures client dignity and self respect as many of

their clients had historically experienced systemic problems resulting from poverty, neglect, addictions, violence, and racism (Ranch Ehrlo Society, 2015, FAQs).

The history of Ranch Ehrlo began with the group homes. Dr. Pawson's dream began with the first group home that housed six boys (Ranch Ehrlo Society, 2014, Founder and History). Today, the group homes provide short-term and long-term stays for youth. Approximately 70% of the youth who come to Ranch Ehrlo are between the ages of 13 and 18 years, followed by 20% who are over the age of 18. These young adults, over the age of 18 years, often continue to experience emotional problems in combination with mental health problems. They find additional support in the program to be beneficial. The final 10% of youth are under the age of 12 at Ranch Ehrlo.

The group homes provide four pillars to treatment including: clinical treatment, education, work, and recreation (Ranch Ehrlo Society, 2014, FAQs). Clinical treatment involves individual and group counselling for youth. Education and recreation includes schooling and extra curricular activities that youth are involved in, and work includes paid employment as well as chores and responsibilities around the home (Kate Langen, personal communication, July 15, 2016).

Services Provided

In addition to group homes, Ranch Ehrlo provides schooling to the youth who attend their group homes, either in partnership with a public school system or through smaller education centres owned and operated by Ranch Ehrlo (Ranch Ehrlo Society, 2014, FAQs). These smaller education centres include: Schaller Education Centre, located on the Pilot Butte Campus; Hanson Education Centre, located on the Buckland Campus; and the Ellen Gunn Education Centre, located on the Corman Park Campus. These centres are designed to provide assessment and

remedial academics to youth while simultaneously providing stabilization for behavioural issues. Within Regina, transitional programs in the Regina Public School Division are also available in order to bridge the gap between the Education Centres at Ranch Ehrlo and the school settings in Regina. The transitional programs are located within specific public schools in order to successfully integrate youth back into the public system. Lastly, Ranch Ehrlo hosts a Community Vocational Education Program (CVEP) which offers youth the opportunity to participate in pre-employment skills development in order to augment employment after graduation (Ranch Ehrlo Society, 2014, FAQs).

In 1995, Ranch Ehrlo noticed a need for more community services in Regina. Therefore, a separate non-profit organization known as Ehrlo Community Services was created to begin filling the noticeable gaps in available community services at that time (Ranch Ehrlo Society, 2014, FAQs). Ehrlo Community Services came to include: Ehrlo Sport Venture, Ehrlo Housing, Avante-Garde College, Ehrlo Early Learning Centre, Paper Crane Community Arts Centre, Family Programs, and Ehrlo Counselling Services. For many years, Ehrlo Community Services worked alongside of Ranch Ehrlo as an associated charity, allowing both organizations the ability to share resources. However, in 2011 a formal amalgamation occurred, renaming the entire organization Ranch Ehrlo Society (Ranch Ehrlo Society, 2014, FAQs). As a result, Ranch Ehrlo Society's mission became to provide "quality prevention, restorative, and advocacy services to vulnerable individuals and families" (Ehrlo Counselling Services, 2015, Mission And Culture, para 2). Today, the culture of Ranch Ehrlo Society as a whole is fundamental to the services it provides. The Ranch Ehrlo Society:

Builds and maintains services founded on respect, caring, and nurturing for individuals and families; recognizes the dignity, value, and personal worth of all people; creates

opportunities for people to reach their full potential through a continuum of practical programs of support, counselling, and training; provides advocacy on behalf of individuals, families and communities with all levels of government; and builds and maintains high levels of competence with the organization through leadership, training, and experience. (Ranch Ehrlo Society, 2015, Mission and culture, para 3)

Ranch Ehrlo Society's community services are located throughout Regina. Each program is unique in its mandate to serve the community of Regina as a whole while also benefitting the many individuals and families who are involved with other Ranch Ehrlo programs.

Aside from Ehrlo Counselling Services where I spent my practicum, I assisted with the facilitation of group therapy for parents at the Ranch Ehrlo Society's Family Treatment Program. The goal of the Family Treatment Program is to provide safe, family-centred programs that support keeping families together whenever possible (Ranch Ehrlo Society, 2014, Treatment Foster Care Program). The Family Treatment Program provides units for families to live where all their basic needs are met. The length of stay varies according to the needs of each family. These units are located in Regina and services for families are delivered by specially trained treatment staff in order to provide families with day-to-day skills and therapeutic family engagement. The program offers group therapy and in-home coaching on topics including: child development, effective parenting, communication, life skills, and budgeting (Ranch Ehrlo Society, 2014, Family Treatment Program).

Ehrlo Counselling Services

Ehrlo Counselling Services (ECS) is located in Regina and opened in 1997 (Ehrlo Counselling Services, 2015, About Us). This is the program where I completed my MSW practicum. Ehrlo Counselling Services expanded the mission of the Ranch Ehrlo Society to focus

on providing preventative and early intervention services to the community in the form of assessment, treatment, education, support, and community services (Pawson, 2004). This organization assumes a developmental treatment model that focuses on a biopsychosocial philosophy. Thus, ECS strives to assist individuals, couples, and families to achieve positive growth, healthy functioning, and enhanced well-being (Ehrlo Counselling Services, 2015, About Us).

Today, ECS has grown significantly and now has nine counsellors on staff (seven registered psychologists, one registered social worker, and one registered counsellor) and two administrative staff. Contract counsellors are also available on evenings and weekends. Ehrlo Counselling Services partners with and hosts two consultants from the Cognitive Disabilities Strategy. In addition, five psychologists are responsible for conducting various assessments for all individuals at Ranch Ehrlo Society. Lastly, practicum students from various programs are always present, portraying the true value that is placed on education and learning.

Last year, Ehrlo Counselling Services provided counselling to over 1200 clients of all ages (Fiissell, 2016). Reasons for service included: parenting skills, separation and divorce, mental health problems, stress, school difficulty, self-esteem, and substance abuse. Clients were referred from national or local Employee and Family Assistance Programs, other Ranch Ehrlo Society Programs, the Ministry of Social Services, or self referral. Additionally, service is not limited to insurance coverage or the ability to pay. Instead, Ehrlo Counselling Services believes in providing services to all who request it. Therefore, a sliding scale fee for counselling sessions are provided when necessary (Fiissell, 2016).

The Counselling Process at Ehrlo Counselling Services

The counselling process outlines a beginning, middle, and end. At Ehrlo Counselling Services, these phases are referred to as the initial assessment phase, intervention phase, and termination. Ehrlo Counselling Services also has an intake process for new referrals. Ehrlo Counselling Services has specific policies and procedures in order to uphold standards to ensure clients have a safe and therapeutic counselling experience. Throughout my practicum, I had the opportunity to engage with clients in each of these phases.

The intake process. The intake process is the first point of contact for an individual seeking counselling. Referrals are sent to an intake coordinator who will then speak with the person requesting services via a phone consultation. Initial intakes at ECS collect various information including demographics, insurance coverage, current employment status, suicidal ideation, any current substance abuse issues, and a brief description of the reason for the call. The client caller is then informed of the approximate wait time. All initial request calls are returned within a 24 hour period during the week and a 48 hour period over the weekend (Ranch Ehrlo Society, 2015).

After the call has been made, information is recorded into a secure, online database and brought to a weekly intake meeting. At this meeting, all counsellors attend and clients are assigned based on the needs of the client and the length of the waitlist. Throughout the time period that individuals spend on the waitlist, the intake coordinator will continue to respond to any questions they may have by phone or email (Ranch Ehrlo Society, 2015). During my practicum, I had the opportunity to be the intake coordinator while the regular counsellor was on holidays. During an intake call, I learned how important it is to make clients feel validated and heard. Support and empathy towards the caller's experiences are important during the initial intake as the first call for counselling can be difficult to make.

The initial assessment phase. The initial assessment phase starts when the first meeting between counsellor and client has been made. The beginning stage of therapy is crucial as it sets the stage for future counselling sessions. Throughout the initial assessment phase, information is gathered in order to obtain a holistic biopsychosocial-spiritual assessment. The beginning phase is also the counsellor's first opportunity to build a relationship with the client.

The ease at which the relationship building phase unfolded depended upon my skills as a counsellor. I would explore, reflect, validate, and summarize the client's story. Furthermore, I was mindful of creating a therapeutic space that the client felt safe in. Based on my experience, some clients were more challenging to engage with, while others were open and willing to share their stories. I soon recognized that engagement with clients happened at different paces. As a result, I developed patience, understanding, and respect for my clients. During times where clients were hesitant to open up, it became especially important for me to be patient with the client and myself and not push forward in the counselling process. Instead, I needed to meet clients where they were at and create a safe atmosphere.

