CLINICAL COUNSELLING FUNDAMENTAL COMPETENCIES IN PRACTICE

Catholic Family Service Regina Clinical Counselling Practicum Placement

A Practicum Report
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By

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ABSTRACT

"How we walk with the broken speaks louder than how we sit with the great"

~Bill Bennot

When I began to research agencies to complete the practicum portion of my Master of Education Degree, the motto of Catholic Family Services (CFS) Regina "Open Hearts. Open Minds. Open Doors. Open to Anyone." resonated with me on various levels. Starting this degree program further opened my heart and mind to concepts and worldviews I had not previously understood, which led to the opening of doors, and new connections with people I would otherwise have likely not known. I believed CFS was a place I would continue to grow on both a personal and professional level; 'open heart & open mind'. Due to the range of clientele provided services at CFS; individuals, youth, couples, family, and psycho-educational groups as required, I considered it fortunate to have my practicum proposal accepted with this non-profit agency.

My caseload was constructed from the counselling intake waitlist, which included new clients, returning clients, and those who were Ministry of Social Services referrals through the CFS Rapid Intervention for Family Therapy (RIFT) and Resolving Adolescent-Parent Strife (RAPT) developed programs, and from the Newcomer Services. Common themes were ruptured relationships, anxiety, depression, youth cutting and addiction concerns, trauma (including intergenerational), parent-teen conflict/crisis, grief work, blended family issues (including parental alienation), and separation/divorce issues.

Regardless of the presenting concerns, clients often felt overwhelmed. Anxiety or depression were common issues for clients. The emotional flooding repeatedly created barriers for these clients to see a way forward, impacting their health, personal, and work life. Also disconcerting

was how many people suffer in silence, not accessing counselling or other resources for support. By 2030 the economic burden of depression is expected to exceed the cost of all other physical barriers according to the World Health Organization (Stockdale Windler, 2014). It is estimated 1 in 5 Canadians experience a mental health illness or substance abuse problem; translating into 220,000 Saskatchewan residents facing some degree of mental health/addiction challenges in any given year. Further statistics bear out that a staggering 43% of Canadians will encounter a mental health problem or illness in their lifetime (Stockdale Windler, 2014).

The increase of mental illness and addictions will have a significant impact on the people of Saskatchewan and reinforces the value I place on a holistic approach to wellness cognizant of physical, emotional, mental, and spiritual health. Prior counselling experience, combined with knowledge attained through this degree program, in addition to continued self-directed learning pursued during the practicum, allowed me to work with clients toward effective and authentic self-care practices. As such the focus of this report will be to explore the practicum experience in relation to my learning objectives, the approaches I incorporated and modified, along with uncovering the common threads experienced by those seeking counselling services. To further facilitate growth as a clinical counsellor I kept a self-reflective journal throughout the process. Journaling allowed me to work through ethical concerns, shortcomings I encountered, as well as successes.

Keywords: *practicum, learning objectives, clinical counselling, diversity, mental health*

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"We don't have to do it all alone, we were never meant to"

~Brene Brown

The value of the services that CFS provides the residents of Saskatchewan are invaluable. Kimberly Young CFS the former Clinical Manager in Counselling Services, and my on-site practicum supervisor was invested, and supportive. Ms. Young was committed to creating a distinct learning, and capacity-building experience with me.

I am grateful for the ongoing support of my supervisor Dr. JoLee Sasakamoose, the faculty in this program and Elders that provided a well-rounded educational opportunity, inclusive of diverse worldviews and experiences. Thanks also to contributions from; Tania Gates initially as Academic Advisor and later as Research & Scholarship Funding Officer, Anne Lauf and Shauna Beylefeld Academic Advisors, and librarian Cara Bradley. I appreciate the support of Accessibility Services throughout my degree, in particular Jasmine Owens who provided me alternate format textbooks essential to my success. I was fortunate to be awarded the Fall 2016 Faculty of Graduate Studies and Research (FGSR) Graduate Studies Scholarship (GSS) and the UR Graduate Winter 2018 Scholarships which have contributed greatly to my ability to progress through this program.

As a person with episodic permanent physical disabilities I have encountered the challenges brought on by flare-ups of my arthritis and iritis. I cannot overlook the wonderful female physician's whose genuine professional care and dedication supported me while I pursued a Masters, and who have sustained me through it; Dr. A.J. Van Heerden, Dr. Renatta Varma, and Dr. Ardeth Milne.

DEDICATION

"Trust in the Lord with all your heart; and lean not unto your own understanding. In all ways acknowledge Him, and He shall direct your paths". Proverbs 3:5-6 has carried me. Instilling strength and confidence especially in times of doubt, that at no time am I making this journey alone. I thank God for placing me where I am, and for providing all the loving, supportive, and wonderful people I have in my life to share in this achievement.

I live for my daughters Jessica, Rebecca, and Emma. It is my genuine hope that my girls know with all my heart that everything I have been guided to accomplish has been to model for them authenticity, determination, resilience, and love. They have been a constant source of love and encouragement during my time in this program. It was challenging not sharing as much time with them and my grandsons as we would have liked. Knowing it was another season in our lives that we would make it through, like many others, made it somewhat easier.

I have been blessed to be raised by parents who while not always giving me what I wanted, have given me what I have needed. They instilled in their children the fundamental core values that guide me to this day. From my parents I know how service to others, acceptance of trials, respect for diversity, and loyalty to family is lived out. I thank them for everything they have done for me, and especially for their support through this Masters program.

My husband Jim brought a very needed skill-set to this endeavor; typing, driving me to classes, listening patiently to me ruminate about all the assignments, and best of all his eternal optimism that I would succeed. Most importantly he has given me the bonus of more people to love through our blended family. I thank him for his heart, and commitment to our life together.

I would like to dedicate this to my incredible family as well as to all the individuals and families I am honored to work with. *"It doesn't matter who you are or where you came from. The ability to triumph begins with you. Always." ~Oprah Winfrey*

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LIST OF ABREVIATIONS

ACT Acceptance Commitment Therapy

ADHD Attention-Deficit Hyperactive Disorder

CBT Cognitive Behavioral Therapy

CCC Certified Canadian Counsellor

CFS Catholic Family Services

CCPA Canadian Counsellor and Psychotherapy Association

CSA Counselling Service Agreement

DBT Dialectical Behavioral Therapy

EAP Employee Assistance Program

ECT Electroconvulsive Therapy

EdGrad Graduate Programs in Education

EPSY Educational Psychology

GSS Graduate Studies Scholarship

MEd Master of Education

MSS Ministry of Social Services

OCD Obsessive Compulsive Disorder

ODD Oppositional Defiant Disorder

ORS Outcome Rating Scale

RIFT Rapid Intervention for Family Therapy

RAPS Resolving Adolescent-Parent Strife

SFBT Solution-Focused Brief Therapy

SRS Session Rating Scale

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INTRODUCTION

"If it's both terrifying and amazing then you should definitely pursue it"

~ Erada

The University of Regina situated on Treaty 4 Territory and the Homeland of the Metis. The Graduate Programs in Education offers a Master of Education (MEd) in Educational Psychology by way of four Routes. Route two, Counselling, involves the completion of nine core and elective classes, along with field-work via the practicum portion of the program for a total of 30.0 credit hours. The Practicum Route 2 requires the completion of 150 field-work hours, granting 3.0 credit units toward the degree. In addition to meeting program requirement goals, I wanted to ensure the practicum contributed toward my ability to register as a Certified Canadian Counsellor (CCC). The Canadian Counselling and Psychotherapy Association (CCPA) parameters around Pathway One certification for CCC requires a student to engage in 150 hours of direct client contact hours. As such my practicum encompassed 200 hours of direct and indirect client contact, cognizant of both the MEd and CCPA requirements.

The practicum routes offer an experiential option for students creating the opportunity to apply theory into practice. Students submit a practicum proposal to their supervisor, and contract to the Faculty of Graduate Studies and Research (FGSR) for approval consideration. Under the direction of a practicum supervisor along with a FGSR approved professional associate, who provides on-site supervision of the practicum, a formal practicum contract is signed. The contract outlines the projected learning objectives and anticipated learning activities for the field-work a student will engage in during the practicum placement. Field-work is an essential component of the MEd in Educational Psychology program, where students apply their program learnings in a supervised environment receiving support, and feedback through the on-site practicum supervisor who fosters opportunity for further professional clinical counselling competency

development. The choice in a practicum placement is more than a practical decision, it is one that must be met with careful consideration in order to meet the orientation of each student, and address their specific learning objectives.

Situating Self

The first Grad class I completed was ED 800-040 with Dr. JoLee Sasakamoose. One of the assigned textbooks *"Indigenous Methodologies"* by Margaret Kovach, revealed the concept of 'situating oneself' and the importance of doing so, since our understanding comes from our experience of life; our worldview. This realization had a profound impact in how I began to see myself and everyone around me. It brought me to a better understanding of my history, privilege, values, strengths, and potential for biases. Situating self also lead me to consider to the challenges I have overcome, discrimination I have faced as a person with a physical disability, and how those have contributed to shaping the person I am and continue to evolve as.

The influence of my worldview, is what led me to pursue the MEd in Educational Psychology (EPSY) Practicum Route 2 Counselling, due to my passion for education, advocacy, and lifelong learning. It is an incredible honor to walk alongside clients developing a therapeutic alliance which can enhance how those clients cope with challenges and incorporate new strategies to deal with mental illness and other hardships. I in turn benefit from the life lessons the clients I work with teach me about courage, vulnerability, and resilience. We have all been broken at one time or another. It is with all of this in mind that I champion the concepts of holistic wellness and worked to further develop my clinical competencies through my practicum experience.

