Creative Interventions with Children and Families in a Mental Health Setting

Submitted to the Faculty of Social Work

In Partial Fulfillment of the Requirements

For the Degree of

Master of Social Work

University of Regina

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Regina, Saskatchewan

August, 2012

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Acknowledgments

I would like to gratefully acknowledge my Field Practicum Committee: Dr. Brigette Krieg, Dr. Donalda Halabuza, and Crystal Petryk. These members have been beyond influential while completing my Master of Social Work. These members illustrate excellence in the profession of social work through policy, research, education, and practice.
Dedication

I would like to dedicate this paper to my brother Tyler, my father Wayne, my mother Shirley, and my step father Craig as they have without a doubt shaped the person I am today. I could have not completed this dream without them and would like to thank them from the bottom of my heart.
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Introduction

Children’s Services (0-12), Youth Services (13-18), and Adult Services (19+) are divisions of Mental Health and Addiction Services within the Saskatoon Health Region. I completed a 450 hour clinical practicum from April 23rd, 2012 to August 2nd, 2012 with Children’s Services. This paper will examine the clinical practicum completed during that time. This paper defines important terms such as mental health, describes mental health disorders, and how they relate to the medical model, attachment theory, family systems theory, strengths-based practice, and anti-oppressive practice. This paper examines the skills I developed throughout my practicum including assessment skills, therapy skills, and reflecting skills. The paper concludes with practicum strengths, practicum challenges, practicum ethical considerations, and practicum recommendations.

Mental Health

What is Mental Health?

The term mental health can have many meanings. The World Health Organization (2012) states that

mental health is different from the absence of mental illness, and is integral to our overall health… [it is] a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make contribution to her or his community.

There are endless factors that contribute to the development of mental health problems through an individual’s life time. These factors are discussed in detail by the Centre of Knowledge on Healthy Child Development (2009), by Children’s Mental Health Ontario (2012), and by Zeanah (2009). The factors are far encompassing and include but are not limited to:
- Biological Factors: genetics, fetal development, exposure to chemicals and/or toxins pre-natal, infant development, childhood development, and exposure to chemicals and/or toxins post-natal
- Individual Factors: gender, attachment style, personal self-esteem, personal conflict style, and personal stress
- Relational Factors: school, peer relationships, sibling relationships, and family relationships
- Social Factors: race, religion, culture, and socioeconomic status
- Life Experiences: history of neglect, abuse, and/or trauma, history of family violence, parental history of mental illness, and parental history of substance abuse

What is a Mental Health Disorder?

The Diagnostic and Statistical Manual of Mental Disorders is the most current tool used globally to diagnose mental health disorders (American Psychiatric Association, 2000). The most current Diagnostic and Statistical Manual of Mental Disorders is the DSM-IV-TR (2000) (American Psychiatric Association, 2000). The DSM-IV-TR (2000) lists and describes more than 400 psychiatric disorders (American Psychiatric Association, 2000). The term mental health disorder refers to a behavioural, emotional, or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions… mental health disorders can occur at any age. Each type of disorder has its own specific pattern of symptoms and levels of severity. Some people may experience a sudden onset of symptoms, while others will notice gradual onset of symptoms. (Children’s Mental Health Ontario, 2012)
The information on mental health disorders and mental health in general is unmistakably complex. The next section will briefly discuss the most common mental health disorders.

*Common Mental Health Disorders*

The Canadian Mental Health Association (2012), the Centre of Knowledge on Healthy Child Development (2009), and Mental Health and Addiction Services (2007) lists the most common mental health disorders as:

- Anxiety Disorders: Generalized Anxiety Disorder (GAD), Obsessive Compulsive Disorder (OCD), Post Traumatic Stress Disorder (PTSD), Social Phobias, Selective Mutism, and Panic Disorder
- Attachment Disorders
- Attention Disorders: Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorders: Atypical Autism (PDD-NOS), Autistic Disorder, Asperger Syndrome, and Tourette Syndrome
- Behaviour Disorders: Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD)
- Eating Disorders: Binge Eating Disorder, Bulimia Nervosa (BN), Anorexia Nervosa (AN)
- Mood Disorders: Dysthymia, Depression, Bipolar Disorder, Multiple Personality Disorder, and Schizophrenia
- Substance Abuse Disorders

*Mental Health in Canada*

The Canadian Mental Health Association (2012) states that one in five or “20% of Canadians will personally experience a mental illness in their life time”. In Canada it is estimated
that approximately one in four or 25% of children and youth have mental health problems and/or a mental health diagnosis (Manion, 2010). It is also estimated that less than 25% of those children and youth will receive specialized services regarding their mental health problems and/or their mental health diagnosis (Manion, 2010). In 2007 the Mental Health Commission of Canada was created to focus on the creation of a national mental health strategy, to promote increased knowledge about mental health, and to combat stigma related to mental health (Kirby, 2008). Changing Directions, Changing Lives: The Mental Health Strategy for Canada was released in 2012. Surprisingly, Canada was the only G8 Country without a National Mental Health Strategy before Changing Directions, Changing Lives: The Mental Health Strategy for Canada was released in May 2012 (Kirby, 2008). The six strategic directions listed within Changing Directions, Changing Lives: The Mental Health Strategy for Canada are:

- promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible;
- foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights;
- provide access to the right combination of services, treatments and supports, when and where people need them;
- reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners;
- work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights, and cultures;
- mobilize leadership, improve knowledge, and foster collaboration at all levels.