The intervention phase. The intervention phase is where client goals, dreams, hopes, and aspirations are truly set in motion. At ECS, client goals are developed into a clinical treatment plan in collaboration with the client. The clinical treatment plan included: the client's goal statements based on the presenting issues, an outline of the therapy models that were used, and any homework or activities that may be utilized throughout the process.

My approach to creating treatment plans for clients began in collaboration with the clients. Seeking to draw on their strengths, I would ask clients what their hopes and goals were for counselling. Afterwards, while reflecting on these goals and building a clinical treatment plan, I used an integrative approach to best meet the needs of my clients and demonstrate best

practices. For example, in my work with children and youth, I found creative interventions were most productive. In addition, children and youth enjoyed activity-based interventions as opposed to talk-therapy.

The termination phase. The termination phase may be planned or unplanned. Sometimes, for various reasons, termination may occur unexpectedly. For example, a family had an unplanned termination because they moved during my practicum. Unplanned termination is not ideal, however, it does occur throughout the therapy process.

At ECS, planned termination is reached when the client and therapist agree that the goals have been achieved and the client feels confident in managing on their own. It is important to prepare clients for termination in order to ensure the client is ready. Termination can be viewed positively or negatively and perhaps even as both. Therefore, it is helpful for termination to be made into a celebration. The achievements made in therapy can be celebrated in order to make the end of therapy seem less frightening. For example, children benefit from certificates of achievement being handed out during the last session. For adults, celebrations, future planning, and planned follow-up may assist clients. By the end of my practicum there were still clients I was seeing who were not ready for the termination process. At ECS, every effort is taken in order to provide continuity of care with clients. Therefore, if the client was not at the point of termination I was contracted by ECS to continue working with the client after my practicum ended.

Confidentiality and informed consent. Ethics in social work are extremely important in shaping the responsibilities and decisions made by counsellors. Professional ethics at ECS are also held in the highest regard. As such, ethical guidelines were represented in the policies, procedures, and protocols at the agency. According to the Ranch Ehrlo Society

“the Code of Ethics and Oath of Confidentiality are fundamental to the work of Ranch Ehrlo and ensures that every action that is extended toward the betterment of a service recipient is conducted in a manner that meets the highest ethical and professional individual and group standards” (Ranch Ehrlo Society, 2015, p. 1).

At Ehrlo Counselling Services (ECS) a confidentiality policy has been designed in order to “uphold its ethical and legal requirements to ensure that every appropriate safeguard is taken to ensure the privacy and confidentiality of service recipients” (Ranch Ehrlo Society, 2015, p. 3). This particular policy outlines how information is to be released with the consent of the clients; how information and records are to be stored for maximum confidentiality to be maintained; and the relevant laws and standards that are the basis for confidentiality and limits to confidentiality. At ECS, there are particular instances where confidentiality cannot be maintained, which are outlined to the client at the beginning of the first session. The limits to confidentiality include: when a person is at imminent risk of harming one’s self or others; when there is suspected or disclosed child abuse; when the court of law has subpoenaed client files; when a release of information has been signed by the service recipient for a counsellor to exchange information with another professional; and for the purposes of supervision (Ranch Ehrlo Society, 2015). At the beginning of the initial session I ensured that clients knew I was a student and that I would regularly seek out supervision from the senior counsellors at ECS. I also explained to clients that each counsellor is held to the same standards of confidentiality in order to safeguard their personal information. Furthermore, confidentiality and the limits to confidentiality were also explained to children and youth. In session, each child or youth was asked what they wanted to share with their parents provided it was within the limits of confidentiality.

In addition to the confidentiality policy at ECS, counsellors also go through informed consent with clients that outline their rights and responsibilities throughout the counselling process. Informed consent includes: the right to refuse service without penalty at any time; the right to ask for another counsellor; consent to release the required information to an insurance company; and an agreement to store information on a secure online database (Ehrlo Counselling Services, 2015).

Conventional Philosophical Beliefs Underlying Therapy

Individual, couple, and family counselling each have their own unique background that has been influenced by belief systems, community values, and societal norms throughout history. Counselling was designed as a way to understand human behaviour by determining the internal thoughts, actions, and behaviours that influence how individuals come to conceptualize and narrate their own lives (Nichols, 2014). For instance, individual counselling was historically developed as a way to concentrate on helping individuals face their fears and live their lives to their fullest potential (Nichols, 2014). Within individual counselling, it was believed that personality was shaped by external forces such as family and the environment. However, these external forces shaping one's personality ultimately became intrapsychic dynamics that needed to be solved in individual therapy (Nichols, 2014).

Couples counselling evolved based on the ideologies of family counselling (Nichols, 2014). According to Mittleman (1948, as cited in Nichols, 2014), understanding the reality of relationships between partners became just as necessary as understanding the internal experiences of individuals. Therefore, seeing couples together, as opposed to individually or as a whole family, allowed for a "more in-depth focus on the experience of individuals...[and]

permits greater focus on both dyadic exchanges and the underlying experience of intimate partners” (Nichols, 2014, p. 15-16).

Family counselling established itself on the belief that the dominant forces that influence people’s lives are located within the family system (Nichols, 2014). When problems occur within families, it often affects each individual differently. Therefore, each family member has different perspectives and experiences of a problem (Nichols, 2014). As a result, a family therapy approach was believed to provide long lasting improvement to families in a way that individual counselling could not (Nichols, 2014). For example, family counselling interrupted the equilibrium in a family. Each change that occurred within the family simultaneously had an effect on the other family members as they strived to achieve cohesion together. As such, family counselling was viewed as less isolating because problems were addressed at the source and continually exerted synchronous change onto other family members (Nichols, 2014).

Despite the advancement in counselling theories and strategies throughout the years, counselling still carried stigmatization with it. For example, problems within individuals and families are commonly viewed by mainstream culture as private matters and therefore, should be left alone as opposed to intervened with outside assistance. As a result, from first engagement with people, it is important to build a foundational rapport in order to make them feel safe and comfortable in the counselling process.

A relationship with clients built on kindness, respect, and a non-judgmental attitude is essential in counselling. Furthermore, focusing on client strengths is important for successful therapy. Collins, Jordan, and Coleman (2010), outline three crucial elements in building a strong therapeutic alliance with clients. These include: having consensus between the worker and client on the goals of counselling; agreement and collaboration on the implementation of tasks; and

having a strong, positive, affective bond between the client and worker (Collins et al., 2010, p. 92). Identifying client strengths as well as engaging clients in their interests is crucial to developing rapport and having success in the therapeutic alliance (Collins et al., 2010).

Research on Presenting Problems

During my practicum, I had clients of all ages and varying needs. However, there were three common presenting themes that I encountered. These issues were: relationship/familial difficulties, mental health problems, and behavioural difficulties. Therefore, it was important for me to understand current research on these problems as well as the effect they had on each client.

Relationship and Familial Difficulties

Relationship and familial difficulties is a common problem that occurs for many couples throughout various stages of life. For example, as couples begin raising children, nurturing their relational bond may fall to the wayside as each of them put the needs of their children first. Additionally, as couples struggle with communication, it is not uncommon for one partner to continually pursue the other in an attempt to seek a reaction (Johnson, 2008). In response, the other partner's tendency is to withdraw as the pursuing continues (Johnson, 2008). And so the cycle continued.

Gottman (1994) identified what he called "The Four Horsemen" that predicted early divorce (p.110). According to Gottman (1994), the Four Horsemen included: criticism, contempt, defensiveness, and stonewalling (p.110). If these four traits were present among couples, divorce was likely to occur in approximately the first 6 years of marriage. For couples who are new parents, their satisfaction in the relationship drops by approximately 67% in the first three years after a child was born (Shapiro & Gottman, 2005). As a result, Gottman and Levenson (1999)

stated that couples need to have a ratio of 5:1 positive to negative encounters in order to maintain a healthy and stable relationship.

While working with couples during my practicum, they often presented with communication difficulty. Navigating daily tasks and chores of life, dealing with finances, and raising children frequently lead to communication breakdown. As a result, couples found that they had no time left for each other. As one partner reached for the other, the attachment cue went unnoticed and conflict would ensue. Assisting couples to understand the cycle that they found themselves in was the beginning of work with couples. The sooner they identified their negative cycle, the greater the likelihood they would be able to stop it, and eventually replace it with a more positive cycle.

Mental Health Problems

Mental health problems were a common occurrence during my practicum with ECS. However, the severity of the problem depended on the client. Some clients had psychiatric diagnoses such as borderline personality disorder (BPD) or depression while others experienced undiagnosed mild to severe anxiety disorders. Therefore, understanding mental health problems and their underpinnings was an important component of my practicum.