Considerations in Practicum Placement

In my current position as an Educational Counsellor I provide personal, academic, and career counselling to adult students. While counselling continued to be my main focus, it was important to me that the practicum experience allow for variation in areas such as; age, gender orientation, cultural background, as well allowed for the potential to engage in couple, family, and group therapy. The wide range of clients seen at CFS allowed me to develop a caseload counselling individuals, couples, and families. In addition to counselling services CFS provide a myriad of programs; Newcomer Services, Intensive Family Support, Families First, Adolescent Parent Support, Young Parent Program, and Marriage Preparation. Often there are inter-agency referrals made thus clients in common between the various programs and counselling services.

Starting from trauma-informed, strength and resilience-based perspectives have served me well in working with students. I wanted a practicum placement that would allow me to build on the solution-based, client-focused, and mindfulness practices I gravitate toward. It was important to counsel in a setting that would allow me to compliment those modalities with narrative, and third wave Cognitive Behavioral Therapy (CBT) therapies such as Acceptance and Commitment Therapy (ACT) and Dialectical Behavioral Therapy (DBT) when appropriate. Developing competencies in other therapeutic methods for couple, and family counselling was also a high priority.

Respect for other worldviews and building confidence in cultural responsiveness by being aware of how systemic oppression, racism, and societal norms impact clients were also key experiential considerations in my practicum. Developing an intentional framework rooted in a decolonizing lens spares me from, as Conwill (2015) in Goodman & Gorski (2016) offers, a colonizing practice focused on narrow multicultural views, toward a practice that respects the

systemic complexity woven into a client's life experience. Conwill (Goodman et al., 2016) speaks to the complex or layered realities of those subjected to a combination of economic injustices, sexism, and racism. This reminds me to build a framework that confidently relies on a social justice perspective as the foundation of cultural humility in clinical counselling.

Significance of Fieldwork

Briefly to summarize the significance of fieldwork as cited in my Practicum Proposal, working with an established and experienced clinician "creates the conditions to foster the growth of my clinical skills and competencies as a counsellor". Additionally, "fieldwork allows me to practice and further develop my own personal style, and preferred theories. There is also opportunity to address areas where I have challenges, or lack experience in". The practicum route which allows for the experiential fieldwork option aligned best with my future goals of providing clinical counselling in a private practice setting.

Practicum Proposal: Anticipated Learning Objectives

Determining learning objectives took place prior to my search for a practicum placement, since it was important to me to ensure the potential for a broad range of experiences in the fieldwork could be made possible. CFS was the best fit for my objectives, and once I received confirmation I would be able to proceed with the practicum at this agency I completed the practicum proposal.

Below are the approved anticipated learning objectives for my field-work:

- To increase competency levels in counselling, and with diverse populations (ie. age, ethnicity, culture, gender, ability).
- To explore different delivery models of provide counselling; individual, marriage, group, and family counselling.

- To receive exposure to various counselling methodologies, and engage in research, and other self-directed activities to build my understanding of counselling theories and assessments.
- To apply theory and knowledge to the process of co-facilitating psycho-educational group sessions.
- To apply skills obtained in class, prior education, and work experience in counselling individuals, families, and conducting psycho-educational group sessions to increase counselling competency, knowledge base, and proficiency.
- To take part in training, or professional development.
- To work effectively with challenging situations, and potential ethical dilemmas.
- To learn processes involved in providing services through a not for profit agency funding model, and aspects of community development that are involved in offering services in this manner.

Practicum Proposal: Anticipated Learning Activities

It is key to coordinate the learning objectives of the student, and the learning activities that a practicum placement agency can offer.

Below are the approved anticipated learning activities for my field-work:

- To observe, and to provide primary counselling services in individual counselling sessions and to implement various theoretical orientations and therapeutic interventions with different client concerns.
- To increase my competency in psycho-educational group sessions as a co-facilitator.
- To learn proper intake procedures for individual, family, and groups, as well as informed consent expectations, and termination of sessions.
- Attend group clinical meeting, professional development training provided during group clinical, and staff meetings if they are conducted on the practicum scheduled day.
- To meet regularly with my professional associate, Kimberly Young M.Ed, RP, CCC-S, to examine my progress, and to discuss any concerns that may arise through the practicum placement process. This will foster a deeper understanding of areas I need to work on and allow me to make adjustments that will help to strengthen my clinical skills.
- To maintain a personal journal to track progress, gain a deeper understanding of biases or challenges that I may have in order to address them. Reflection will foster opportunity for me to engage in researching any areas, topics, and evidence-based practices that will support my practicum experience, and ultimately my clinical skills. This self-directed learning activity will aid in personal and professional growth.

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Overview of Practicum Placement Agency & Counselling Services

CFS is a not-for-profit agency whose operating capital comes through Ministry of Social Services (MSS) block funding, along with contributions from the United Way, Archdiocese, EAP, fee for service, and private donations. The premise for CFS existence as an agency is "to assist individuals and families to utilize their capacities and strengths to grow toward enhanced well-being in spirit, mind, and body and preserve the integrity of their relationships, foremost the family". Flowing from CFS vision is the mission statement that "to realize one's potential, one must outgrow those things that detract from well-being and grow into those things that facilitate well-being". The mission of CFS then defines their priorities which are three-fold; healing, stability, and wholeness of individuals and families. Healing is achieved through counselling services; stability is achieved through supportive program services; wholeness is achieved through integrating the experiences of counselling, programs services, and additional skill building through facilitator led groups for adults and youth.

Logic Model

Counselling Services at CFS value a process based in mutual respect, trust, and hope between the client and counsellor. This is achieved through listening to the client, supporting client reflection on experiences shared, and focus toward possible solutions or alternate options to alleviate suffering however those difficulties manifests for each client. Counselling Services incorporates the following logic model for counselling outcomes:

1. Clients report being heard, understood, and respected
2. Clients set goals, and report progress
3. Clients rate positive movement on individual, interpersonal, and sociability areas of life
4. Clients report a positive change in overall functioning

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Outcome Measurement

Outcomes are measured through self-reporting on the Outcome Rating Scale (ORS) and Session Rating Scale (SRS), although participation in rating at each session is optional. Both the ORS and SRS are brief, four-item instruments with editions for adults and for children (See APPENDIX A & B). The ORS assesses change in three areas considered valid indicators of progress in treatment; individual functioning, interpersonal relationships, and social role performance. The SRS measures four interrelated elements; the relational bond, the degree of agreement between the client and counsellor on the goals, methods, and overall approach of therapy. Another key attribute to the implementation of these measurement tools is that it can be used to guide therapy in order to make the required adjustments if ratings deteriorate, but also to continue with treatment plans that demonstrate progress.

Counselling Program

During my fieldwork the Counselling Services staff at CFS consisted of a Clinical Manager, Kimberly Young, and two full-time Clinical Counsellors. Clients were seen between the hours of 9am and 5pm Monday to Friday, with one counsellor providing evening appointments on Wednesday and Thursday evenings until 8pm. The fee for a one-hour session with a Clinical Counsellor is $110 and with a Registered Psychologist the fee is $130 per hour. Although CFS does not turn anyone away, offering a sliding scale option for those who do not have coverage through EAP, insurance, or a MSS referral which is covered through block funding.

On every 1st and 3rd Tuesday of the month a Counsellor provides free walk-in counselling services at the Regina Food Bank in the afternoons from 1-4pm. Counsellors are also responsible

for facilitating psycho-educational groups as required. A waitlist was kept for various groups, and once the numbers reached upward to 12 participants a group could be offered. During my time at CFS they were gearing up for Spring psycho-educational group sessions, and I was unable to take part as a co-facilitator. However, while I was attending to my practicum hours at my workplace I assisted a colleague in the development and implementation of a 4 session Mindfulness Group for staff and students. This experience reinforced the value in the group experience and the supportive dynamics that develop from participants connecting with others who have therapeutic needs.

Weekly case consultations between the Clinical Manager and the Clinical Counsellors were regarded as crucial to maintaining a high standard of service delivery focused on providing clients optimal assistance. Group clinical was held every third Tuesday of the month to support professional development, address program concerns, and provide for a peer to peer learning environment. In addition to in-house capacity-building, every two months' outside agencies including various units from the Ministry of Social Service attended CFS for presentations on the many services provided. This allowed for networking, Q&A, as well as opportunity for both agencies to learn from each other of any changes to programming or policy.

Intake

Each week a counsellor is assigned Intake duties during which time it was suggested they not book more than 2-3 clients on those days. Intake involves responding to in-person, call-in, or email inquires for services. A brief Intake assessment is completed with the potential client to obtain information on the presenting concern, what attempts to cope have been made, if any other professional has in the past or is currently being seen. At Intake a fee is determined (if any)

for service or if coverage through an employee assistance plan (EAP) exists. Those eligible for services are placed on the waitlist, and provided an approximate timeframe for an appointment with a Counsellor.

CFS counselling does not provide services to individuals in immediate crisis situations, presenting with a main concern of substance dependence, experiencing interpersonal violence, or with severe acute and chronic mental illness. Appropriate referrals are made if an intake assessment reveals that services required do not meet CFS mandate or expertise. However, safety plans are made with those presenting such concerns to the Counsellor on Intake, and an appropriate referral is completed at that time.