(Mental Health Commission of Canada, 2012, p. 11)
The Medical Model

The Medical Model and Mental Health

The medical model is associated with the terms ‘naming’, ‘managing’, and ‘curing’ – that being naming the medical condition, managing the medical condition, and/or curing the medical condition (McCarthy, 2008; McCulloh, Ryrie, Williamson, & St. John, 2005; Mental Health and Addiction Services, 2007). The foundation of mental health services was historically rooted in the medical model where diseases of the mind were explained in physical terms (McCulloh et al, 2005; Mental Health and Addiction Services, 2007). The medical model prospered as the accepted foundation in mental health and this began to change after the work of Erikson on psychosocial development (McCulloh et al, 2005; Mental Health and Addiction Services, 2007). Over time mental health has evolved from a pure medical model to an integrated biopsychosocial model (McCulloh et al, 2005; Mental Health and Addiction Services, 2007). McCulloh et al (2005) states that

The medical model is concerned with an external, objective reality whereas the psychosocial model is more interested in internal, subjective realities… both approaches may be considered to coalesce in the cognitive behavioural model where, internal subjective cognitions are integrated with external, objective behaviour… different models tap into different aspects of the human condition, practitioners need to view them as complimentary rather than conflicting. (p. 12)

The practice of combining medication with psychotherapy is a good example of the integration between the medical model and the psychosocial model. The research in this area has shown that a combination of medication and psychotherapy is more effective than using medication alone
for people experiencing mental health problems and/or a mental health diagnosis (Bromfield, 2007; Gabbard, 2006; Thase, 2006; Zuzma & Black, 2004).

An Integrated Perspective on Mental Health

Mental Health and Addiction Services (2007) acknowledges that they as an agency have shifted from the medical model to an integrated perspective. This was done by shifting from a medical based focus to a health based focus; from individually focused treatment to family focused treatment; from isolated directed care to connected supported care; and from institutionally based treatment to community based treatment. I personally practice from an integrated perspective by using the biopsychosocial model. I acknowledge that mental health therapists often work in systems that are guided by the medical model but it is important to include all aspects of health throughout the assessment stage and the treatment stage. My practicum in a medical setting has allowed me to learn about the medical model. I now have the ability to incorporate techniques that may be beneficial to children/families in my future practice.

The Practicum Placement

Mission Statement

As stated earlier, I completed my clinical practicum placement at Children’s Services at Mental Health and Addiction Services. Mental Health and Addiction Services (no date) states that “The purpose of the Child and Youth Program is to meet the mental health and addiction needs of children and youth, and support healthy development in all spheres of daily life”.

Practicum Objectives

The first objective was to complete assessments, set goals, and develop interventions with clinical direction and supervision. The second objective was to increase my overall clinical skills through direct practice with children and their families. The third objective was to compare and
contrast therapy used in school settings and therapy used in mental health settings. I completed both a midterm evaluation and a final evaluation with my academic supervisor and my professional associate. The first evaluation was completed via phone and discussed the progress I had made towards my practicum objectives. The second evaluation was completed in person and discussed how I achieved my practicum objectives.

Practicum Activities

The fifteen week practicum can be explained in three words – a rich experience. I use these powerful words to describe my practicum as no other words can be used to describe the diversity of my practicum. I had the opportunity to complete a variety of activities with a variety of disciplines in almost every program offered by Children’s Services. My practicum placement focused on the following activities: individual therapy, family therapy, group work, community mental health programs, school based mental health programs, supervision, and training. First, the majority of my practicum placement focused on competing therapy with children and families. I also had the opportunity to work closely with an animal assisted therapist and an art and play therapist throughout my practicum placement. Second, I had the opportunity to complete a recreational therapy group for children called READY and a psychoeducational group for parents/guardians called Understanding Children’s Anxiety (UCA). Third, I had the opportunity to work with community mental health programs such as the Case Management Program and Behavioural Consultation Services (BCS). Fourth, I had the opportunity to work with school mental health programs such as the School Wellness Team, Early Skills Development Program (ESDP), and Children’s Therapeutic Classroom (CTC). Lastly, I completed weekly supervision with my supervisor Crystal Petryk and bi-weekly clinical meeting with the clinicians at Children’s Services. I also completed grief training at Mental Health and
Addiction Services and attended a conference on resiliency at the Saskatchewan Association of Social Workers Annual Conference in Melfort.

**Practicum Clients**

Although many of the clinicians at Children’s Services have specialties they are unable to choose clients based on their preference to work with specific populations or diagnoses. I as a practicum student on the other hand was able to choose my clients which allowed for diversity throughout my practicum. I had the opportunity to select a variety of clients based on age, gender, and primary presenting problem. I closed half of my client files and transferred the other half of my client files to my supervisor. The clients assigned to my caseload throughout my practicum included:

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Primary Presenting Problem</th>
<th>Closed or Transferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client 1</td>
<td>6</td>
<td>Female</td>
<td>Behaviour (Anger/Aggression)</td>
</tr>
<tr>
<td>Client 2</td>
<td>7</td>
<td>Female</td>
<td>Behaviour (Anger/Aggression)</td>
</tr>
<tr>
<td>Client 3</td>
<td>4</td>
<td>Male</td>
<td>Behaviour (social skills)</td>
</tr>
<tr>
<td>Client 4</td>
<td>12</td>
<td>Male</td>
<td>Behaviour (social skills)</td>
</tr>
<tr>
<td>Client 5</td>
<td>8</td>
<td>Female</td>
<td>Grief (Separation/Divorce)</td>
</tr>
<tr>
<td>Client 6</td>
<td>10</td>
<td>Male</td>
<td>Grief (Separation/Divorce)</td>
</tr>
<tr>
<td>Client 7</td>
<td>12</td>
<td>Female</td>
<td>Self-Esteem and Anger</td>
</tr>
<tr>
<td>Client 8</td>
<td>11</td>
<td>Female</td>
<td>Behaviour (Anger/Social Skills)</td>
</tr>
<tr>
<td>Client 9</td>
<td>10</td>
<td>Female</td>
<td>Anxiety (Death)</td>
</tr>
<tr>
<td>Client 10</td>
<td>10</td>
<td>Male</td>
<td>OCD (Order)</td>
</tr>
</tbody>
</table>
Referrals

The agency receives referrals from a variety of sources including but not limited to: Parents/Guardians, Psychiatrists, Family Doctors, Day Cares, Schools, and the Ministry of Social Services (Mental Health and Addictions Services, no date). The child being referred must either have mental health problems and/or a mental health diagnosis listed in the DSM-IV-TR (2000).