Anxiety is a natural biological response to a threatening situation (Schab, 2008). Anxiety serves an important purpose, allowing individuals to be alert and aware of threatening situations so they can get away from them. However in today's world, it is not always possible to immediately respond with a fight or flight response when anxiety arises (Schab, 2008). For example, I worked with a client experiencing anxiety about attending class with a teacher she did not like. Be that as it may, it was not appropriate for this client to fight with the teacher, even though that may be a natural reaction to stress. Therefore, anxiety remained in her body, leaving

her feeling paralyzed with panic, fear, and intense emotional reactions (Schab, 2008). As a result, counselling focused on practicing strategies to cope with her anxiety when it was triggered.

According to the American Psychiatric Association (2013), there are several types of anxiety disorders including: separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder, panic disorder, panic attack specifier, agoraphobia, generalized anxiety disorder, substance/medication-induced anxiety disorder, anxiety disorder due to another medical condition, other specified anxiety disorder and unspecified anxiety disorder (p.190-234). With each of these disorders, emotional feelings and physical reactions to specific places, people, things, or situations are invoked. Anxiety can cause feelings of apprehension, irritability, restlessness, and leads people to constantly anticipating the worst (Smith, Robinson, & Segal, 2016). Physical manifestations of anxiety may be exhibited through sweating, upset stomach, shortness of breath, insomnia, and muscle tension (Smith et al., 2016). Anxiety is also frequently diagnosed in conjunction with other mental health problems, such as depression. Co-morbidity of mental health problems increases an individual's risk of suicide (Smith et al., 2016). Therefore, seeking professional help and social support, as well as maintaining a balanced diet and actively practicing relaxation techniques will assist individuals in coping with anxiety (Smith et al., 2016).

Depression manifests in different ways depending on age and gender (Smith, Saisan, & Segal, 2016). For men, depression may portray itself through complaints of fatigue, irritability, and loss of interest in work and hobbies (Smith et al., 2016). Women tend to experience extreme guilt, excessive sleep, over eating, and weight gain (Smith et al., 2016). In addition, teens experience depression differently from adults. Depression in youth manifests itself through

irritability, anger, and agitation, as well as somatic complaints including head aches and stomach pains (Smith et al., 2016).

Overall, the signs and symptoms of depression are identified as feelings of helplessness and hopelessness, loss of interest in daily activities, anger, loss of energy, self-loathing, reckless behaviour, or unexplained aches and pains (Smith et al., 2016). Furthermore, depression is a major risk factor for suicide (Smith et al., 2016). To date, the American Psychiatric Association (2013) identifies eight types of depressive disorders that an individual may be diagnosed with including: depressive mood deregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder (p.155-188).

Finally, borderline personality disorder (BPD) is a mental health problem primarily diagnosed in women (Centre for Addictions and Mental Health, 2009). Borderline personality disorder might seem as though it is an inherent problem within the personality of a person. However, personality disorder actually refers to the difference in one's personality in comparison to the norm (Smith & Segal, 2016). Borderline personality disorder is a complex mental health problem that causes the brain to be on high alert and individuals experience extreme sensitivity to internal and external stimuli (Smith & Segal, 2016). Small things may trigger intense and often volatile emotions that are remarkably challenging to calm down from. Individuals diagnosed with borderline personality disorder have an extreme fear of abandonment, impulsive nature, self-destructive behaviours, extreme emotional swings, explosive anger, and a history of unstable relationships (Smith & Segal, 2016). Furthermore, suicidal behaviours in individuals with a BPD diagnosis are common including an increased likelihood of self-harming behaviour

(Smith & Segal, 2016). Borderline personality disorder is frequently diagnosed in conjunction with other disorders including depression and anxiety (Smith & Segal, 2016).

Behaviour Difficulties in Children

Behaviour difficulties are a presenting problem in many children that parents and caregivers struggle with. Behaviour difficulty may result from a variety of factors including, but not limited to: family history, inconsistent disciplinary practices, maltreatment, prenatal addictions, genetic abnormalities, altered brain functioning, and trauma (Puzzo, Smaragdi, Gonzalez, Martin-Key & Fairchild, 2016). Furthermore, the severity of behavioural difficulties ranges from typical childhood misbehaviours to being diagnosed as a disruptive behaviour disorder (Puzzo et al., 2016).

According to Barasso-Catanzaro and Eslinger (2016), childhood and adolescence are marked by continuous developmental changes and maturation in the brain. The development of the executive functioning areas of the brain, specifically the areas responsible for self regulation, operational processes, and representational knowledge are necessary in order for children and adolescents to adapt to different settings and social roles (Barasso-Catanzaro & Eslinger, 2016). Emotional regulation “is a key building block of human development” (McMillan, Katz & Claypool, 2014, p. 443). Emotional regulation involves children’s ability to up-regulate or down-regulate depending on the situation they are in. The ability to regulate emotions is also affected intrinsically within the self, and extrinsically by others and the environment (McMillan et al., 2014). A child’s ability to regulate their emotions and behaviours is largely affected by early childhood experiences. For example, if a parent or caregiver’s expression of emotions were undeveloped, these styles will be modeled and replicated by the children who witness them (McMillan et al., 2016). Therefore, when children enter counselling it is important to work as an

interdisciplinary team of parents, caregivers, and other supports. The multitude of support will model the consistency necessary to teach them how to regulate their own emotions (Straus, 2016).

Theories That Influenced My Practice

Trauma-Informed Care

According to Klinik Community Health Centre (2013) in Winnipeg, they state that “trauma hides in plain view” (p. 15). Trauma involves exposure to a specific experience “that is overwhelming, usually life-threatening, terrifying, or horrifying in the face of helplessness” (Bloom, 2014, p. 39). Traumatic experiences trigger the stress response system in the brain, commonly known as fight, flight, or freeze (Bloom, 2009). With each traumatic experience, the brain forms new connections. As a result, these new connections are repeatedly triggered with every new or imagined threatening experience (Bloom, 2009). Adverse experiences may happen to anyone. However, over time, exposure to repeated traumatic experiences can have detrimental effects of the body, mind, and spirit (Bloom, 2014).

Trauma manifests itself in various ways depending on the person, when the traumatic event occurred, and the number of times a traumatic experience has happened (Perry & Szalavitz, 2006). Trauma tends to have two typical responses: hyperarousal or dissociation (Perry & Szalavitz, 2006). Hyperarousal is a response to perceived threats. During any perceived threat, the brain sends information for a person to either fight or flee (Perry & Szalavitz, 2006). Therefore, any new potential threats will send a person into hyperarousal. Hyperarousal shuts

down other parts of the brain, focusing on the threat at hand (Perry & Szalavitz, 2006). Over time, constant exposure to real or imagined threats results in maladaptive coping. As a result, “the threat system becomes sensitized to keep us in that state [of hyperarousal] constantly” (Perry & Szalavitz, 2006, p. 49). As such, it is understandable why people who have been exposed to trauma may struggle with regulating their emotions and behaviours and display difficulty in holding attention, managing aggression, and withstanding impulsiveness (Bloom, 2009; Van Der Kolk, 1996). The only thing these individuals are focused on is the potential threat to one’s safety (Van Der Kolk, 1996).

Dissociation, on the other hand is the “loss of integrated function of memory, sensation, perception, and identity” (Bloom, 2009, p. 147). Dissociation results from the inability to escape a fearful situation (Perry & Szalavitz, 2006). As a result, dissociation prepares the body for injury. When someone experiences dissociation, the heart rate slows down in order to reduce potential blood loss. Pain and fear response systems shut down and individuals come to believe that what they are experiencing is not real and happening outside of their own body (Perry & Szalavitz, 2006). According to Van Der Kolk (1996), dissociation allows a person to be protected from the awareness of what has happened. Thus, the effects of dissociation may render individuals unable to identify emotions or even attach words to their experience. As such, dissociation makes it difficult for counsellors to fully understand the situation and provide treatment (Van Der Kolk, 1996).

More often than not, both a combination of hyperarousal and dissociation are present as a result of a traumatic experience (Perry & Szalavitz, 2006). However, these traumatic experiences have many similarities to attention deficit disorder, hyperactivity, or oppositional defiant disorder (Perry & Szalavitz, 2006). As a result, these behaviours may be misdiagnosed,

particularly in children. Trauma changes the brain and increases the experience of physical and mental stress (Bloom, 2009). Therefore, the earlier traumatic experiences occur, the more likely it is that arousal and emotion regulation will be compromised during development (Bloom, 2009).