Waitlist: Direct, EAP, Insurance, & Indirect Clients

Through Intake a waitlist for services is created. For clients who ‘re-contact’ within 12 months from their last appointment and would like to continue with the same Counsellor, the Counsellor arranges an appointment. In the case that the last appointment is over 12 months, or the client wishes to see a different Counsellor the request is processed through the regular Intake waitlist protocol. At Intake clients are advised of the brief strengths-based orientation used in counselling. The number of sessions clients require varies, but in keeping with a brief strengths-based model up to 12 sessions are provided based on client need. However, no one is denied if they require additional sessions.

Clients are classified as direct or indirect on the waitlist. A direct client is one who has been referred by the Ministry of Social Services (MSS) who provide block funding for several CFS programs. A portion of referrals are made due to concerns in the home regarding parenting difficulties with the challenging behaviors of pre-teens and teens. Other MSS direct referrals are

for the Rapid Intervention for Family Treatment (RIFT) program or the Resolving Adolescent Parent Strife (RAPS) program. Any direct referral is at the top of the appointment scheduling hierarchy with an expectation that contact is made with the client within three days of placement on the waitlist. Following direct clients, are employee assistance program (EAP), then insurance, and finally indirect waitlist clients.

RIFT Program

The RIFT program is for families with children 10-15 years of age experience disruptive and challenging behaviors from their teen(s). This program provides immediate and intensive family counselling to avoid foster care placement. Goals include improving problem solving, communication, and opportunity for youth to develop an understanding of social reciprocity. The use of conflict resolution is typical implementing in working with this population.

RAPS Program

Adolescents between the ages of 16-18 in conflict with their family, school, or community are eligible for the RAPS program. These youths may already be in a Section 10 (supervised boarding arrangement) with the Ministry of Social Services, or at risk of removal from the family home when they come into the program. The goals and strategies used in the RAPS program align with that of the RIFT program.

The open-door policy of CFS ensure that regardless of race, orientation, religious beliefs, family or financial status, those in need of services are able to access the assistance they require. From a social justice perspective, the open-door policy of CFS was a major influence in

approaching this agency for the opportunity to complete my fieldwork with Counselling Services.

Practicum Structure

As agreed upon in my Practicum Contract I would commence fieldwork in November 2017 and complete 200 hours of direct and indirect client hours by the end of March 2018. I spent the week of November 26th working full days Monday to Friday to participate in the initial training regarding office and counselling procedures. After that time, beginning the week of December 4th, I worked every Tuesday from 9am-5pm and Wednesday evenings 4pm-8pm. I was provided training by my Practicum Supervisor along with the Clinical Counsellors in intake procedures, Casework database, therapeutic modalities, and the initial session process for documentation completion. Weekly case consults were scheduled between Ms. Young and I, in addition to impromptu meetings regarding caseload or ethical concerns.

Caseload Responsibilities

To build a caseload my practicum supervisor and I evaluated the current waitlist, then reviewed it each month thereafter. It was determined I would book RIFT, RAPS, other MSS direct clients, as well as Regina Separate School Board employees for which CFS retains a service contract. Due to my work schedule it was difficult to be assigned regularly on the Intake rotation. Out of office walk-in services at the Regina Food Bank were also challenging to attend because of booking conflicts with my established caseload.

While cognizant of seeking clients available for day time appointments, my late afternoon and evening times booked up quickly. I debate if carving out time during the work day is a narrative on society's views of counselling, as most people do not find issue in taking time

off to attend doctor and dentist appointments throughout the work week. Society has more work to do to end the stigma around mental illness and promote the holistic wellness of our community members.

At the initial session clients were advised that I was a MEd practicum student. I also shared that I counsel in my current job and have been in the human service field for 23 years. During the initial session various documents were reviewed and signed with the client: Confidentiality, Counselling Service Agreement (CSA), Personal Data, Informed Consent, and the ORS & SRS Graph (See APPENDIXES C, D, E, F). Exceptions to confidentiality are discussed in addition to providing reassurance to the client that services are provided in a confidential manner. Clients have the right to access their file upon written request. The CSA covers the qualifications of counsellors, speaks to voluntary participation, and if required referrals to other counsellors or agencies. The counselling process in general is reviewed, along with the counsellors right to end services. The Personal Data document covers contact information, family status, and main problems or areas of concern. Informed Consent is obtained in order to voluntarily and anonymously collect ORS and SRS data. The ORS and SRS graph is used at each session the client chooses to scale their experience. Once the file is closed the graph document and Informed Consent is removed.

I was responsible for setting up all initial and ongoing appointments as well as documenting cancellations and no-shows. I kept my caseload paper files in my office during work hours and locked in the filing room when I was not on site. Any outgoing mail to clients was sent in unmarked envelopes so that client privacy was maintained. In addition to business cards I provided to clients for follow up appointments, I had a CFS email address used primarily for internal communication, and for connecting with outside agencies.

CFS uses Caseworks software, a database management system that allows for client registration, scheduling, billing, and documentation. All case-notes, contacts, and documentation of the treatment plan for each client file is entered on Caseworks. Caseworks is a versatile software, that while intricate, allows for comprehensive management of a Clinical Counsellors caseload. Session notes are recorded each session and a treatment plan is formulated throughout the first few sessions and documented typically by the 4th session.

The treatment plan covers the presenting problem from the client's perspective; assessment including individual and systemic issues, therapist's hypothesis, client strengths/resources; service plan goals. Additionally, the treatment plan includes the therapy method, actions/homework, learning, and implementation of other services if required. I entered each session recording, and treatment plan electronically into Caseworks to be reviewed by my practicum supervisor for feedback, revision if required, and final approval.

Client Profiles

Over the span of four months my caseload remained consistent at 15 primary clients. This number increases to 26 when counting all family members involved directly in counselling. The youngest client seen as part of family counselling was 11 years old, and the oldest client I worked with was 57. Of the 10 clients I met with for individual counselling two were male, and of the remaining 8 female clients two were Newcomers. The families I counselled numbered 5, with three headed by a female single-parent. Blended family issues, including concerns of parental alienation were two of the presenting dynamics within family counselling. Within individual counselling for clients who were managing separation and divorce issues those same dynamics along with other elements such as grieving the end of a relationship came to light.

Eighty percent of my caseload consisted of Caucasian clients, while 13% were Newcomers, and 6% were Indigenous (See APPENDIX G). Sixty percent of the families I counselled had Indigenous family members parent, &/or children. Two teens in family counselling self-identified as bi-sexual having been in relationships with both males and females. One adult seen for individual counselling identified as pan-sexual, and disclosed she participated in an 'open' relationship with her partner.

Five of my primary clients indicated they were persons with a physical disability including; diabetes, hepatitis C, Crohn's disease, and debilitating knee issues. One client disclosed complex present and past issues with self-harm/cutting, a bowel disorder, eating disorder, and substance abuse. Several clients related their dependent children were diagnosed with a range of disorders; autism spectrum disorder, obsessive-compulsive disorder (OCD), oppositional defiant disorder (ODD), depression, anxiety, and attention-deficit hyperactive disorder (ADHD). In some cases, yet to be confirmed, there were suspected diagnosis of personality disorder, major depressive disorder, and ADHD. One 17-year-old dependent child of a client was receiving electroconvulsive therapy (ECT) treatment. Three dependent teenagers from separate families ranging in age from 13-17, struggled with drug and alcohol use or misuse. All three youth had varying degrees of gang affiliation. The resulting challenges caused major problems in the home, to the point that two of the three were no longer residing with their parent.

Therapeutic Alliance

"Counselling is both a science and an art" according to Ivey, Ivey, Zalaquett, 2018. In any counselling session the client is the focus, but many factors contribute to the formation of a successful relationship between client and counsellor. As stated in Ivey et al., (2018)

effectiveness in counselling is a combination of therapist, client, treatment, feedback, "and the contextual factors surrounding this process". Eaton, Abeles, and Gutfreund (1988) as cited in Martin (2000) maintain that the "strength of therapeutic alliance is established within the first three sessions of psychotherapy with little significant change over the course of therapy" p.93.

Creating a comfortable environment, conveying warmth and interest along with sharing a commitment to the client and their therapy goals supported trust-building. Appropriate and timely disclosures of my own challenges contributed to authenticity in the collaborative client-counsellor relationships. Establishing connections that placed confidence in the client's resilience, and providing assignments that were capacity-building, helped to shape strong equitable working relationships with the people I counselled.

Presenting Issues in Counselling

Regardless of diversity in ethnicity or family composition, there were common threads in the presenting issues clients brought to counselling. Whether it was the pressure of family conflict, destructive behaviors of their teens, or interpersonal conflict with current/previous partners, clients were experiencing anxiety, situational depression, and overall imbalance in their lives. Strategies initially used to cope (drugs, alcohol, binge eating) over time became unhelpful and created additional complications in their lives. It was especially challenging for women to consider the concepts of self-care, self-compassion, and prioritize creating wellness first in themselves.

Anxiety and depression were common pathology clients displayed for a multitude of reasons ranging from post-partum depression, panic disorder, situational depression due to divorce, and depression resulting from chronic illness. Other causes of anxiety were related to

conflict in the workplace, in managing blended family dynamics, and from ongoing conflict with dependent children. Emotional flooding was visible in each client particularly at the initial session. One couple experienced such a high range of emotional flooding that individual counselling was required first in order to stabilize them sufficiently to re-enter couple counselling.