Disciplines

The agency had representation from a variety of disciplines including but not limited to: Psychiatry, Psychology, Social Work, Nursing, Dietician, Speech and Language, Recreational Therapy, Kinesiology, Teaching, and Early Childhood Education (Mental Health and Addiction Services, no date).

Theoretical Models

This section discusses the theoretical models used in my practicum and throughout this paper. Attachment Theory and Family Systems Theory guide the work completed at Mental Health and Addiction Services. For example, “The service is committed to promoting and supporting the family as the primary context within which the emotional needs of children and youth are met” (Mental Health and Addiction Services, no date). I personally follow a strengths-based philosophy based on anti-oppressive practice.

Attachment Theory

Attachment theory was developed through the work of John Bolby (Bolen, 2000; Caffery & Erdman, 2003; Rothbaum, Rosen, Ujiie, & Uchida, 2000). The concept attachment is described as “a biological based system between the attachment figure (usually the parent) and the child to ensure the child’s proximity to the attachment figure… the primary function of attachment behaviors is to protect the young and to maintain their survival” (Bolen, 2000, p.
Three attachment styles were developed through the work of Mary Ainsworth (Bolen, 2000; Caffery & Erdman, 2003; Rothbaum, Rosen, Ujiie, & Uchida, 2000). These styles include: secure attachment, ambivalent attachment, and avoidant attachment (Bolen, 2000, Caffery & Erdman, 2003, Rothbaum et al, 2000). The premise of attachment theory is that attachment usually occurs between a parent and a child but other theorists believe that attachment actually occurs in the larger family context (Caffery & Erdman, 2003; Donley, 1993).

**Family Systems Theory**

Family systems theory believes that problems are due to attachment insecurities, problems are maintained by family systems, and treatment is focused on changing family interactions and improving attachment (Caffery & Erdman, 2003; Rothbaum et al, 2000). Family systems theory is concerned with family dynamics and believes that no matter how different families appear on the outside they all have common characteristics such as hierarchy, roles, rules, boundaries, and equilibrium (Caffery & Erdman, 2003; Garris-Christian, 2006). Some common assumptions of family systems are disengagement and enmeshment. First, disengaged or under involved families are likely to produce children with an avoidant attachment – the unresponsive child (Berk, 2005; Caffery & Erdman, 2003; Rothbaum et al, 2000). Second, enmeshed or overinvolved families are likely to produce children with an ambivalent attachment – the anxious child (Berk, 2005; Caffery & Erdman, 2003; Rothbaum et al, 2000). Third, adaptive families are likely to produce children with a secure attachment – the confident child (Berk, 2005; Caffery & Erdman, 2003; Rothbaum et al, 2000).

**Strengths-Based Practice**

I personally follow a strengths-based philosophy in my social work practice when working with children/families. The strengths-based philosophy focuses on strengths rather than
weaknesses. The following quote is enlightening and reminds me why it is important to follow a strengths-based philosophy as social work “is not just the study of weakness and damage; it is also the study of strength and virtue. Treatment is not just fixing what is broken; it is nurturing what is best within ourselves” (Seligman, 1991, p. 1). The stages of working with clients in a strengths-based practice may include: Stage 1: Creating the Therapeutic Alliance; Stage 2: Identifying Strengths; Stage 3: Assessing Presenting Problems; Stage 4: Encouraging and Instilling Hope; Stage 5: Framing Solutions; Stage 6: Building Strength and Competence; Stage 7: Empowering; Stage 8: Changing; Stage 9: Building Resilience; and Stage 10: Evaluating and Terminating (Smith, 2006).

Peterson and Seligman (2003), Peterson and Seligman (2004), and Smith (2006) discuss ten categories that clinicians should address when working within a strengths-based practice to help clients/families see that their cup is often half full, not half empty. These categories are: emotional strengths such as optimism; cognitive strengths such as problem solving; character strengths such as perseverance or resiliency; educational strengths such as informal education and/or formal education; creative strengths such as openness to new experiences; nurturing strengths such as compassion; survivor strengths such as survival from adversity; provider strengths such as food, shelter, and love; social support such as family, friends, and the community; and wisdom.

Seligman (1991) and Smith (2006) explain that the presence of strengths in a person acts as a buffer to mental illness.

The strength-based model of counseling is based on the premise that all individuals possess the potential to suffer from mental disorder. Strengths allow humans to function with or keep in check psychological disorders so that they can continue to function.
Mental illness occurs when strengths are insufficient to deal with the threats to psychological well-being. (Smith 2006, p. 36)

The therapist is responsible for assessing the strengths in each person and then helping each person build upon those strengths.

Anti-Oppressive Practice

The key features of anti-oppressive practice are a commitment to social justice and challenging social relations that highlight social injustices (Larson, 2008; Martin, 2003). Anti-oppressive practice is concerned with recognizing power imbalances and changes that redress the balance of power (Dalrumple & Burke, 1995; Larson, 2008). According to Moosa-Mitha and Turner (2005), when social workers practice anti-oppressive social work it involves an awareness of personal location and how this can contribute to the oppressiveness of the intervention through racism, sexism, classism, ageism, ableism, and other ways that human beings unfairly judge and interact with others. The concept of anti-oppressive practice is important when addressing the complexity of mental health. For example, using anti-oppressive practice reframes private problems to public issues.