When the negative impact of trauma is combined with the individualized way trauma manifests, it creates difficulty for therapists to recognize trauma as the presenting problem. Therefore, organizations must always consider underlying trauma in all people who seek counselling services. According to Hooper, Bassuk, and Olivet,

trauma-informed care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. (2010, p. 82)

Trauma-informed care involves having organizations understand and provide services to individuals based on their specific needs. According to Hanson and Lang (2016), trauma-informed care includes three primary domains: workforce development, trauma-focused services, and organizational environment and practices. Hanson and Lang (2016) go on to say that workforce development should focus on training and awareness of trauma including the signs and effects of secondary traumatic stress in care providers. Additionally, trauma-focused services should utilize standardized screens and evidence-based practices in order to best serve clients (Hanson & Lang). Lastly, Hanson and Lang (2016) believe that organizational environment and practices should comprise of collaboration, service coordination, creating safety for clients, and writing policy reflective of trauma-informed care.

In my practicum, I had the opportunity to work with an eleven year old girl who had experienced various traumatic events in her life. She had been exposed to many instances of violence and abuse and had lived in many homes. There was also suspected physical and sexual abuse, although this was never confirmed. Initially, I obtained an in-depth history of this girl's life from her child protection worker. Her presenting issues included behavioural problems and difficulty with emotion regulation. The knowledge of the effects of trauma kept me cognizant of that fact that her presenting problems may be a result of her past traumas.

In our first few meetings, this girl was very curious and challenging. Throughout the session she explored the counselling room, asking questions about counselling and what she was supposed to do here. I answered all her questions and continually engaged with her as she explored the room. For several weeks, this is how our sessions began. Understanding the effects of trauma on the brain, I understood she was likely experiencing hyperarousal, assessing the environment for any potential threats each time she arrived to counselling.

Once she was comfortable in our first session, I asked her if she could draw a picture of herself showing how she felt about being in counselling. This activity was titled, "Welcome to therapy!" and was taken from an evidence based, best practice workbook for use with children exposed to trauma (Hendricks, Cohen, Mannarino, & Deblinger, 2006, p. 1). The following week, I used another activity from the workbook entitled "About you" where she could draw a picture or write things about herself that made her special (Hendricks et al, 2006, p. 2).

Throughout my work with this girl, I was constantly aware of the trauma she was exposed to in her life. As the weeks passed, we made a "Feelings survival kit" that would help her to cope with strong feelings as they arose (Hendricks et al, 2006, p. 11). This survival kit included child friendly activities including: a mindfulness activity for children, lavender infused

play-doh, a stress ball, and cards she could pull out with self care strategies on them. I also used various games and activities related to feelings in order to help her cope with strong feelings. By focusing on emotion regulation, she began associating words with feelings about the traumatic experiences of her childhood. Until we explored emotions and feelings, this young girl would go blank when asked about the trauma in her past. To me, this signified that she had likely dissociated from many of the negative experiences she witnessed.

My knowledge of trauma and trauma-informed care prepared me for my work with this girl. Trauma-informed care kept me patient and empathetic when challenges occurred in counselling. Furthermore, trauma-informed care helped me to understand more about her and how her early experiences of trauma may have affected her brain, resulting in her presenting behavioural problems and difficulty with emotion regulation.

Attachment Theory

Attachment theory states that humans have a wired in primary need that is even more basic than food. This need is to have a safe haven of closeness and caring with another person (Johnson, 2007). John Bowlby, the original founder of attachment theory, spoke of attachment as a way of “being with” another person (1988, Johnson, 2007, p. 8). When an emotional bond to another person is hard to find, people go into a “primal panic” (Panskepp, 1998, as cited in Johnson, 2007, p. 8). According to Panskepp (1998, as cited in Johnson, 2007), this panic is a perfectly normal response. When individuals experience this panic, the “threat behind it is the trauma of isolation, loss, and the hurt of feeling unimportant to a loved one” (Johnson, 2007, p. 8). Furthermore, Bowlby (1988, as cited in Johnson, 2007) states that there is “nothing immature or disordered about this response” (p. 8). According to Johnson and Zuccarini (2010), “positive attachments create a safe haven that offers a buffer against the effects of stress and uncertainty...

Secure attachment also offers a secure base from which individuals can explore their universe and adaptively respond to their environment” (p. 2). As a result, the ability to reach for others is actually a source of strength as opposed to weakness, immaturity, or enmeshment (Johnson, 2007).

John Bowlby’s attachment theory was solidified during his work with Mary Ainsworth (Fraley, 2010; Johnson, 2004). During this time, an experiment called the Strange Situation Test analyzed the attachment relationship between infants and mothers through separation and reunification after a short period of time (Fraley, 2010; Johnson, 2004). This experiment revealed three types of attachments that occur between children and their caregivers: secure attachment, anxious attachment, and avoidant attachment (Fraley, 2010; Johnson, 2004). Secure attachment accounted for approximately 60% of children. Secure attachments were characterized by children who had the ability to cope with their own distress after being separated from their mothers. Upon return, these children were able to reconnect with their mother and be easily comforted and soothed (Fraley, 2010; Johnson 2004). Anxiously attached children accounted for about 20% of children and these children displayed extreme stress when mothers left the room. They were also difficult for mothers to soothe upon return. These children would display conflicting behaviours upon the mother’s return. They appeared to want to seek comfort, but also appeared to want to punish their mothers for leaving (Fraley, 2010; Johnson, 2004). Finally, avoidant attachments, which account for about 20% of children, revealed children that displayed very little emotion upon the mother leaving the room and returning. Children avoided seeking contact with their mother altogether upon return. Instead, they engaged in other activities around the room (Fraley, 2010; Johnson, 2004).

Early attachment experiences can affect children well into adulthood (Larkin, Felitti & Anda, 2014). The Adverse Childhood Experiences (ACE) study displayed just that. Between 1995 and 1997, Kaiser Permanente and the Centers for Disease Control partnered to conduct a study analyzing the effects of adverse childhood experiences over a lifespan (Centres for Disease Control and Prevention, 2015). ACE study participants “were self-selected members of Kaiser Permanente who visited a health clinic, seeking comprehensive medical evaluation for preventive purposes” (Larkin et al., 2014, p. 2). A total of 17,421 individuals agreed to participate in the study (Larkin et al., 2014). Each participant answered a questionnaire about childhood experiences they had been exposed to before 18 years age. According to Larkin et al., (2014), “an ACE Score was created on a scale of 0-10, based on the number of categories (not incidents) experienced. These categories are inter-related and linked to health risk behaviour and health problems” (p. 2).

The ACE questionnaire included questions about childhood experiences related to parental separation and divorce, mental health problems, exposure to abuse and neglect, and alcohol and drug use (Straus, 2016). Results showed that the higher the ACE score (the more of these experiences young children had), the greater the likelihood that these individuals will experience persistent emotional problems, health risk behaviours, social problems, disease and disability, health and mental health problems, and poorer life expectancy (Straus, 2016). Therefore, the ACE study displayed the benefits of healthy attachment figures throughout life. The more support, protection, and care that children receive is correlated to reduced risks of attachment disorders and other health issues in adulthood (Straus, 2016).

Having positive attachment relationships in childhood enhances a person’s ability to cope and make changes. However, changing or healing from early attachment experiences will vary

depending on individual differences, life stage, and the type of attachment problems individuals have experienced (Perry & Szalavitz, 2006). Children need continual physical and emotional affection in order for the brain to begin connecting the pleasure and reward systems with human contact (Perry & Szalavitz, 2006). In adulthood, romantic love becomes just as essential as the primary attachments between mothers and infants (Fraley, 2010). As a result, healthy attachments at any age are necessary and vital for an individual's development.

My practicum experience offered many opportunities to understand attachment from a child and adult perspective. For example, I worked with one nine year old girl who was living in foster care. The presenting problems included behaviour problems and difficulty regulating her emotions. She had been exposed to multiple traumatic events of violence and abuse and had moved to and from various homes with various family members. Therefore, she was in a state of hyperarousal and dissociation as a result of early attachment problems and traumatic experiences.

In every meeting with this young girl, she was constantly playing with things around the counselling room, peering through the one-way mirror, hiding behind the couches, or walking out of the room. It was noticeable that she was experiencing hyperarousal, always looking for any potential threats that may occur. Being in this hyperaroused state inhibited her ability to engage in the counselling activities. However, eventually a relationship began to build and she would engage in and enjoy activities such as colouring and games. As we began talking about her traumatic experiences I noticed that she would dissociate. When asked about a troubling experience from her past, this young girl would go silent for some time. She often did not have the words to describe her experience and frequently stated that she could not remember anything. As a result, she also had no feelings about her past experiences.