Clients from the RIFT and RAPS programs reported difficulties around communication. Along with ineffective, unhealthy communication were issues regarding lack of respect and adherence to family rules, truancy, stealing, as well as drug and alcohol usage. For some of the teens there were additional complications included dealing in drugs and gang affiliation. A majority of the teens had suicidal ideation, and past or present relationships with cutting to alleviate emotional discomfort. For the most part parents wanted to be understanding their child's cutting behaviors, but self-blame and guilt often interfered with their ability to fully accept the reality of the situation. At times this lack of acceptance impeded strategizing on effectively supporting their teen to transform their relationship to cutting.

Cutting along with substance abuse was used by one teen who experienced years of traumatic rejection and abandonment in the relationship with his biological father. Warshak (2010) cites the connection between a father's abandonment and the increased likelihood a child will suffer psychological problems. This teen's mother was his primary caregiver throughout his life. They came into the CFS RAPS program to work on their relationship which had become volatile. The teen was no longer residing in the home. Years of rejection as a child and youth deeply impacted this teen who turned to substance use, as well as cutting to dull and manage the emotional distress he felt. It often takes time and patience for caregivers to understand cutting is

a trauma survival method used for self-soothing, one that can be replaced in order to promote 'thrive' over survive.

Similarly, other clients who had experienced trauma, some decades old, were doing their best to manage the resulting ongoing pain they lived with daily. Complex trauma, and intergenerational trauma were also evident in clients. Due to a family history of drug, alcohol, and physical abuse, one client continued to use substances to deal with the pain of familial and intimate partner violence. This role modelling had impacted her young teen who was also using drugs and alcohol to manage the distressing emotions she was experiencing. The resulting ongoing conflict between the parent and child impacted other family members in the home.

Blended families were experiencing high levels of anxiety and anger due to the multiple issues that arise when bringing together unrelated often times resistant children. Differing parenting styles, demands of both biological and non-biological children, as well as interference from ex-partners created layers of issues that at times felt insurmountable to couples. A high conflict divorce left a single parent facing disconnection and tangible alienation from her two young teens. Hopelessness over the situation led to depressive feelings, anger over the situation, and ultimately to counselling for reunification work. Divorced parents were facing similar but generally less complex issues as the blended families, and those with signs of parental alienation. However, in common were concerns about their children's welfare, making good parenting choices, decreasing uncertainty in family routines, establishing a cohesive family unit, and workable transitions between homes.

Individual counselling for certain clients involved grief work for varying reasons, for some it was the due to the loss or impending loss of a family member, or an intimate relationship. I worked with a couple for which grief came from the loss of physical wellness due

to chronic illness, and for the partner grieving the loss of the vibrant spouse they once had. One client was we addressed in counselling the debilitating anticipatory grief he was experiencing due to a close family member being moved into palliative care. Despite the differences in the underlying issue that resulting in varying states of grief, the stages that clients were working on and at times stuck in, were consistent with the five stages of grief model that Elizabeth Kubler-Ross identifies people cycle through.

Professional Development

Prior to Practicum

Preparation for my practicum commenced prior to my November 27th start date. I met with Ms. Young to review learning objectives, and the potential learning activities that would be available to me at CFS. At her suggestion I purchased the textbook *"Counseling and Therapy Skills"* by David G. Martin. Although similar to the textbook "*Intentional Interviewing and Counseling"* used in EPSY 832: Deconstructing Counselling Skills, I found value in the concepts presented in Martin's book, which reinforced prior learnings from my program.

Existing & Limits to Competencies

Working in a counselling role brought me a certain level of confidence and competence, however I was also cognizant that there were specific populations I had little to no experience with. Working with pre-teens and teens I realized would take me out of my comfort zone. I did not want my concerns about my lack of experience with this population to render me ineffective in working with them. I have always admired the gift some counsellors have for connecting with children and teens in what appears to be a relatively effortless manner. This reminded me of the importance of trust building, authenticity, and in order to form connections I needed to create

connection through discussing their: interests, activities, sports, hobbies, music, and ‘causes’. Journaling was another way in which I could work through concerns about any shortcomings I felt I had, to strategize on how to effectively address them.

Skills Training: Webinars

During my practicum it was important to me to find ways to easily access skill-building opportunities. Webinars provided me with such a way to watch professionals share their expertise on a variety of relevant topics. Most webinars were an hour in length although some had two part sessions. Once concluding each webinar viewing, I was provided with a certificate of completion. The certificate documented that I attained ‘1’ continuing education credit hour acceptable to various regulatory bodies including the CCPA who I plan to pursue a CCC designation with. I attended 10 webinar viewings (see APPENDIXES X) which included:

1. Self-Injury Behavior in Youth-Developing an Understanding Part 1
2. Self-Injury Behavior in Youth-Strategizing for Helping Part 2
3. Challenging Behaviors in Youth
4. Helping Children Part 2
5. Addictions and Youth-An Introduction and Overview Part 1
6. Addictions and Youth-Creating Opportunities for Change Part 2
7. Motivating Change-Understanding Resistance and First Steps of Engagement Part 1
8. Solution Focused Therapy
9. Narrative Therapy-Strategies from Leading Frameworks
10. Disordered Eating-From Image to Illness

Online Certificate

In addition to clinical consultations, textbook reading, researching articles, and webinar learning, I completed a 10 credit hour continuing education certificate on Brain Health through Medicine Hat College distance learning in partnership with ALLEGRA Learning Solutions, LLC (see APPENDIX R).

CLINICAL COUNSELLING FUNDAMENTAL COMPETENCIES IN PRACTICE

Modules in this certificate course encompassed:

1. The Amazing Brain: Understanding the Basics
2. Wire Your Brain for Happiness
3. Music, Sound, and the Healthy Brain
4. Mediation and Brain Health
5. Sleep and the Brain: What's the Connection?
6. Play and the Brain: Why Play Matters to your Gray Matter
7. Healthy Lifestyles: How Stress, Nutrition, Physical Activity, Substance Abuse, and Nature Affect Brain Health

I was prompted by a realization that occurred after completing EPSY 836: Neurodevelopment, on the importance of the brain in relation to holistic wellness. The certificate in Brain Health allowed me to further explore the connection I observed between a client's brain health and their current challenges. Offering options based on evidence-based therapies supporting mindfulness, music therapy, and the benefits of sleep in dealing with anxiety, depression, and overall health was transformational for clients.

As cited in Stockdale Winder (2014) "as we understand more about the science behind the brain, we are recognizing the benefits of keeping our brains healthy as a society" p.7. Protecting brain health is relevant across the life span as it "ensures our children get the education they need to be successful; stay well in our prime working years; remain healthy and independent for as long as possible" (Stockdale Winder, 2014, p.7). Further Ivey et al. (2018) expound on the importance of neuroscience and neurobiology to the practice of counselling offering that "each conversation we have with a client has the potential for affecting not only the mind but also the brain, which in turn can change the body" p.7. Because of the importance of the brain to overall functioning, especially in the case of drug usage and the developing brain, it was essential that I increased my understanding in this area.

CLINICAL COUNSELLING FUNDAMENTAL COMPETENCIES IN PRACTICE

Practicum Clinical & Professional Development

At my practicum placement I was able to obtain the Gottman Method Couples Therapy Level 1 Training. The Gottman's method of therapy is based on 30 years of research with over 3000 same, and opposite sex couples.

The learning objectives of this level training included:

1. Summarize the research that allows us to predict future relationship stability
2. Describe the seven levels of the Sound Relationship House theory
3. Conduct a couple's therapy assessment using elements of the couple's narrative, the Oral History Interview, written questionnaires, observations of conflict and individual interviews
4. Describe two interventions to help strengthen a couple's conflict management
5. Describe two interventions to enhance a couple's friendship system
6. Describe two interventions to explore a couple's system of shared meaning
7. Explain why physiological self-soothing is essential for a healthy relationship
8. Create a therapeutic contract with a couple, discuss and decide on goals and include a summary of the couple's strengths and areas that need improvement
9. Describe the Philosophy of Therapy and including assumptions, overview of techniques and goals of therapy
10. Describe the Rapoport Intervention and when to use it
11. Describe the process of therapy, including the structure of a session

Therapeutic Approaches & Interventions

Existential Psychotherapy

For several decades I have been drawn to the work of Viktor Frankl who developed Logotherapy, a therapy considered to be aligned with Existential Psychotherapy. Corey (2017) Existential therapy is viewed as a philosophical approach that influences a therapists practice. Further this is a therapy that focuses on exploring meaning, freedom, responsibility, and anxiety as it relates to the client's current life challenges (Corey, 2017). Frankl posits that life has meaning in all circumstances, as well as the importance of integrating "body, mind, and spirit to be fully alive" (Corey, 2017, p. 130). Key is Frankl's position that somatic complaints be placed

in context to relevant social, psychological, and spiritual factors of a client which impact the approach used in treatment (Maritime Institute of Logotherapy, 2009).

This approach resonates with me due to the social justice lens it presumes to represent, along with the holistic assessment of a client. I view the potential to re-frame suffering as offering clients the opportunity to be empowered and experience growth from their struggles rather than to be defeated by them. I believe what has helped me to transform my own suffering has been to see the gift in it. Although most often not apparent when I am in the struggle, there is a sense of hope that comes with knowing I can use a painful experience ultimately for my benefit. As such I understand how Existentialism can be considered a counsellor's philosophy influencing the therapeutic alliance. An influence I have determined provides me with a strength-based perspective. When assessing the effectiveness of an existential intervention, the clients I worked with conveyed a sense of relief at the ability to re-frame their challenges into valuable growth opportunities.