For social workers who engage in anti-oppressive practice, there is a strong connection between, on the one hand, providing individual assistance to people belonging to disempowered groups, and, on the other hand, working with social movements connected to these disempowered groups. (Dalhousie University, 2012)

This paper will discuss both private problems and public issues as they relate to therapy techniques used with children and families in a mental health setting – the micro level, recommendations to Mental Health and Addiction Services within the Saskatoon Health Region – the mezzo level, and the Government of Canada – the macro level.
Clinical Background

I always knew that I wanted to be a counsellor and my journey is as follows. I learned baseline information about common therapies used in counselling throughout my Bachelor of Social Work. I had an opportunity to build on that baseline through a clinical mini practicum with Saskatoon Public Schools and a clinical major practicum with Catholic Family Services of Saskatoon. I finished my Bachelor of Social Work through the University of Regina in 2009.

In June 2009 I began employment as a Counsellor and the Coordinator of the Children Exposed to Violence Program with Catholic Family Services of the Battlefords. My first position as a social worker proved to be quite the learning curve. I was responsible for completing intakes, individual counselling, family counselling, case management, group development, group facilitation, and community education. In that time I also familiarized myself with several therapies that I continue to use today. The approaches that I became familiar with included Bowen family systems therapy, narrative therapy, structural family therapy, solution focused therapy, and art and play therapy. My clinical foundation was small but sturdy.

My first job in a clinical setting allowed me to realize my passion for working with children, youth, and families. I continue to have an interest in pursuing further training as a Registered Art and Play Therapist. My desire to build upon my clinical foundation was the motivation to apply into a Master of Social Work Program. I was aware that both Children’s Services and Youth Services at Mental Health and Addiction Services incorporated creative therapies such as animal assisted therapy, art and play therapy, and recreational therapy. They also use traditional therapies such as Bowen family systems therapy, narrative therapy, structural family therapy, and solution focused therapy. Stolenberg (2005) believes that universities provide minimal training in terms of clinical skills and that the best training comes from a
clinical practicum. I, therefore, pursued a clinical practicum within Mental Health and Addiction Services so I could learn more about these creative therapies and to once again build upon my clinical foundation.

Assessment Skills

Initial Assessment

The completion of a thorough assessment is a cornerstone in all social work services. The completion of a thorough assessment should allow the social worker to understand the present problem, what caused the problem, and suggest ideas for interventions and improvement (Grier, Morris, & Taylor, 2001; Keith, 2006; Weist, Rubin, Moore, Adelsheim, & Wrobel, 2007). I discussed previously that I incorporated a biopsychosocial model through my practicum in both the assessment stage and the treatment stage. Mental Health and Addiction Services currently uses the Provincial Assessment which was developed by the Saskatchewan Ministry of Health.

The Provincial Assessment is completed on all children and youth who receive mental health services in all health regions across the province. My clinical practicum placement at Mental Health and Addictions Services allowed me to learn the importance of completing a thorough assessment for each client. For example, before meeting the child I would meet with the parent(s)/guardian(s) for 1-2 hours to complete the Provincial Assessment. Keith (2006) states that

There is no clinical problem for which an extended family interview is not a crucial contribution… the history that can be obtained during the interview, the interactions that are observed and in which the therapist participates, and the sequelae interview are all vital to working with children and families. (p. 333)

The information collected in the Provincial Assessment is included in the following chart:
<table>
<thead>
<tr>
<th>Identifying Information</th>
<th>Personal and Family History Information</th>
<th>Treatment Plan Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name</td>
<td>Clients Developmental History</td>
<td>Extracurricular Activities</td>
</tr>
<tr>
<td>Client DOB</td>
<td>Clients Physical Health History</td>
<td>Resiliency Factors</td>
</tr>
<tr>
<td>Client HSN</td>
<td>Clients Educational History</td>
<td>Parent/Guardian Understanding of the Problem</td>
</tr>
<tr>
<td>Client Treaty Number (if status)</td>
<td>Family Relationships History</td>
<td>Service Providers Understanding of the Problem</td>
</tr>
<tr>
<td>Family Physician</td>
<td>Family Financial History</td>
<td>Client/Parent/Guardian Goals</td>
</tr>
<tr>
<td>Known Allergies</td>
<td>Family Spiritual/Cultural Background</td>
<td>Clinical Treatment Plan</td>
</tr>
<tr>
<td>Parent/Guardian Name(s)</td>
<td>Client/Family Psychiatric History</td>
<td>Privacy/Confidentiality Information</td>
</tr>
<tr>
<td>Parent Guardian Phone Number(s)</td>
<td>Client/Family Abuse/Violence History</td>
<td>Consent to Release Info and Consent to Obtain Info</td>
</tr>
<tr>
<td>Parent/Guardian Address(es)</td>
<td>Client/Family Substance Abuse History</td>
<td>Agreed by Parent/Guardian</td>
</tr>
<tr>
<td>Reason for Referral</td>
<td>Client/Family Legal History</td>
<td>Signed by Service Provider</td>
</tr>
</tbody>
</table>

**Traditional Therapeutic Skills**

This section discusses the traditional therapies that both myself and many therapists use today with children and families. This section discusses the history, the purpose, and the techniques of four therapies including Bowen family systems therapy, narrative therapy, structural family therapy, and solution focused therapy.