Throughout counselling, this young girl did become more comfortable and I decided to plan an activity where she could talk about her family. This activity was called “About your family” and was taken from a trauma focused workbook for children (Hendricks et al, 2006, p. 3). It was during this activity that I learned about her early attachments. This girl had a strong relationship with her dad and sister. She spoke very highly of them. Therefore, I recognized her secure attachment with these two family members and was able to continually build on those positive relationships in counselling by advocating for her to be able to talk to them more often. However, during the “About your family” activity I also asked about her grandma and cousins whom she lived with prior to going into foster care (Hendricks et al., 2006, p. 3). Based on the information provided by the child protection worker, she did not feel safe with them and she did not go to them when she was feeling insecure. As a result, she had few kind words to say about them. Therefore, it could be argued that she had an avoidant attachment style with these family members as she seemed unaffected by leaving when she was apprehended.

Therapy Models

In the following section, an outline of the therapy models I used during practicum are reviewed, including my experiences using them in counselling sessions with clients.

Narrative Therapy

The world revolves around stories. Stories are always being told and these stories are based on the personal, intimate lives that people are living (Ricks, Kitchens, Goodrich, & Hancock, 2014). Stories are influenced by personal values and beliefs or societal values and cultural norms. People tell stories based on memories from the past and present and hopes and worries for the future (Ricks, et al., 2014). Stories emerge during interactions with others and tell us how people ascribe meaning to experiences they have encountered (Ricks, et al., 2014).

However, a story may never fully encompass the richness of lived experience. Dominant stories are the stories that are most important to people and frequently retold while other stories may be lost throughout a lifetime. As a result, many lived experiences may go untold or unexpressed (Ricks, et al., 2014).

Narrative therapy was first developed by Michael White and David Epston in the 1980s as they navigated new theory based on the ideologies of Foucault and his concepts of the influences of power. Foucault believed that institutions were dehumanizing and served individuals with privilege and power as opposed to people who were oppressed (Nichols, 2014). Therefore, narrative therapy is built on postmodern and social constructionist ideologies and “rejects the notion of a universal truth,” instead favouring multiple realities and perspectives (Gibbs, 2006, para 1). As such, narrative therapy theorizes that people make meaning of their lives based on the stories that they live (White & Epston, 1990). Narrative therapy also strongly emphasizes the role that culture and society play in the development of personal narratives. As such, deconstructing client’s societal and cultural narratives is needed in order to rewrite an individual’s narrative. Deconstructing past narratives is also essential as clients design a more positive, meaningful experience that aligns with their beliefs and values (Gibbs, 2006).

In narrative therapy it is essential for a therapist to identify his or her own position and feelings about counselling. Narrative therapy is not about giving advice, solutions, and opinions to clients (Morgan, 2002). Instead, the practice of narrative therapy holds “the person’s ideas and resources at the fore” and declines invitations to be the expert of another person’s life (Morgan, 2002, p. 86). Therefore, rapport building is extremely important throughout therapy as the therapist adopts a position of consultant who collaborates with a client (Carr, 1998).

Narrative therapists deconstruct stories by separating problem stories from an individual through a process called externalizing conversations. The externalizing process assists clients in understanding that they are not confined to the dominant negative stories they tell themselves, or that are told about them (Gibbs, 2006). During externalization, individuals and therapists collaboratively label, objectify, and personify problems in order for them to be seen as separate entities, rather than inherent problems (Gibbs, 2006). From there, the influence of the problem on the individual as well as the individual's influence on the problem is mapped out in order to truly understand the full effects of the problem (White & Epston, 1990). White and Epston (1990), believed that by identifying an individual's relationship with the problem, the problem story is deconstructed. Deconstruction of old stories makes room for alternative stories to be reconstructed, allowing for new meaning making to occur about the past, present, and future (White & Epston, 1990).

Narrative therapy assists individuals by sequencing their stories across time, shaping them into a beginning, middle, and end. As stories are sequenced and mapped out, therapists explore times when an individual was not being influenced by the problem, a process known as identifying unique outcomes (Carr, 1998). Unique outcomes are "experiences or events that would not be predicted by the problem-saturated plot or narrative that has governed the client's life and identity" (Carr, 1998, p. 493). Uncovering unique outcomes allows individuals to redescribe and redefine themselves and their relationships based on these unique events (Carr, 1998). Thus, a new story begins.

Once unique outcomes are identified, an individual's new story is "thickened" by mapping the landscape of action and the landscape of consciousness events (Carr, 1998, p. 493). Mapping the landscape of action includes identifying the meaning of events, sequences, time,

and plot (Carr, 1998, p. 493-494). For example, a therapist may seek to understand how a particular event was uninfluenced by a problem from the past. Mapping the landscape of consciousness events includes identifying meaning, effects, evaluation, and justification of events (Carr, 1998, p. 494). In this instance, a therapist searches for how people justify the problem and its effects on their life. By utilizing this technique strengths and competencies that were unrecognizable in the problem-saturated story now become evident. Each of these techniques allows for alternative narratives to be developed that begin to deepen the plot of the new story. Therapy starts to shift towards a positive narrative that is future-focused (Gibbs, 2006).

Within narrative therapy, White and Epston (1990) have also incorporated therapeutic letter writing, outsider witness groups, the use of documents into therapy sessions with people. Therapeutic letter writing is when a therapist provides a summary of what transpired in a therapy session (Gibbs, 2006). Therapy that includes letter writing aims to privilege peoples' lived experiences (White & Epston, 1990). Furthermore, therapeutic letter writing allows the therapist to appreciate people as they are based on the accomplishments they have made in therapy (White & Epston, 1990).

Outsider witness groups enhance the new story of an individual (Carr, 1998). An outsider witness group is a group that contains members of a person's social network who understand the situation. These people are able to provide guidance and knowledge on how to manage a problem (Carr, 1998). Outsider witnesses may also be prior clients of a therapist who share similar stories with the current client. A narrative therapist will ask prior clients to share personal narratives, knowledges, and skills with current clients who are facing similar difficulties (Carr,

1998). The idea is that guidance and knowledge from outside sources will induce positivity and benefit therapeutic outcomes for the client (Carr, 1998).

Finally, narrative therapy recognizes that documents used in traditional therapy often include a file for each client which can only be read by a professional. In contrast, alternative documents are used in narrative therapy and are designed to appreciate and celebrate the accomplishments of a client's new narrative. Documents are used to encourage the new narrative to continue in the future (White & Epston, 1990). Alternative documents may take the form of awards, certificates, or declarations seeking to consolidate the new meanings and narratives that were created in therapy (White & Epston, 1990).

The techniques used in narrative therapy are re-authoring and re-framing of narratives that will change their lives (Ricks, et al., 2014). However, narrative therapy may not always have long term benefits for clients. According to Nichols (2014), problems may not necessarily disappear because a family has banded together to temporarily fight an external problem. Even after the problem has been solved, conflict may still occur. Additionally, Nichols (2014) believes that narrative therapy has the tendency to view unhappy emotions, such as anger, as something to avoid rather than explore and learn to deal with (p. 255).

In my experiences during practicum, I found that specific techniques of narrative therapy assisted in my treatment plan with clients. Externalizing the problem assisted clients to cope better with the problem. Externalization changed client perspectives from seeing themselves as the problem. In one particular instance, an adult female client I worked with had received a recent mental health diagnosis of borderline personality disorder. In my initial sessions working with her, I assessed how she felt about having this diagnosis. She described the diagnosis as a relief because she had struggled with several misdiagnoses throughout her lifetime. Therefore, in

conjunction with dialectical behaviour therapy (DBT) that was prescribed by her psychiatrist, narrative techniques were also used to externalize the diagnosis. In the initial sessions after the diagnosis, we spoke of how she could now shake hands with BPD and get to know more about it.

Interventions took place about how she could live with BPD and still have a meaningful life. For example, BPD frequently affects interpersonal relationships (Moonshine, 2008). This client had frequent conflict with her mother-in-law so much so that their relationship had nearly completely broken down. However, she did state that she was able to call her mother-in-law and have a polite conversation for a short period of time. Recognizing this as a unique outcome, I was able to explore with her how she was able to overcome her fears and make this call. Utilizing a narrative approach in this situation instilled hope for the client that the relationship with her mother-in-law was not completely ruined. As a result, she felt encouraged that she could continue to take small steps in mending the relationship.

Emotionally Focused Therapy

Expressing emotion, affection, and one's deepest needs is a significant risk in today's world. Western culture has prided itself on the ability to be independent as opposed to interdependent and rational as opposed to emotional. However, particularly when it comes to couple relationships, the need for one another to be emotional and to respond to one another's emotional cues during times of distress is believed to be at the heart of maintaining a bond and love that will last a lifetime (Johnson, 2004). Emotionally focused therapy (EFT) was designed for couples in distress by Dr. Sue Johnson. After working with couples for many years, she deemed that the relationship between couples seemed to be all about negotiations. However, "as I watched couples shout and weep, bicker and shut down, I began to understand that there were key negative and positive emotional moments that defined a relationship" (Johnson, 2008, p. 4).