Narrative & Solution-Focused Brief Therapy

Everyone has a story to tell, and honoring those stories is important in developing a therapeutic alliance. There are times that clients keep themselves stuck in stories that no longer serve a purpose. Narrative therapy as a strengths-based approach was of interest to me to because of how the stories we tell ourselves shape our reality; which in turn can be used according to Rice (2015) in Corey (2017) to encourage clients to live in ways of their choosing. Searching for and acknowledging times the client was resourceful in solving issues (Corey, 2017) is similar to the concepts used in Solution-Focused Brief Therapy (SFBT). In SFBT the counsellor seeks out

exceptions, when things did not go wrong but could have, and then encourages the client to use those ‘successes’ to make other changes (Corey, 2017).

I observed that opportunity for clients to share various stories of their lives provided them with a chance to be heard, respected, and supported. Once a client experienced my genuine interest, and authenticity they were more open to considering that the decision resided with them on how they wanted the story of their life to continue. For one mother and her 17-year-old son once they were able to let go of the stories they had told themselves on what each thought about the other, they began to become solution-focused rather than problem-focused. I concentrated on finding exceptions, times they got along, and encouraged them to do more of what helped not hindered their relationship.

Central to SFBT is the ‘miracle question’ posed to a client; if a miracle took place overnight solving the problem they had, how would they know it was solved, and what would be different (Corey, 2017). The magic wand is a technique I offer whereby I ask clients if they had a magic wand and with a wave could change their life, what specifically would be different. I found teens responded easily and quickly to the magic wand, offering such answers as “my family would laugh together again”, “my mom wouldn’t hang around with her friends that drink”, “I could have a relationship with my dad, and sister without hurting my mom”. Adult clients took more time to consider their answer and typically provided more details. The answers became roadmaps to start the journey toward healing self, and family relations. Comparable to the principle of the miracle question the point is for clients to envision a life that is beyond the problems and see a “range of future possibilities” (Corey, 2017).

Acceptance Commitment Therapy (ACT) & Mindfulness

Russell Harris (2006) describes ACT as an existential, humanistic, cognitive behavioral therapy that is mindfulness-based. Because ACT is evidence-based, and works well with a wide range of issues clients bring to therapy; anxiety, depression, addictions, disordered eating, PTSD, chronic pain, and so on (Harris, 2006) it's my preferred approach for clients who are open to ACT concepts. Similar to Existential therapy, ACT focuses on creating a life of meaning while accepting the inevitable pain and struggle that is part of living. As such ACT promotes psychological flexibility, committing to ones' values, and accepting current life experiences in the here and now (Corey, 2017). When clients make space for uncomfortable thoughts and feelings they are able to make decisions that align with their values, even in the midst of struggle.

Clients that I found benefitted the most from ACT were ones experiencing high levels of anxiety with or in the absence of depression. Being able to consider that they were causing themselves pain by being stuck in the past or catastrophizing the future instead of experiencing the peace of the present helped to calm attacks of anxiety. A client found that ACT reinforced the value system she had, and the expectation of respectful behavior from her teenager. But it also allowed her to make space to consider his experience of how she had been conveying her expectations toward him, which had to that point resulted in ongoing conflict. Also by applying concepts from Gottman's work on 'relational bids' for connection, she was able to understand that while some bids her son made were done so in negative ways, the underlying purpose was a desire for his mom's attention.

Indigenous clients appeared to respond well to mindfulness-based interventions, with positive results noted in a case of a client who had endured trauma. It was not until we worked

on honoring the coping strategies this client had used, that we could work on how trauma manifested in her life with feelings of shame, anger, and helplessness. Focus on balance, wellness, and a return to ceremony along with participation in cultural activities slowly began to impact her choices for coping. For this client the components of self-compassion, self-care, and kindness in mindfulness (Corey, 2017) contributed to her starting to value wellness. We were able to shift out of trauma responses used for survival, by replacing them with alternatives that promoted holistic balance.

Additional Mental Health Tool-Box Strategies

The Four Horsemen

In addition to the relational bids for connection from Gottman couple's therapy, I found *'The Four Horsemen and Their Antidote'* (see APPENDIX S) was a useful tool to address communications styles within families. Identifying the forms of unhealthy communication; criticism, contempt, defensiveness and stonewalling that were eroding their relationships was transformational for some clients. The 'antidotes' to unhealthy responses that of; gentle start-ups, building a culture of appreciation, taking responsibility, and physiological soothing, were communication alternatives I worked on with clients during sessions, and encouraged them to practice at home.

Exhaustion Funnel

The exhaustion funnel developed by Professor Marie Asberg was an excellent visual, and descriptor of what many of the clients I met with were experiencing (see APPENDIX S). Their lives were not in balance leading to exhaustion physically, mentally, and emotionally. As they

became more overwhelmed clients began taking away activities they deemed were the non-essentials, in order to keep functioning. However, failing to recognize they were subtracting from their lives what nurtured them, leaving only the activities or problems that were depleting them.

Based on the work of Williams & Penman (2011) I encouraged clients to keep track for a set time period (day, week, month), a list of activities acknowledging whether the activity 'nurtured' or 'depleted' them. Clients reviewed what they were doing, how it was impacting them, and what they could do to change things around when their life was out of balance. In order to avoid sinking further into the exhaustion funnel one client planned to bring back game night once a week with friends, another would start take friends up on offers for an outing, and yet another felt nurtured when she spent time at Chapters.

Self-Compassion & Vulnerability

I created a hand-out based on the work of Kristin Neff in self-compassion which lends itself well to the concepts of mindfulness. As Corey (2017) states mindfulness encourages "open awareness and acceptance of what is rather than being self-critical" p. 254. A large percentage of the female clients I worked alongside found the concept of developing self-compassion helpful in supporting them to address the absence of self-care in their lives. There tends to be society expectations that women take the caregiver role, and meet the needs of everyone, which often results in neglect of ones' own wants and needs. At times it was difficult for women to identify what they needed for self-care.

Along with the absence of self-compassion were issues around vulnerability, shame, and living un-authentically due to past and present painful experiences. Although discussed during sessions, I suggested bibliotherapy outside of therapy. This included the work of Brene Brown

with books such as; the *Gifts of Imperfection*, *Rising Strong*, and *Daring Greatly*. Brene Browns research centers on concepts of acceptance, authenticity, releasing shame, and building resilience, which aligned well with the intervention strategies used in counselling sessions.

Blended Families

Knowing I would counsel in blended family issues I purchased several highly recommended books; *"Stepcoupling: Creating and Sustaining a Strong Marriage in today's Blended Family"*, *"Surviving and Thriving in Stepfamily Relationships: What works and What Doesn't"*, and *"Stepmonster: A New Look at Why Real Stepmothers Think, Feel, and Act the Way We Do"*.

I commenced searching for up-to-date research, and case management options prior to the start of my fieldwork. This was somewhat challenging as Nixon and Hadfield (2016) note in their work *"Blended Families"*, as much of the research on blended families tends to focus on how children are adjusting to the new family dynamics. Believing as Wisdom and Green (2002) assert that "the eventual success of the new family hinges on the quality and strength of the stepcouples relationship" p.2, I sought interventions that supported the couple to in turn cohesively lead the 'family'.

Once a couple was able to understand that what they were experiencing was a normal part of blending a family, we could develop a 'roadmap' of how they could best address the concerns; starting with issues causing the most distress in their family life. Expert in the field of stepfamilies, Patricia Papernow, asserts that blended families face 5 challenges and offers best practices in a three-level framework for addressing these challenges.

Level I: Psychoeducation; navigating the complexity of blended families, realistic expectations.
Level II: Interpersonal Skills; assessing and building interpersonal skills is essential.

Level III: Intrapsychic Dynamics; avoid mistaking the intensity of feelings in a stepfamily as individual psychopathology (Papernow, 2013).

Stepfamilies cannot rely on the natural bonds that form in a 'first-time family'. It may be the unrealistic expectations that a blended family function just as cohesively as a first-time family that contribute to the statistics wherein 6 out of 10 remarriages end in divorce (Wisdom and Green, 2002). My focus then was to assist the couple to strengthen their bond in order to role model for the children in the home; healthy communication, respect, flexibility, and stability. I provided hand-out, websites, and bibliotherapy resources to stepcouples, as a majority of their capacity-building would take place outside of counselling as they implemented their learnings.

Families of Divorce

As I began to work with families in negotiating divorce and the shared parenting of children this often involved forms of sabotaging by their ex-partner regarding the client's parent-child relationship. I reviewed *"Divorce Poison: How to Protect Your Family from Bad-mouthing and Brainwashing"* the work of Dr. Richard Warshak a pioneer in the area of parental alienation. Warshak (2010) provides important insight into the tactics used and the reasoning behind why people go to such lengths to interfere in their children's relationship with the other parent.

It is paramount to the success of therapy to enter into counselling with intervention strategies when working with youth who have been encouraged by one parent to reject the other parent. It can be a slow process to repair the relationship, and I witnessed the resistance teens in one family demonstrated toward feeling any warmth for their mother. In this situation I wanted to bring into their awareness how perception can be influenced, also that what we focus on we will find; whether good or bad. Because both teens were heavily involved in sports I knew they

could relate to the work of Carol S. Dweck on mindsets. Mindsets; fixed and growth oriented, according to Dweck (2006) influence our beliefs that ultimately guide our life. Both teens could understand and agree that growth mindsets were key to success in their teamwork dependent sports. I intentionally planted the seed that mindsets can be changed, but are also responsible for the way we view life which in turn ultimately impacts the choices we make about ourselves and others.