* Bowen Family Systems Therapy *

Murray Bowen from the United States is the founder of Bowen family systems therapy (Nichols, 2011). Bowen family systems therapy describes how the family which is a multigenerational network of relationships shapes the interplay of individuality and togetherness using five concepts: differentiation of self, triangles, multigenerational emotional processes, societal emotional processes, and emotional cutoff (Nichols, 2011). I incorporated two visual concepts of his work throughout my clinical practicum placement – genograms and triangles.
First, genograms are often completed in the assessment stage and throughout therapy. Genograms can also be called ‘family tree diagrams’ (Nichols, 2011; Rovers, 2004). Genograms list family members and map their relationships (Nichols, 2011; Rovers, 2004). Genograms can also show history, change, and loss. The following symbols and abbreviations are used in genograms:

- □ = male
- ○ = female
- △ = child in utero
- | = offspring
- a = abortion/stillbirth
- x = deceased
- ________________ = married/common-law
- \ / \ / \ / \ / \ / = separated/divorced
- _________[_____]_______ = conflict
- _______{}_______ = coalition

Second, triangles are used to illustrate relationships where people are brought in when conflict arises. For example, triangles are visible threesomes driven by anxiety and “as anxiety increases, people experience a greater need for emotional closeness – or in reaction to pressure from others, a greater need for distance” (Nichols, 2011, p. 77). The following are examples of triangles often seen in therapy.
Narrative Therapy

The term narrative “applies to what is told, a story or an account of real events of experiences told like a story in connected and interesting form” (Gage Canadian Dictionary, 1983, p. 758). Michael White from Australia and David Epston from New Zealand are considered to be the founders of narrative therapy (Carr, 1998; Besley, 2002; Nichols, 2011). According to Nichols (2011), narrative therapy “is concerned with the way people construct meaning rather than the ways they behave. The underlying premise is that personal experience is fundamentally ambiguous” and that these meanings are not fixed and therefore can have multiple interpretations (p. 266). Michael Foucault from France also influenced narrative therapy (Carr, 1998; Besley, 2002; Nichols, 2011). According to Foucault, “language not only affects how we frame our notions of the ‘self’ and ‘identity’, but also how counsellors deal with people and the meanings they make of the world they live in” (Besley, 2002, p. 126). The use of a post structural theoretical view is also used in narrative therapy (Madigan, 2011).

White (1989) states that not “only do the stories that persons have about their lives determine the meaning that they ascribe to experience, but these stories also determine which aspects of lived experience are selected out for the ascription of meaning” (p. 7). The key tenant of narrative therapy therefore is that all people have stories and that all people construct their world differently due to these stories (Madigan, 2011; Nichols, 2011). The concept externalize is important in narrative therapy. In this approach therapists recognize that people externalize the negative stories that they have of themselves, the negative stories that others have about them, and the negative stories that society has about them. For example, someone who is externalizing their depression might say: “I get sad sometimes so that must mean I am depressed, if I am depressed then I should go and talk to someone, if I go and talk to someone then they will think I
am crazy”. The purpose of narrative therapy is to assist people to resolve problems by enabling them to separate their lives and relationships from those stories that they judge to be draining, assisting them to challenge the ways that they find subjugating, and encouraging people to re-author their own lives according to alternative and preferred stories of identity (Besley, 2002; Madigan, 2011; Nichols, 2011).

*Structural Family Therapy*

Salvador Minuchin from Salvador is considered to be the founder of structural family therapy (Nichols, 2011; Vetere, 2001). Minuchin and his colleagues taught themselves family therapy by observing each other through a one-way mirror (Nichols, 2011). Minuchin eventually wrote two books that changed the face of family therapy. The first was *Families of the Slums* written in 1967. The second was *Families and Family Therapy* written in 1974. Structural family therapy captivated the therapeutic field in the 1970s and has continued to grow (Nichols, 2011).

Structural family therapy identifies the importance of both family structure and hierarchical structure. For example, families are organized into subsystems where interactions are regulated by hierarchy, rules, and boundaries (Nichols, 2011; Ryan, 1997; Vetere, 2001). There are three subsystems in a family and they include the spousal subsystem, the parental subsystem, and the child/sibling subsystem (Ryan, 1997). It is important to note that family structure is reinforced by family rules and the expectation to follow family rules (Nichols, 2001; Ryan, 1997; Vetere, 2001). Ultimately, all families have a hierarchical structure whether they know it or not. There are several therapeutic techniques in structural family therapy which include: joining and accommodating, enactment, structural mapping, highlighting and modifying interactions, boundary making, unbalancing, and challenging unproductive assumptions.

The term ‘enactment’ is a central concept in structural family therapy. According to Simon (1995),

The term enactment, as is well known, refers to those moments in therapy when family members interact directly with each other. In enactment, the therapist moves to the periphery of the therapeutic space while the client space system moves to the center. The therapist may elicit an enactment either for the sake of assessment or as an intervention. (p. 18)

The family not only describes the problem, but acts out the problem. This allows the therapist to observe subsystems, boundaries, and behaviours within the family system (Simon, 1995; Nichols, 2011). The therapist is then able to address dysfunctional behaviours within the family and then help them to modify these dysfunctional behaviours. This approach to therapy also defines subsystems or families as enmeshed or disengaged. In enmeshed families, the boundaries are diffused, subsystems are dependent, and support is at the expense of individual autonomy (Nichols, 2011; Stroh-Becvar & Becvar, 2006). In disengaged families, the boundaries are rigid, subsystems are independent, and although autonomy is promoted, there is little support and often a lot of stress (Nichols, 2011; Stroh-Becvar & Becvar). The following symbols are used to represent boundaries in genograms:

- __________________ = rigid boundary or disengagement
- - - - - - - - - - - - - = normal boundary or adaptive
- . . . . . . . . . = diffused boundary or enmeshment
Solution Focused Therapy

Steve de Shazer from the United States and Insoo Kim Berg from Korea are considered to be the founders of solution focused therapy (De Jong & Kim Berg, 2002; Nichols, 2011; O’Connell, 2005). According to Nichols, solution focused therapists “assume that people who come to therapy are capable of behaving effectively but that their effectiveness has been blunted by a negative mind-set” (2011, p. 247). He also states that the “art of solution-focused therapy becomes a matter of helping clients see that their problems have exceptions – times when they don’t occur – and that these exceptions are solutions they already have in their repertoires” (2011, p. 247). There are three important features in solution focused therapy which include describing the problem, developing well focused goals, and exploring exceptions (De Jong & Kim Berg, 2002; Nichols, 2011; O’Connor, 2005).

It is important to assess motivation for change. In solution focused family therapy practitioners describe clients as ‘visitors’, ‘complainers’, and ‘customers’. A visitor is someone who is not in the market for therapy and they often come to therapy at the insistence of another (De Jong & Kim Berg, 2002; Nichols, 2011; O’Connor, 2005). A complainer is someone who has clear complaints and they come to therapy to complain about others but not to make personal change (De Jong & Kim Berg, 2002; Nichols, 2011; O’Connor, 2005). A customer is also someone who has clear complaints but they come to therapy ready to take action and to make personal change (De Jong & Kim Berg, 2002; Nichols, 2011; O’Connor, 2005). The act of goal setting in solution focused therapy helps “clients think about constructive actions they can take, rather than how they can get others to change” (Nichols, 2011, p. 253).

The use of miracle questions and scaling questions are paramount in solution focused therapy as they allow clients to set goals and see a different vision for themselves (De Jong &
Kim Berg, 2002; Nichols, 2011; O’Connor, 2005). The following is an example of a miracle question.

Now, I want to ask you a strange question. Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that the problem which brought you here is solved. However, because you are sleeping, you don’t know that the miracle has happened. So when you wake up tomorrow morning, what will be different that will tell you that a miracle has happened and the problem which brought you here is solved? (Nichols, 2011, p. 253)

Nichols (2011) states that scaling questions are “used to get clients to quantify their confidence that they can maintain their resolve” (p. 255). An example of a scaling question might include “on a scale of one to ten, with one being how depressed you felt when you called me and ten being how you feel the day after the miracle, how do you feel right now?” (Nichols, 2011, p. 255). I used both miracle questions and scaling questions throughout my clinical practicum placement.

**Creative Therapeutic Skills**

This section discusses three creative therapies which are animal assisted therapy, art and play therapy, and recreational therapy. I then present illustrations based on actual cases from children that I worked throughout my practicum placement while at Mental Health and Addiction Services. According to Carson and Becker (2003), “creativity has been defined as the ability to bring something new into existence, a way of thinking, and one form of ordinary creativity as a kind of novel adaption to one’s environment” (p. 58). I choose to focus on creative therapies throughout my practicum placement as I consider myself to be a very creative person. I can personally speak firsthand about how my love for animals, arts and crafts, and dance have all
been sources of therapeutic release to me throughout my life. It is noteworthy that “creativity involves a resolution of subjective tension or disequilibrium that can lead to resiliency, enhanced growth and awareness” (p. 58).

*Animal Assisted Therapy*

Animal assisted therapy “utilizes the human/animal bond in goal directed interventions as an integral part of the treatment process” (Geist, 2011, p. 244). The animal is used to build rapport with the child and/or family through non-verbal communication. The animal becomes the co-therapist when it interacts with the child and/or family.

The benefits of using animals in therapy are well documented and include but are not limited to:

- Developmental Progress: perceptual development, cognitive development, social-emotional development, language development, and moral development
- Emotional Health Benefits: an increase in feelings of acceptance, comfort, and trust
- Physical Health Benefits: a decrease in blood pressure and pain
- Mental Health Benefits: a decrease in anxiety, loneliness, and depression
- Sensory Benefits: an increase in tactile, visual, auditory, and olfactory stimulation
- Ego Control: decrease in impulsivity and increase in self-control and self-confidence
- Resistance: even the most resistant children seem to be disarmed by the presence of an animal
- Social Interaction: the ability to learn social skills, the ability to attach to a living being in a safe manner, and the ability to develop a trusting relationship
- Communication: verbal (simple commands) and non-verbal (grooming)
- Emotions: emotional awareness (of the animal) and emotional regulation (of the child)
- Learning: teaching an animal enables children to learn about themselves
- Problem Solving: working with an animal allows children to encourage the animal to behave in a certain way and follow that behavior
- Power and Control: working with an animal allows children to explore problem areas without getting into trouble
- Stress Management: working with an animal allows children to release stress in a healthy and respectful way

(Chandler, 2005; Melson, 2011; Pichot, 2012; VanFleet, 2008).

Illustration Using Animal Assisted Therapy

This is the story about a boy named ‘Johnny’. Johnny is an 8 year old male and he is Aboriginal. Johnny was diagnosed with Fetal Alcohol Syndrome as a toddler. Johnny was also diagnosed with Oppositional Defiant Disorder and Conduct Disorder two years ago. Johnny has a 6 year old brother. The children both went into foster care six years ago when their mother was unable to care for them due to a drug addiction. The first two years were spent in over ten foster homes. The last four years have been spent in the same foster home. Their current foster mother is in the process of legally adopting the two children. Johnny was referred to Mental Health and Addiction Services by his current foster mother. Johnny’s primary presenting problem is anger. I had the opportunity to work with clinical social worker Crystal Petryk, her therapy dog Kona, and Johnny.