According to Dr. Johnson, “you can’t bargain for compassion, for connection” (Johnson, 2008, p. 4). EFT is based on the understanding that relationships are about emotional bonds and the innate need for a safe emotional connection with one’s life partner. Just as John Bowlby had developed a theory of attachment between mothers and children, Dr. Johnson realized that adults had the same attachment needs in intimate relationships with one another (Johnson, 2008).

There are several key assumptions that have evolved from EFT. They are summarized by Johnson and Whiffen as follows:

- Emotion is primary in organizing attachment behaviours and how self and others are experienced in an intimate relationship. Emotion guides and gives meaning to perception, motivates and cues behaviour, and when expressed, communicates to others. It is a powerful link between intrapsychic and social realities.
- The needs and desires of partners are essentially healthy and adaptive. It is the way such needs are enacted in a context of perceived insecurity that creates problems.
- Problems are maintained by the way interactions are organized and by the dominant emotional experience of each partner in the relationship. Affect and interaction form a reciprocally determining feedback loop.
- Change occurs not through insight, catharsis, or negotiation but through new emotional experience in the context of attachment-salient interactions.
- In couple therapy, the client is the relationship between partners. The attachment perspective on adult love offers a map to the essential elements of

such relationships. Problems are viewed in terms of adult insecurity and separation distress. (Johnson and Whiffen, 1999, p. 367)

The unique part of EFT is that by understanding one's attachment style, EFT can be used in both individual and couple sessions. Individual EFT sessions can be utilized in order to assist a person in recognizing, naming, and expressing an internal emotion. According to Johnson (1998), understanding one's own emotions and attachment style is congenial to having others understand it as well. Johnson dubs the process of identifying personal emotions as "listening to the music" (Johnson, 1998, p. 1).

With couples, EFT provides therapists with a map in order to navigate through the intimacy of relationships. This map includes nine specific treatment steps:

Cycle De-Escalation.

Step 1. Assessment - creating an alliance and explicating the core issues in the couple's conflict using an attachment perspective.

Step 2. Identifying the problem interactional cycle that maintains attachment insecurity and relationship distress.

Step 3. Accessing the unacknowledged emotions underlying interactional positions.

Step 4. Reframing the problem in terms of the cycle, the underlying emotions, and attachment needs.

Changing Interactional Positions

Step 5. Promoting identification with disowned needs and aspects of self and integrating these into relationship interactions.

Step 6. Promoting acceptance of the partner's new construction of experience in the relationship and new responses.

Step 7. Facilitating the expression of specific needs and wants and creating emotional engagement.

Consolidation/Integration

Step 8. Facilitating the emergence of new solutions to the old problematic relationships issues.

Step 9. Consolidating new positions and new cycles of attachment behaviour.

(Johnson, Hunsley, Greenberg, & Schindler, 1999, p. 70)

Throughout each of these steps, a strong therapeutic alliance is important. The therapist must continually reflect and validate each partner's feelings, all the while relating it to their emotional experience and attachment needs (Johnson, et al., 1999, p. 70). Therefore, it is important for the therapist to empathetically attune to the attachment needs and longings that each partner expresses (Johnson, 2004).

Emotionally focused therapy speaks the language of attachment in order to help people solve their problems through a lens that focuses on emotion. When people feel listened to and understood, primary attachment needs are met and emotional bonds are strengthened. As a result, problems will not feel as insurmountable when one has a secure base from which to explore and interact with the world (Johnson, 2004).

Emotionally focused therapy is an effective way to assist couples in identifying their emotions and begin responding to one another's attachment cues. However, during my practicum, I also noticed times in couple sessions when it was not appropriate to focus on emotions. For example, during a co-therapy session, the wife believed that her husband became a different person when he drank. Therefore, it became imperative that my co-therapist and I assess the husband using motivational interviewing techniques to understand if he considered his

drinking a problem, and if he was thinking about changing this habit. Throughout this assessment and conversation, we were then able to refer the husband to another counsellor who specialized in substance problems in order for him to get the help he needed with his addiction. That way, we could continue providing EFT to the couple in order to strengthen their emotional bond with one another and solve their marital problems.

I provided co-therapy with a psychologist at ECS to one couple who presented with marital issues involving communication difficulties with one another. The first step for the co-counsellor and I was to assist them in identifying the cycle of pursue/withdraw that they frequently found themselves caught in. As the couple began to recognize their triggers that led to the pursue/withdraw cycle, they slowly began to recognize when the cycle was taking over in the midst of an argument. For example, when the husband felt pressured or judged by his wife he would begin to shut down. When the husband shut down, this triggered his wife to continue trying to engage with him, hoping to get a response. Emotionally focused therapy focuses less on the attachment style of partners and instead on how each responds to bids for attention from the other. As the co-counsellor and I continued to work with this couple, we would recognize and identify the attachment cues that each partner was exhibiting. By drawing on the attachment cues, each partner was able to discuss what it meant to them when they found themselves caught in the cycle. From there, we would ask them how they could re-create a more positive cycle with one another.

The couple worked hard to create a more positive cycle and they soon began to recognize the moments when the pursue/withdraw cycle began between them. It turned out that when tension arose between the couple, each partner was desperately needing and seeking safe,

emotional contact with the other. After this realization, the couple decided that instead of getting caught in the cycle they would try to reach out to one another instead.

Cognitive Behavioural Therapy

A person's thoughts, behaviours, moods, physical reactions, and environment are all intricately interconnected and affect one another (Greenberger & Padesky, 1995). Therefore, people's thoughts are very influential in how they come to handle problems that arise. The connection between all thoughts, behaviours, and actions is the basis to understanding cognitive behavioural therapy (CBT). Cognitive behavioural therapy posits that individuals can change their lives and solve their problems by simply changing the way they think. Cognitive behavioural therapy was first introduced by psychiatrist, Dr. Aaron Beck in the 1960s. Throughout therapy sessions with clients, Dr. Beck noticed that individuals seemed to be having an ongoing, continual, internal dialogue with themselves, all the while speaking to him (Martin, 2015). He also believed that he was only privileged to hear a small amount of these internal thoughts from his clients. Dr. Beck soon realized that there was a link between thoughts and feelings, which he described as automatic thoughts. These automatic thoughts pop into the mind and affect one's emotions (Martin, 2015). In order to identify these thoughts, individuals must notice what goes through their mind when they experience a strong feeling or reaction towards a situation or event (Greenberger & Padesky, 1995). Cognitive behavioural therapy believes that it is not the event that is upsetting, but rather the meaning that is ascribed to it (Martin, 2015).

Cognitive behavioural therapy is built on the principle that a strong, collaborative therapeutic relationship is essential in order for therapy to be successful (Beck & Emery, 1985). This includes having a relationship that is reciprocal, as opposed to hierarchical. The therapist remains transparent as opposed to having a hidden agenda, designs homework tasks in

collaboration with the client and admits mistakes to avoid ruptures in the relationship (Beck & Emery, 1985).

The principles of cognitive behavioural therapy are necessary to its success with clients. First, CBT posits that therapy should be focused on the present. As a result, sessions focus on present feelings, thoughts, and behaviours that are described by a client as opposed to finding out the cause of their problems (Beck & Emery, 1985). Second, CBT emphasizes homework as an integral part of successful therapy outcomes. Practicing the skills introduced in therapy is necessary in order for individuals to know what to do the next time the situation arises (Beck & Emery, 1985). Additionally, practicing these skills increases the likelihood they will be utilized, as opposed to forgotten in crisis situations (Greenberger & Padesky, 1995).

Burns (2000) identifies ten cognitive distortions that are the basis for the development of negative thought patterns that frequently restrict peoples' ability to solve their own problems. Assisting an individual to recognize these cognitive distortions is the beginning of being able to change the underlying beliefs associated with them. The 10 cognitive distortions include:

1. All or Nothing Thinking: the fear of making a mistake restricts a person from completing the task at hand.
2. Overgeneralization: the belief that one negative experience will lead to that experience always being negative.
3. Mental Filter: continuing to focus on the negative details of a situation, therefore making the whole experience negative.
4. Disqualifying the Positive: changing the focus of a positive experience to a negative one.