Later with this same family I utilized the dual image of the old/young woman (see APPENDIX U), conveying I was curious to know what these teen clients were seeing in the image. We were able to discuss in non-threatening (no finger-pointing at dad) ways how there was two sides to this image-as such two stories. I would invite them to hold their gaze on one image and then on the other. They began to understand they could make a choice about what they focused on, and what they were unwilling to see or to see. In subsequent sessions we started to work on negotiating three things each family member would do in order to contribute to their relationship, later reviewing what was working, and what else would appeal to each to try. I demonstrated genuine and positive regard toward their mother which was important for them to witness. In line with Warshak's (2010) work I suggested the mother allow her children's friends into the home on a regular basis. This strategy allows the teens to witness their peers being respectful to, and enjoying time with, their mother. Negative influences had distracted from their relationship with their mother, as such positive influencers would be essential to counteract it.

Ethical Considerations

I had maintained membership with the Saskatchewan Association of Social Workers as a Registered Social Worker for over 20 years, following the Code of Ethics for this profession.

CLINICAL COUNSELLING FUNDAMENTAL COMPETENCIES IN PRACTICE

Adhering to ethics is foundational to any counselling profession. As a student member of the CCPA, my fieldwork was guided by the CCPA Code of Ethics *'Ethical Principles'*, and with regard to their Standards of Practice 5th Edition. EPSY 829: Ethics and Professional Practice ensured students were aware of ethics in practice and the Canadian Code of Ethics for Psychologists. The decision to take courses that have met the Saskatchewan College of Psychologists 4 Foundational Knowledge was done so with an eye toward registering with the College, as such it was important to regard their Code of Ethics as well.

Limits to Confidentiality

For the most part clients were not concerned about breaches to confidentiality in counselling. CFS outlines in their confidentiality document reviewed by both the client and counsellor, what the expectations are regarding this. Assuring clients that what is disclosed in counselling is not shared unless there are issues around self or other harm, the abuse of children, or a subpoena from the court, provided reassurance. There were instances where I had to be cognizant of the choices I was making that could potentially impact confidentiality, and ensure the proper steps were being taken to safeguard it.

Confidentiality and Potential for Breaches

In an initial session an adult client disclosed to me that I personally knew her parent, this was cause for concern to her. Unbeknownst to this client I had also worked for the same employer as her parent. Because I did not work directly with the parent, and this person was no longer in my workplace, the decision was made with my supervisor I could provide services. It was important to reassure this client that I would not discuss her sessions with the parent, and for

to ultimately make the choice to continue in counselling with me or not. I also had to consider if my previous knowledge or belief system about the parent could interfere personally or professional for me in the sessions. I reflected on this potential dilemma and came to a decision that I could confidently move forward with counselling, which my supervisor supported.

Confidentiality and Shared Files

There were concerns at times about which family members would be kept on a file for documentation purposes. Anyone named on the file would be able to access the information. In the case of a couple that I initially met with together, and then only the husband for individual sessions, intending to resume the couple therapy once there was stability to do so, I explained the options for documentation to him. This particular client was agreeable to opening a separate file and keeping his contact notes, and treatment plan separate, and confidential from his spouse. In this way they could both access the couple file that was opened, while he maintained his privacy with an individual file.

Confidentiality with Youth

When working with a family, and as part of the process, meeting individually with members, especially those underage, I had to be cognizant of respecting privacy. It was imperative to consider the best interests of the youth and family as a whole. A working alliance requires trust to relationship build, and there were times that a teen would specifically ask me to keep their confidence. For the most part their disclosures were benign, however if warranted I would request a case consult with Ms. Young. We would discuss the concerns over what the youth disclosed and whether it warranted a discussion with the youth and parent.

Continuity of Care

Cognizant of continuity of care, clients were made aware at the initial session that I was a grad student and reminded again 6 weeks prior to the conclusion of my fieldwork. For the most part client files came to a natural close. Clients worked on issues within 6-8 sessions, learned coping or replacements skills, and felt confident to have their file closed. Of my 15 ongoing clients 4 client files required referral for ongoing support. Two of the referred files were complex cases that due to scheduling had missed, or not been able to book successive appointments. This made it challenging for continuity and progress. Due to these hindrances it was important that I consult with the clients and with my supervisor to ensure appropriate in-house referrals. I did not want to leave my practicum feeling any unease about the ongoing care of the clients I worked with.

Practicum & Professional Reflections

As important as it is to practice within your competencies, there is immeasurable value to the experiential opportunity in a practicum setting. Working with pre-teens and teens brought me outside of my comfort zone. I had limited understanding of the relational aggression teens girls experienced or the cutting and gang culture that many of these youth were facing. I felt an incredible amount of stress, fearing I would say or do the wrong things. To alleviate that fear I connected with my practicum supervisor, read books, attended webinar training, and engaged in additional research. Most importantly I listened to these teens, and honored their pain and the way in which they found relief in various forms of coping. I worked with them to consider and develop replacement options to substance abuse, cutting, and other ultimately life harming

decisions. I mediated with these youths and their parents. At times this meant helping parents understand their teens choices were not done so to make the parent suffer, but rather done to in some way alleviate their own suffering.

At times in a session it became necessary to confront a client, when this occurred we were able to repair and move through the challenge of confrontation. It is worthwhile to note that when the therapeutic relationship was focused on support, trust, and capacity building most times teens felt that authenticity and could tolerate being gently challenged. For one teen living in a Section 10 with a friend's family, out of concern for his wellbeing, I pointed out the unwise guidance he was receiving from the Section 10 guardian. It was a difficult decision to make, as we had established a strong working bond. But, I also factored in I made the choice with his best interest at heart. It was a decision that did not come without risks. But, I had to believe that he would eventually understand that not confronting the issue would have been uncaring, and reckless on my part.

I read recently how important it is to convey to a client when counselling is not working, that they have not failed therapy, but that the modality has failed them. This accentuates the planning that must go into therapeutic interventions. As I reflect on the theories and interventions that I prefer it is evident that each can stand alone, but also have commonalities between them. An existential perspective and ACT align, as does mindfulness with both of the aforementioned. A modified narrative with solution-focused brief therapy work well with mindfulness as they are concerned with the here and now, and re-framing stories in order to support the client.

Maintaining a trauma-informed, strengths-based perspective is possible when using the counselling theories mentioned. Ivey et al. (2018) reference that the therapists personal style and building competencies with theories and in microskills usage as important to practice. I would

add to this, my recognition that multiple approaches and adaptations should also be considered when working with clients, in order to tailor interventions to meet their individual needs. While common threads like anxiety, depression, interpersonal conflict were observable, interventions that resonated from client to client often differed.

A brief-strengths based approach has its merits, but for some of the clients there were layers of past issues affecting them and exacerbating the suffering they were experiencing in the here and now. For these clients the time and dedication of a counsellor who was willing to work alongside them longer-term was essential to holistic treatment. In a few cases parents would need to access other resources to help their teens such as mentors, psychoeducational groups, or community-based agencies. The reality is that risk factors (poor social skills, family stress, racism) for some of these teens outweighed the protective factors (coping skills, role models, positive relationships) that would support their wellness. Collaboration with outside agencies provided additional required interventions for these families with teens. It is crucial for a Clinical Counsellor to make appropriate and timely referrals for optimal case management.

As important as it is for the counsellor to convey understanding, acceptance, and empathetic care, the reality as Martin (2000) offers is that the counsellor is not the solution. While this realization can provide relief, it can also take time as a developing Clinical Counsellor to accept that we cannot ‘fix’ people. Accepting that I cannot change someone else does not distract from my passion to support people in living to their fullest potential, and my belief that the word breaks us all, but that we *can* be stronger in our broken places. Being able to accept and let go of the outcome is something I continue to work on as I would not want anyone to feel I had given up on them.

CLINICAL COUNSELLING FUNDAMENTAL COMPETENCIES IN PRACTICE

Summary

Timely access to therapy is foundational to creating healthy functioning individuals. The Royal University Hospital in Saskatoon is scheduled to open a new unit for urgent mental health care, staffed by psychiatric physicians and nurses. In a recent Global News article, it is reported that approximated 5000 patients visit the Royal University Hospital yearly with mental health concerns. This unit is set up in the interim until a new adult emergency department is opened which will contain private space for emergency mental health care and assessment. Eliminating the stigma of mental illness, providing options for urgent and ongoing care and counselling is within a holistic framework, and important to the future of mental health wellness.

The benefit of working with the knowledgeable and committed professional Clinical Counsellors at CFS was paramount to the success of my practicum experience. The openness and willingness of the clients I met with to entrust their struggles, their stories, and their hopes to me as a practicum student was humbling. I endeavored to provide interventions, practices, and replacement supports that would further promote their holistic wellness. Championing wellness throughout the life cycle is paramount as wellness impacts the individual, and many other systems including the family and society as a whole.

As my caseload was diverse in the nature of the presenting issue, family composition, ethnicity, and the response to therapy, I was able to utilize various therapeutic modalities. While third-wave CBT such as ACT, and DBT have provided effective results, I was able to relevantly introduce Narrative, Logotherapy, Solution-Focused Brief therapy, and Gottman relationship counselling successfully. The end result has allowed me to increase my competencies and expand my confidence in implementing a variety of therapeutic options.