I observed three therapy sessions with Crystal and Johnny. The first session focused on building rapport with the dog through grooming. It is important to note that the therapy dog almost instantly builds rapport with the child or family because there is little or no pressure. Working with animals is less pressure for children and adults than working with a human. Geist
(2011) explains that grooming an animal reduces physiological reaction a person feels to stress as the person can develop comfort and non-verbal attunement with the animal.

The next two sessions focused on commands, emotions, and tone of voice. First, simple commands such as sit, stay, and lie down allowed the group to discuss boundaries such as who is in charge and when this may change. Second, the group discussed emotions by asking “how do you know when the dog is happy/mad/sad?” and “how do you know when you are happy/mad/sad?” Third, the group also discussed tone of voice and the difference between passive, aggressive, and assertive. The relationship that evolved in a short time between Johnny and Kona was remarkable. The relationship allowed the normally very aggressive child to engage in discussion with Crystal and myself. It was fascinating to see Johnny engage in therapy and at the same time be respectful to Crystal, Kona, and myself. The use of animal assisted therapy for children with behavioural problems is said to decrease negative self-talk, decrease negative comments to others, increase compassion, increase eye contact with people, and increase relationships with people (Chandler, 2005; Phillips-Parshall, 2003). It was reported by Johnny’s foster mother that he was increasing eye contact with her, increasing positive interaction with the people in his life, and decreasing negative behaviour in general.

Art and Play Therapy

The importance of play in childhood development is well research and widely documented (Landreth & Bratton, 1998; Russ & Niec, 2011; VanFleet, Sywulak, & Sniscak, 2010). In play therapy “toys are viewed as the child’s words and play as the child’s language” (Landreth & Bratton, 1998, p. 2). The use of art in play therapy “is an excellent tool for helping children make a picture of what’s going on in their lives right now and what they would be doing
that would indicate that things would be better” (Nims, 2007, p. 57-58). Wilson and Ryan (2005) describe play therapy as

a means of creating intense relationship experiences between therapists and children or young people, in which play is the principle medium of communication. In common with adult therapies, the aim of these experiences is to bring about changes in an individual’s primary relationships, which has been distorted or impaired during development. The aim is to bring children to a level of emotional and social functioning on par with their development stage, so that usual developmental progress is resumed. (p. 3-4)

The three most common forms of play therapy include: directed play therapy, non-directed play therapy, and family play therapy.

In directed play therapy the therapist takes the lead role in structuring an activity to bring about therapeutic change for the child (Carson & Becker, 2003; Landreth & Bratton, 1998; VanFleet, Sywulak, & Sniscak, 2010). In non-directed play therapy the child takes the lead role in an unstructured activity by picking out the toys that they would like to play with (Carson & Becker, 2003; Landreth & Bratton, 1998; VanFleet, Sywulak, & Sniscak, 2010). In family play therapy the emphasis is placed on supporting the relationship between children and parents and this is done by helping parents learn new skills that build attachment and skills that alleviate problem behaviors (VanFleet, Sywulak, & Sniscak, 2010). In family play therapy the therapist would normally ask each family member to draw a picture of their family which would allow the therapist to gain information on the family. The picture often allows the therapist to see family structure, relationships, hierarchy, and boundaries. The therapist would then ask each family member to draw a free picture of whatever comes to mind which would allow the therapist to gain insight into each individual. The practice is to complete half the session with directed play
therapy or family play therapy and then the other half of the session with non-directed play therapy. Play therapy has been found to contribute to physical development, psychological development, emotional development, social development, creativity skills, communication skills, and coping skills (Landreth & Bratton, 1998; Russ & Niec, 2011; VanFleet, Sywulak, & Sniscak, 2010).

Illustration Using Art and Play Therapy

This is the story about a girl named ‘Amber’. Amber is a 6 year old female and she is Caucasian. Amber was recently diagnosed with an Attachment Disorder. Amber has a 4 year old sister and an 8 year old brother. The children came into foster care two years earlier as their mother was unable to care for them. The mother died last year and the children were in foster care until recently. The children are now with their much younger maternal aunt and she is in the process of legally adopting the children. Amber was referred to Mental Health and Addiction Services by the Ministry of Social Services. Amber’s primary presenting problem is grief. I had the opportunity to work with clinical social worker Leah Tetreault and Amber.

I observed three therapy sessions with Leah and Amber. The first session focused on an animal genogram. The first part of the activity included Leah asking Amber who was on her ‘family map’. The second part of the activity included Leah asking Amber questions such as “if you were similar to an animal what animal would you be?” and “if your auntie was any animal what animal would she be?” The third part of the activity included Amber placing plastic animals on the paper genogram. Leah then asked Amber questions about relationships such as “how do the cat and the horse get along?” or “what does the cat think about the shark?” The animal genogram incorporated the traditional genogram from Bowen family systems therapy and
play therapy with plastic animals. This activity allowed Leah to complete the traditional

genogram in a fun and friendly way with Amber.

    The second session focused on dollhouse play. The dollhouse play allowed Amber to
discuss the different homes that she had lived in before coming to her aunties. The third session
used puppet play. Puppets “are one of the most useful tools in working with children because
they are naturally attractive and fun” and they can be useful to act out the past, present, and/or
future (Nims, 2007, p. 58). In Amber’s case the puppets allowed her to act out her thoughts and
feelings on what she would like to say to her mom.