5. **Jumping to Conclusions:** this includes two ways of jumping to negative conclusions. The first is taking a mind reader stance. That is, the belief that everyone else is looking negatively at a person. Second, the fortune teller error believes that if a person imagines something bad will happen then it will manifest.
6. **Magnification or Minimization:** The ability to make problems larger than they are or smaller than they are.
7. **Emotional Reasoning:** taking one's emotions as truth.
8. **Should Statements:** statements that can lead to feeling pressured to have to do something.
9. **Labeling and Mislabeled:** believing one error defines a person's entire self-image.
10. **Personalization:** assuming responsibility for negative experiences. (Burns, 2000, p. 42-43)

Cognitive behavioural therapy's ability to change cognitive distortions has been found to be effective with a variety of presenting problems, including, but not limited to: anger management, anxiety, depression, phobias, chronic pain, trauma, or drug and alcohol problems (Martin, 2015). In addition, it can be adapted for use with all ages, including with children and adolescents (Stallard, 2005). Cognitive behavioural therapy consists of structured sessions and is educational because it is meant to be a time-limited therapy (Martin, 2015). The goal is to collaboratively work with individuals in order for them to become confident in their ability to use these skills outside of the therapeutic environment (Martin, 2015).

Despite the advances of cognitive behavioural therapy with mental health problems it still comes with limitations. According to Holmes (2002), studies examining the effectiveness of CBT are usually compared with waiting list controls or no therapy at all. As a result, research has found that CBT is an effective therapy but it has not necessarily been compared to other reputable methods of therapy. Additionally, CBT has been a reputable method of therapy for use with several mental health problems. However, according to Linehan (1993, as cited in Holmes, 2002), CBT alone is unlikely to be effective with more complex mental health problems such as borderline personality disorder. As a result, integrative approaches that include CBT should be considered in order to best meet client needs.

In my practicum, I provided counselling to a 16 year old youth who presented with anxiety. A variety of skills were used including: CBT to address cognitive distortions; dialectical behaviour therapy (DBT) to practice mindfulness techniques; solution focused therapy to rate anxiety during sessions; and narrative therapy to externalize anxiety. As this youth was particularly artistic, interventions that were creative in nature (i.e., drawing) were used in conjunction with talk therapy in order to increase the likelihood of success in counselling.

In one particular activity, CBT approaches were used to address the cognitive distortions she had that triggered her anxiety. For example, this particular youth was a perfectionist who always felt that everything had to be done perfectly or it was not worth doing. As a result, she was rarely completing her school work because she believed her assignments were never completed perfectly and so she would not hand them in. As such, one activity looked at the cognitive distortion of “all-or-nothing thinking” (Schab, 2008, p. 29). Throughout this activity, all-or-nothing thinking was explained as the tendency to judge things in black or white. However, “judging yourself in this way raises your anxiety level... [and] you are always afraid

that if you don't achieve perfection (one extreme) you will be a complete failure (the other extreme)" (Schab, 2008 p. 29). The activity focused on learning that reality often exists in the grey area of life, as opposed to the black or white. Throughout the activity, this adolescent evaluated where her grades, relationships with family and friends, talents, and attitudes would fall in the grey area. By placing her cognitive beliefs into the grey area, the teen deconstructed her thoughts and feelings that perpetuated her all-or-nothing thought patterns. The teen was then asked to share what it was like to rate these categories in the grey area. She said that it was interesting to think of it in this way as she did find herself thinking in black or white a lot. She said that thinking in the grey area seemed more realistic. However, she still believed that it would be difficult to implement regularly. As a result, we brainstormed ways in which she could become more successful in deconstructing her black and white thoughts. She decided it would be best to begin with easier ones such as her relationships with friends and slowly work towards changing her thought patterns about school work which was the biggest trigger of her anxiety.

Services Provided In Practicum

Individual Counselling

Individual counselling was the approach that I used most often during my practicum. At ECS, individual counselling is conducted in hour long, confidential sessions. I also provided telephone and email counselling to provide support. For example, one client emailed to let me know she was unable to attend a session. Since we already had the next session booked, I responded to let her know she could email me during the week if she felt as though she needed a check-in between appointments. She emailed back about a crisis that had occurred between her and her husband. Therefore, I was able to provide email support to her. I reminded her of her

progress and encouraged her to use the skills she had been practicing. I was also able to send her some information to help her build her skill set and defeat the crisis she was experiencing.

The individuals that I counselled in one-to-one sessions were referred by different agencies or by people within the community. They were a variety of ages, from children to adults. Each client allowed me to use a variety of interventions while building the therapeutic relationship. My clients often reported that they enjoyed coming to therapy and having the one-to-one attention because they felt heard and understood. As a result, they were more willing to share their experiences and continue to work on positive changes.

Couples Counselling

During my practicum at ECS, I had the opportunity to provide co-therapy to three couples. All my couple sessions were done jointly with a psychologist at ECS. These joint counselling sessions created an interesting dynamic. For example, while my co-counsellor was speaking and engaging with the clients, I was observing their facial expressions, body language, and responses to each other. It was during these times that key emotions were expressed that may have otherwise been missed. In one session, as my co-counsellor explored feelings with the husband, I noticed the wife's facial expression. She was wide-eyed, flushed, and holding back tears. After the co-counsellor explored the husband's feelings, it was an opportunity for me to turn to the wife and ask what she was experiencing in that moment. I asked her if she had ever heard her husband speak like this before. She stated that she had never heard this from her husband and it helped her to understand him better. As a result, the emotional bond between the couple changed and a more positive cycle of interactions began.

Family Counselling

Family counselling at ECS transpires in ways that reflect the needs of the client. In my practicum, I had two youth that I worked with. I used CBT while working with one 16 year old youth on specific skills to target anxiety and depression. This youth had seen a counsellor before, but needed additional skills to manage her anxiety. Sessions were structured to include a review of homework; time for her to share how things had gone since our last appointment; and practicing new skills in session. Within these sessions, the parents were only present as deemed necessary to support the youth in implementing the skills and techniques she was learning.

I also worked with a 15 year old youth, utilizing CBT to target her depression. At each session, the parents were involved at the beginning and end. Meeting with the parents at the beginning of each session allowed me to check-in on how things went in the previous week and they could share their perspectives and concerns. By meeting with the parents at the beginning, I was able to build rapport with them as well as the youth. I would then spend the majority of the session with the youth. Together, we utilized CBT and mindfulness interventions to build skills and coping strategies for her depression. Prior to the parents returning at the end of session, I discussed with the youth what she wanted to share with her parents which respected her confidentiality and gave her choice and control in sessions. Afterwards we would invite her parents back in to discuss her progress, their concerns and how the parents could support their child at home.

These opportunities allowed me to see how important the family is to the change process for youth. The families I worked with were supportive and loving. They were willing to support their children and encourage positive change for the future. According to family systems theory, the family is where most problems arise (Collins et al., 2010). Therefore, it felt natural to include

them in the therapeutic process as much as possible in order to provide additional support outside of counselling.

Group Counselling

Group counselling occurs less frequently at Ehrlo Counselling Services, however, various programs within Ranch Ehrlo Society facilitate groups for youth, parents, and families. During my practicum, I had the opportunity to co-facilitate a six week parenting group with a family therapist at the Ranch Ehrlo Family Treatment Program. This parenting group was called the *Common Sense Parenting Program* (Burke, Herron, & Schuchmann, 1999). The participants included parents, grandparents, and caregivers who were currently participating in the Ranch Ehrlo Family Treatment Program. The chapters included: encouraging positive behaviour, preventing misbehaviour, correcting problem behaviours, dealing with emotionally intense situations, and assisting children to succeed in school (Burke et al., 1999). Each week the topics would build on one another in order to assist parents in learning and practicing various skills to unify the family and have more positive experiences together. The topics provided parents with several hands on techniques and creative interventions that they could practice. The workbook also included ways to incorporate positive and negative consequences into the family's routine and how to clearly communicate with children and youth. Each week, the family therapist and I would review the previous session and plan the next session. We split up each chapter into easy to use information that was presented to the families. Throughout this group, parents and caregivers were able to share their hopes and dreams they had for their children while also describing the struggles they were experiencing as parents. Furthermore, they looked to us as facilitators for validation and guidance on how to handle various situations and receive support throughout their trials and triumphs.

Unique Skills and Opportunities at Ehrlo Counselling Services

A variety of skills were used throughout my practicum and expanded on my current skill set all the while pushing my comfort zone and strengthening my competencies as a social worker. During my practicum with Ehrlo Counselling Services, I had the opportunity to use a variety of interventions for children, youth, and adults. I also experienced several learning opportunities outside of the counselling room such as presentations and professional development.