CLINICAL COUNSELLING FUNDAMENTAL COMPETENCIES IN PRACTICE

Pursuing a Master of Education in Educational Psychology Route 2 Counselling was both an immensely challenging and rewarding endeavor. I believe the practicum route allowed me to practice Clinical Counselling from an avenue I had not yet experienced in this field. Spending each day in sessions with people intent and intentional about their healing and wellness solidified for me how Clinical Counselling is a direction that I plan to work towards as an ongoing practice.

REFERENCES

Corey, G. (2017). Theory and Practice of Counseling and Psychotherapy 10th Edition. Boston, MA., Cengage Learning.

Dweck, C.S. (2006). Mindset: The New Psychology of Success How We Can Learn to Fulfil Our Potential. New York, NY>, Ballantine Books.

Goodman, R.D., Gorski, P.C., (2016). Decolonizing "Multicultural" Counseling through Social Justice. New York, NY., Springer.

Harris, R. (2006). Embracing Your Demons; an Overview of Acceptance and Commitment Therapy. *Psychotherapy in Australia* Vol. 12. No. 4. August 2006.

Ivey, A.E., Ivey Bradford, M., Zalaquett, C.P., (2018). Intentional Interviewing and Counseling. Boston, MA., Cengage Learning.

Kovach, M. (2009). Indigenous Methodologies: Characteristics, Conversations, And Contexts. Toronto, On: University of Toronto Press.

Marshall, M., (2009). Life with Meaning Guide to the Fundamental Principles of Viktor E. Frankl's Logotherapy. Halifax, NS, Maritime Institute of Logotherapy.

Martin D.G., (2000). Counseling and Therapy Skills 2nd Edition. Long Grove, IL. Waveland Press, Inc.

Nixon, E., Hadfield, K., (2016). Blended Families. *The Wiley Blackwell Encyclopedia of Family Studies* First Edition. Wiley and Sons Inc. DOI:10.1002/97811119085621.wbefs207.

Papernow, P.L., (2013). Surviving and Thriving in Stepfamily Relationships: What Works and What Doesn't. New York, NY., Routledge.

Stockdale Winder, F. (2014). Working Together for Change: A 10 Year Mental Health and Addictions Plan for Saskatchewan.

Warshak, R.A., (2010). Divorce Poison: How to Protect Your Family from Bad-Mouthing and Brainwashing. New York, NY., Harper.

Williams, Penman (2011) Mindfulness An Eight-week Plan for Finding Peace in a Frantic World. New York, NY., Rodale Press.Conversations,

Wisdom, S., Green, J., (2002). Stepcoupling: Creating and Sustaining a Strong Marriage in Today's Blended Family. New York, NY., Three Rivers Press.

CATHOLIC FAMILY SERVICES

(for new clients)

CONFIDENTIALITY

All information obtained by agency staff in the course of providing services to you will be treated in a confidential manner. No information pertaining to your situation will be disclosed to persons outside of Catholic Family Services.

Exceptions to this policy are:

- **Agency staff are obligated under the Child and Family Services Act to report all suspected incidents of child abuse (physical, sexual) to the Department of Community Resources or a peace officer.**
- **Agency staff may, by order of a Judge under subpoena, be required to give evidence in a court of law.**
- **Where a client divulges that their intended behavior puts their own life or the life of another person at imminent risk, the agency is required to take action for the protection of this individual.**
- **Where a parent who has access to their child (under 16 years) requests information about services their child is receiving, they have a legal right to receive information about them without prior permission from the other parent.**
- **At your written request.**
- **A counsellor may consult with a supervisor/colleague to review treatment plans and therapeutic dynamics for best practice.**

INTER-AGENCY REFERRAL

You may authorize the agency to give personal information to other persons, counsellors or professionals assisting you. In order to do this, you must complete the *Consent to Release Information* form.

Similarly, if information is required by Catholic Family Services from other professionals assisting you, a *Consent to Receive Information* form must be signed by you authorizing the other professional/agency to give information about you to Catholic Family Services.

TWO-PARTY COUNSELLING

Where two parties, (e.g. couple counselling) are receiving counselling services, each party must sign a Permission form before the agency can comply with a request to release information.

LEGAL PROCEEDINGS

The agency does not act as witness or give evidence or prepare reports in civil or legal

proceedings on behalf of clients of Catholic Family Services (e.g. divorce, separation or child custody actions).

TELEPHONES

Catholic Family Services does not subscribe to Call Display.
The telephone number of Catholic Family Services does not appear on maestro or call display units outside the agency. This does not apply to the Families First Program.

GRIEVANCES

If you feel that the services provided have contravened your personal/civil rights, you may lodge a grievance with the Executive Director. The grievance procedure is posted in the wait room.

CLIENT REVIEW OF RECORDS

The Agency is committed to the security of files. Clients may submit a written request to review the content of the file in the presence of the counsellor or Executive Director. If you disagree with the content or record contained, you have the right to submit a typed statement giving your view point and information, or any other information that is to be appended to the file.

CLIENT RIGHTS

- To speak to an Intake Worker, supervisor or the Executive Director within 24 hours of a request
- To be informed before engaging in services, of the areas of expertise and practice of counsellors, program limitations, fees, waiting periods and relevant policies of CFSS (such as client rights)
- To access services in a timely manner
- To be accorded respect, confidentiality, patience and open communication when being engaged by CFSS staff
- To lodge a concern or grievance with the Executive Director about the service or manner of interaction experienced with CFSS staff
- To review their client record with their counsellor or the Executive Director as per policy
- request a change of counsellor

I, _____ have read these items and understand their meaning.

_____ Signed

____/____/____ mm / dd / yy

COUNSELING SERVICES AGREEMENT

This document contains important information about the counseling services being offered at Catholic Family Services *(CFS)* in Regina. Please feel free, at any time, to ask questions about this document. Signing this document will indicate an agreement between you and CFS involving counseling but your participation is completely voluntary and so this agreement can be cancelled by you at any time. The cancelling of the agreement would then end the relationship between you and your counselor at CFS.

Professional Qualifications:

Counselors at CFS may have various professional qualifications but all will have professional degrees in a counselling profession and all are registered with a professional college or association, and abide by the Code of Ethics and Standards of Practice for that college or association. The counselors may be Social Workers (BSW, MSW), Psychologists (MA, PhD, Psy.D & M.Ed.)

Counseling Services:

The nature of counseling is not easily described as it can be something very different depending on the specific counselor you receive and your own reasons for wanting counseling. There are many counseling methods or techniques but the counseling used at CFS will consist of the standard, acceptable methods that are supported by the relevant professions, experience and/or research. If you are not liking what has been happening during sessions; please feel free to talk with you counselor about your concerns or contact the Clinical Supervisor/Manager or Executive Director.

Counseling is not like a medical appointment; the person or persons coming for counseling actively takes part in the session in a collaborative fashion and then work on what was discussed between sessions. Counseling can have great benefits for specific clients but there are no guarantees that counseling will specifically work for you. There are also possible risks involved with counseling. Counseling often involves talking about unpleasant topics so you may feel sad, anxious, frustrated, challenged or worried from time-to-time.

Counseling at CFS is considered short-term and the number of sessions you receive is determined through discussions between you and your counselor. Counseling typically ends when you believe your goals have been met. However your counselor may end the counseling relationship if it is viewed that counseling is not of help or if there has been **90 days** without any contact with you.

Your signature indicates that you understand and agree to the above information and so represents the Counseling Services Agreement.

Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

INFORMED CONSENT FORM

I, _____, agree to participate in the outcome evaluation process that Catholic Family Services Agency is undertaking to evaluate the effectiveness of its service delivery. This process helps us to ensure the Agency is providing the best possible service to clients and to make adjustments where necessary. At the beginning of each session I will be asked to complete an Outcome Rating Scale and at the end of each session a Session Rating Scale, both of which should take less than two minutes. I understand that my participation is entirely voluntary, that my willingness to participate or not will not affect in any way my access to services, and that I am free to change my mind at any time and decide not to participate. In that case, I need simply tell my counselor. I understand further that the process will be entirely anonymous in that names will not be used on the scales. The data gathered will be collated by an independent researcher who will then use the data to determine client satisfaction and the effectiveness of the counseling. I understand that completing the scales may raise issues for me and that my counselor is prepared to assist me to address the issues.