Creative Interventions

Prior to beginning my practicum, I had very little experience in working directly with children and youth in a counselling setting. My previous family work was often with adults around parenting strategies and skills, as opposed to direct work with children. Needless to say, beginning to work with children left me feeling nervous and inexperienced. However, the experience significantly changed me and I learned several valuable lessons about providing counselling to children. The first is the necessity of building a relationship with children and youth prior to beginning any therapeutic interventions. This relationship building included exploring what the kids knew about counselling, what confidentiality was, and what can and cannot be kept confidential. My initial few sessions with children and youth involved engaging them in activities they enjoy such as games or coloring. Additionally, I modeled appropriate boundaries and built up their self-esteem by continuing to encourage their good work and validate their strengths. Each of these activities allowed for me to strengthen the relationship that I had with each child. Creative interventions were used at all stages of counselling with children in order to engage, assess, and build skills. The following includes some creative interventions that were used in my work with children and youth.

Butterflies in my stomach. “Butterflies in my stomach” is a creative intervention that is helpful in the assessment phase with younger children and is used to discuss children’s worries and problems including how they feel stress in their bodies, like butterflies in their tummies (Lowenstein, 1999, p. 9). The child is provided with three butterflies, some smaller and some larger. After talking with children about their worries, I would explain to them that sometimes children have big worries that might feel like they have a big butterfly in their tummy while other times the worries are smaller, like smaller butterflies in their tummy. Children could then write their big worries on the big butterfly and write their small and medium worries on the other butterflies. According to Lowenstein (1999), this “is a particularly useful activity with children who have a multitude of presenting problems, as it enables them to communicate to the therapist which problems are most pressing and need priority in treatment” (p. 10).

I found this activity particularly useful with one young child that I worked with. This young child was nine and had recently been reunified with his family after being in the foster care system for the past seven months. After discussing with him what his worries were and how they might be big or small, he revealed that one of his biggest worries was that his parents may have to leave him again. From that information, it was important to implement a treatment plan outlining ways to make him feel safe with his family.

Road rage. In beginning my work with children and youth, I soon learned that not every child is going to want to colour and do creative activities. Therefore, I had to adapt accordingly and learn to incorporate other methods of creative interventions. While working with an 11 year old girl, my Professional Associate showed me the Road Rage game (Lowenstein, 2002). This game assisted children in understanding and normalizing anger. It also allowed children to learn healthy ways to express their anger, problem solve and practice ways to cope with this feeling.

Each square had a red, yellow, or green light on it. Children would pick from the corresponding colour cards and the colour of card determined which square they drove to next. When children landed on a red light that meant it was time to stop and practice an anger management technique. Yellow lights meant that children had to slow down and ask a true or false question about anger and feelings. Green lights meant the children got to ask a question of their choice and get a sticker as a reward (Lowenstein, 2002). This activity was a fun way to begin talking about emotional regulation and how to identify angry feelings. With the young girl, she explored what was true or false about angry feelings and identified situations when she might start to feel angry. She also practiced techniques to cope with anger throughout the game. This game opened up the opportunity for feeling identification and how to cope with difficult feelings.

Presentations

Case consultation. At ECS, case consultations were presented by any counsellor at a team meeting as a way of obtaining additional support and suggestions. Case consultations provided information including: relevant background information, problems that the client had, and the current treatment plan and goals. After the presentation, the counsellor would then present a question to the staff about where they wanted input and guidance.

Approximately halfway through my practicum, I was asked to prepare and present a case for consultation during a team meeting at ECS. This experience was extremely valuable as it allowed me to reflect on the goals the client had made and review how she was doing in completing them. I gained various ideas and intervention strategies that other counsellors had used in the past. Afterwards, I was able to implement ideas from the consultation into the treatment plan.

Self-care for professionals. At a team meeting, another practicum student studying a master of educational psychology and I were asked to prepare a presentation regarding self-care for professionals. Collaboratively, we prepared a presentation entitled, “Caring for Ourselves While Caring for Others” (Kuckartz & Rieger, 2016). The presentation outlined topics on burnout, vicarious trauma, secondary trauma, compassion fatigue, and self-care. Information was provided about how burnout and trauma affects the physical and mental capacity of counsellors in their work and home life. We provided strategies for self-care that included: keeping a journal, spending time with family, getting enough rest, exercising, and maintaining a healthy diet, to name a few. In order to enhance the likelihood of using the self-care techniques we provided, the team practiced journaling on various topics that we provided and participated in exercises that promoted wellness which could be done throughout a work day.

Presentations are an area that I feel confident and comfortable with. Therefore, when I was asked to prepare a presentation, it was something that I was eager to do. The preparation and presentation on self-care for professionals was a rewarding experience because I was able to collaborate with another practicum student at ECS. Each of us were able to bring our experiences and expertise together to create a holistic presentation, identifying all aspects of self and environment that contributes to burnout, vicarious trauma, and self care for professionals.

Ethical Dilemmas

As I began to work in the field of clinical social work, I was constantly reflecting on the Code of Ethics (2005) for social workers. During my practicum, I wanted to ensure I was providing all the best possible services for the clients at ECS. Additionally, I engaged in weekly supervision in order to receive feedback on my skills.

One of the first ethical dilemmas I encountered in my practicum was during my work with a couple. This couple was seeking marital and individual counselling. In the initial couple session, they asked if I would be willing to work with the wife in individual counselling while also providing counselling to the couple. As a social worker, it is important that I uphold integrity and therefore, “demonstrate and promote the qualities of honesty, reliability, impartiality, and diligence” (CASW, 2005, p. 7). In this particular instance, it was deemed that I would not be impartial in individual sessions while also meeting with the couple together. For example, if one partner were to have disclosed an affair in an individual session, it would have created an impasse in couples counselling if that partner chose not to disclose infidelity to the other partner. As a result, through supervision it was decided that I would continue to provide individual counselling to the wife and another counsellor would see the husband individually. As each partner began to achieve their personal goals, the other counsellor and I decided to co-counsel the couple together. As a result, each partner would have their needs heard and validated, while still being able to pursue couples counselling for their relationship needs.

As a social worker, the first value in the Code of Ethics is to have “respect for the inherent dignity and worth of persons” (CASW, 2005, p. 4). This value involves upholding human rights, having respect for each individual’s unique worth, and respecting the client’s right to make choices (CASW, 2005). During my practicum, I worked with two young girls who had been exposed to severe trauma in the past. Coming to counselling was an extremely daunting experience for them as they navigated yet another new environment. I was to meet with each child individually for an hour, which left the other child in the waiting room alone for at least an hour. Having been recently apprehended from their family by social services, each of these girls became anxious when they were alone and the other was in a counselling session with me. As a

result, I advocated for the girls to have a consistent person available to bring them to counselling and stay with one of them while I was in session with the other. This created more reliability, security, and comfort for the girls which enhanced their trust in the counselling environment.

Conclusion

Envisioning my future as a clinical social worker excites me. The education and work experiences I obtained during my masters program and practicum focused on my true passion of working with others to help them achieve their hopes, goals, and dreams. Each day, I was motivated by the philosophies of Ehrlo Counselling Services to provide preventative and holistic counselling services. I was inspired by the resiliency and dedication I witnessed in my clients as they strived to make changes in their lives. I feel confident and competent in making ethically sound, client-centred, informed decisions with the theoretical knowledge I have gained from this practicum experience. Finally, I feel passionate and wholeheartedly committed to working with others in a counselling setting, as I have truly come to believe that this is the type of work I am supposed to do.

I believe social work on a micro level changes people's lives. In the counselling setting working with people, I am continually reminded of a quote by Vonnegut (as cited in Modelle, 2012), "enjoy the little things in life for one day you'll look back and realize they were the big things" (n.p). Sometimes, small changes that occur in counselling or in everyday life may seem rather insignificant. However, these are the moments that can change and shape each individual's story and put them on a path to overcoming obstacles.

Reflecting on all the things I learned throughout my practicum creates a long list that cannot be confined to the concluding paragraph. Professionally, I learned how to build strong therapeutic relationships with clients which became the heart of the change process. I learned

about the resiliency in children, youth, and adults when the odds were increasingly stacked against them. I learned how to collaboratively set goals with people and build treatment plans that were reflective of these goals. I learned from everyone at Ehrlo Counselling Services about what it truly means to work empathetically and respectfully with clients.

I was aware of how I have grown professionally throughout this experience and I kept a journal of my personal development as well. As a person, I came to realize that I was still carrying internal biases and stigmas of the dominant society without even knowing it. Furthermore, I learned how to let these biases go and see people for who they truly were, listen to their stories, and admire their strengths. I believe that these personal changes in myself have contributed to the changes I made professionally. Therefore, I now look towards the future as a passionate, dedicated clinical social worker who is eager to make change in the world.

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