_____ _____

Signature of Client Date

_____ _____

Signature of Counselor Date

PERSONAL DATA

Name: _____ Date: _____

Address: _____

Postal Code: _____ Referred By: _____

Telephone: Home # _____ Contact: ____Yes ____ No

Work# _____ Contact: ____Yes ____ No

Cell# _____ Contact: ____Yes ____ No

Sex: ____ Birthdate: _____

PARTNER'S DATA

Partner's Name: _____

Sex: ____ Birthdate: _____

RELATIONSHIP STATUS

____ Single

____ Married – Date Married _____

____ Separated – When _____

____ Divorced – When _____

____ Widowed – When _____

____ Common Law – Number of Years _____

____ Engaged

____ Dating Relationship

____ Remarried – When _____

____ Other (Specify) _____

FAMILY STATUS

____ Two-Parent Family

____ One-Parent Family (Female Head)

____ One-Parent Family (Male Head)

____ Couple (No Children)

____ Individual

____ Other _____

(over)

CHILDREN'S NAME	BIRTHDATE	CUSTODY ARRANGEMENT	RESIDES WITH:

GROSS FAMILY INCOME

____ Under - $15,000	____ $15,000 - $19,999	____ $20,000 - $24,999
____ $25,000 - $29,999	____ $30,000 - $34,999	____ $35,000 - $39,999
____ $40,000 - $44,999	____ $45,000 - $49,999	____ $50,000 - $54,999
____ $55,000 - $55,999	____ $60,000 - $64,999	____ Over - $65,000

TYPE OF PROBLEM I / WE ARE HAVING (Please check all that apply)

____ Aging ____ Children of Alcoholic Parents

____ Alcohol Abuse ____ Anxiety ____ Depression

____ Blended Family Issues ____ Differences / Concerns about our Parenting

____ Divorce / Re – Adjustments ____ Drug Abuse ____ Domestic Violence / Child Abuse

____ Wife Abuse: Victim ____ Offender ____ Elder Care ____ Environmental Issues

____ Financial Issues ____ Grieving ____ Incest ____ Multiple Family Problems

____ Couple Conflicts / Relationship Problems ____ Personal Concerns ____ Physical Health

____ Parent / Child Difficulties ____ Parent / Teen Difficulties

____ Pre-Marital Issues / Preparations ____ Psychiatric Disturbance of a Family Member

____ Separation Process ____ Sexual Assault: Victim

____ Suicidal Thoughts / Attempted Suicide ____ Unemployment

ANY OTHER CONCERNS OR COMMENTS? _____

_____

_____

(over)

Session Rating Scale (SRS V.3.0)

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

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

Relationship

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

Goals and Topics

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

Approach or Method

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

Overall

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

Institute for the Study of Therapeutic Change

www.talkingcure.com

Outcome Rating Scale (ORS)

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

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

Individually
(Personal well-being)

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

Interpersonally
(Family, close relationships)

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

Socially
(Work, school, friendships)

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

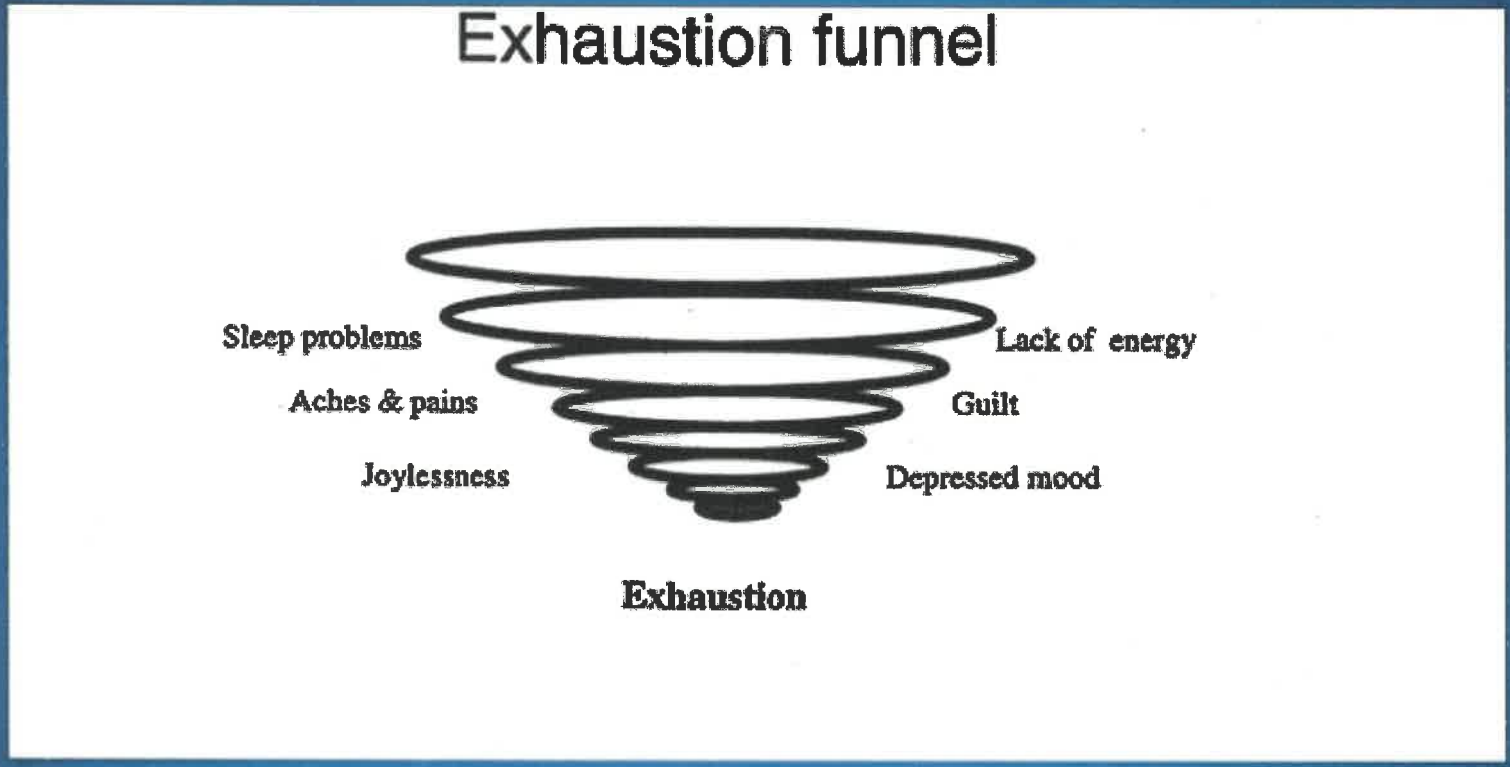
Overall
(General sense of well-being)

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

Institute for the Study of Therapeutic Change

www.talkingcure.com

Stress, Exhaustion and Burnout



The Exhaustion Funnel (Professor Marie Asberg)

When we get tired or overwhelmed, life tends to narrow down– the range of our behavioural repertoire narrows, the spaciousness of our thinking and emotional responses restricts, and any sense of ease in our bodies tends to disappear.

ACTIVITIES YOU DO IN A DAY	N/D Nurturing or Depleting

from Mindfulness An Eight-Week Plan For Finding Peace in a Frantic World
by Mark Williams & Danny Penman

CTRI | CRISIS & TRAUMA RESOURCE INSTITUTE

This certificate confirms that

Marissa Landry-Dixon

has completed

Self-Injury Behaviour in Youth - Developing an Understanding - Part 1 Webinar

through the Crisis and Trauma Resource Institute

January 14, 2018

Continuing Education Credit Hours - 1

Helping Communities and Organizations with Issues of Crisis and Trauma

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Self-Injury Behaviour in Youth - Strategies for Helping - Part 2 Webinar

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January 16, 2018

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Narrative Therapy – Strategies from Leading Frameworks Webinar

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Solution Focused Therapy Webinar

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January 23, 2018

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Motivating Change – Understanding Resistance and First Steps of Engagement – Part 1 Webinar

through the Crisis and Trauma Resource Institute

January 14, 2018

Continuing Education Credit Hours - 1

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Challenging Behaviours in Youth Webinar

through the Crisis and Trauma Resource Institute

February 09, 2018

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Helping Children - Part 2 Webinar

through the Crisis and Trauma Resource Institute

February 11, 2018

Continuing Education Credit Hours - 1

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Addictions and Youth - An Introduction and Overview Webinar Part 1

through the Crisis and Trauma Resource Institute

February 18, 2018

Continuing Education Credit Hours - 1

Helping Communities and Organizations with Issues of Crisis and Trauma

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Addictions and Youth - Creating Opportunities for Change Webinar Part 2

through the Crisis and Trauma Resource Institute

February 19, 2018

Continuing Education Credit Hours - 1

Helping Communities and Organizations with Issues of Crisis and Trauma

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Helping Children - Part 2 Webinar

through the Crisis and Trauma Resource Institute

February 11, 2018

Continuing Education Credit Hours - 1

Helping Communities and Organizations with Issues of Crisis and Trauma

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has completed

Disordered Eating - From Image to Illness Webinar

through the Crisis and Trauma Resource Institute

March 04, 2018

Continuing Education Credit Hours - 1

Helping Communities and Organizations with Issues of Crisis and Trauma

CERTIFICATE OF COMPLETION

This is to certify that

Marissa Landry-Dixon

has successfully completed

Certificate in Brain Health

on

3/3/2018
Date

10
Number of Contact Hours

By: ALLEGRA Learning Solutions, LLC

Authorized Signature

This certificate must be retained by the licensee for a period of six years from the date of issuance.
Do not send this certificate to your State Board of Nursing. Retain it for your personal records.

ALLEGRA Learning Solutions, LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

ALLEGRA Learning Solutions, LLC, is a provider approved by the California Board of Registered Nursing, Provider #CEP 14693, for the stated number of contact hours.

California Board of Behavioral Sciences Provider Number PCE 1564. This program meets the qualifications for the stated hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences.

ALLEGRA Learning Solutions, LLC is approved by the National Certification Board for Therapeutic Massage & Bodywork (NCBTMB) as a continuing education Approved Provider. Provider Number 451562-11

National Association of Alcohol and Drug Abuse Counselors (NAADAC)
ALLEGRA Learning Solutions is an approved provider with the National Association of Alcohol and Drug Abuse Counselors (NAADAC) (Provider #813).

ALLEGRA Learning Solutions, LLC

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