    Leah almost always used sandtray therapy with Amber during her choice of non-directed
play therapy. Children use miniatures “in sand as a vehicle for communicating and expressing
their emotions and resolving conflicts in their internal and external experiences” (Taylor, 2009,
p. 57). Amber enjoyed hiding miniatures and looking for them. Leah and I believed that the
process of hiding miniatures and looking for them was related to the loss of her mother. Leah and
I used this metaphor to elicit discussion about the loss of her mother. The sandtray therapy
allowed us to discuss the loss of her mother in an indirect way. The use of play therapy was
effective for both the client and the clinicians in this case. For example, we were able to gather
necessary information for her assessment and provide support to the Amber by incorporating
captivating interventions in therapy.

Recreational Therapy

    Recreational therapy provides clients who have a variety of disabilities the opportunity to
experience chosen activities and to utilize recreational resources available in their home
communities (Mobily & MacNeil, 2002; Mobily & Ostiguy, 2004). The use of recreational
therapy is documented to contribute to physical health, mental health, emotional health,
independence, socializing and spirituality (Long, 2002; Mobily & MacNeil, 2002; Mobily & Ostiguy, 2004).

Illustration Using Recreational Therapy

The READY Program is a program for children who have behavioural problems and/or behaviour disorder diagnoses. The READY Program is run through Mental Health and Addiction Services. The child being referred to the READY Program must be already connected to services at Mental Health and Addiction Services. The READY Program is an all-day program that runs throughout the summer. The READY Program employs a female recreational therapy student and a male kinesiology student. The READY Program has four groups that run in ten day cycles throughout the summer. In July two boys groups run including one for those aged 7-9 and one for those aged 10-12. In August two girls groups run including one for those aged 7-9 and one for those aged 10-12. I had the opportunity to complete a ten day cycle at the beginning of July with the group for boys aged 7-9. The children in the group exhibited a variety of behavioural problems including anger, aggression, and violence. The children in the group had a variety of behaviour diagnoses through the DSM-IV-TR (2000) such as Attention Deficient Disorder, Oppositional Defiant Disorder, and Conduct Disorder.

The READY Program includes a variety of activities that are both recreational and community based. I participated in a number of activities during the first ten day cycle and they included: archery, karate, gymnastics, swimming, horseback riding, the Forestry Farm, a hike at Beaver Creek, a hike at Pike Lake, a tour at the Western Development Museum, a tour of the Police Station, a tour of the Fire Station, a tour of Petland, the Fun Factory, and Marca College. The hope is that children involved in the program can find an activity or sport that they enjoy doing that actually contributes to the release of their anger/aggression in a positive and healthy
way. The original service provider that referred the child to READY is responsible for the follow up with the family to determine which activities were useful for a child.

Reflecting Skills

What is Reflection?

The notion of personal reflection is paramount in my experience. I was constantly reflecting between the theory I have learned and the practice I was doing. According to Bulpitt and Martin (2005), reflection is a process triggered by an unsettled sensation, either by choice or by chance, which has the potential to be beneficial to counsellors in their counselling practice. It has a meta or set-apart quality about it. It takes the form of an internal conversation and comprises a process of anticipating the consequences of the available courses of action in order to make an informed choice, and occurs before, during or after the triggering event. It involves emotions, learning, thinking, daydreaming, instincts, pondering, gut feeling and awareness, and is influenced by our spirituality and our personality. It can be enabled by external input, such as supervision or discussion with others. (p. 210)

It is important to add that reflection is a cumulative process that enables clinicians to build and store knowledge on which they can draw from (Bulpitt & Martin, 2005). I participated in personal reflection daily, reflection with my supervisor weekly, and reflection at clinical team meetings bi-weekly. I often reflected on the privilege and choice that I have being white, middle class, and educated. It is important to reflect how ones privilege may oppress other people. I also reflected on how I could be credible with children and parents/guardians as I am not married and do not have children. I found that research was therefore vital in this respect. I also found myself
thinking how I would deal with situations if I was a parent faced with mental health problems and/or a mental health diagnosis.

**Practicum Strengths**

*Friendliness, Flexibility, and Variety*

The staff on both the Children’s Team and the Youth Team were incredibly friendly and kind throughout my practicum placement. I was rather shy the first month and the staff made an effort to make me feel comfortable whenever possible. The staff shared compliments with both my supervisor and myself about my large client load as a student, my independent nature, and my work ethic. I appreciated the flexibility of my supervisor in completing my required hours for my practicum placement. For example, she was flexible in the number of hours I completed each day and the number of days I completed each week. She was able flexible if I needed to meet with her outside of our assigned supervision times. I also appreciated the variety of clinicians, therapies, and programs I had the opportunity to work with throughout my practicum placement.

**Practicum Challenges**

*Time Frame*

The limited time frame (450 hours from April 23rd, 2012 to August, 2nd, 2012) proved to be a challenge. My time went by extremely quickly. For example, in the last week of April I attended the conference *Counselling Children and Families With Complex Needs*. In May I familiarized myself with Saskatoon Health Region policies, Mental Health and Addiction Services procedures, researched therapeutic techniques, observed clinicians, contacted parents/guardians to schedule the initial assessment, and met with parents/guardians to complete the initial assessment. In June and July I was able to meet weekly or bi-weekly with my clients and/or their families. I closed five of my client files and transferred the other five files as the
children and/or families still required service at the end of my practicum placement. It was difficult to fit this all in. I had hoped to spend more time with other animal assisted therapists and other art and play therapists but was unable to in such a short time. I questioned whether or not it would have been better to spread out my hours over a longer time period of time after completing the practicum in only three months. Developing a therapeutic relationship takes time to build and in my practicum some relationships had only been loosely established when the child/family had to be transferred to my supervisor. I had also hoped to participate in a variety of groups other than READY and UCA but was unable to as groups do not run in June, July, or August.

Office Space

The lack of office space while completing my practicum placement was also a constant challenge. First, clinician office space was a challenge. I was originally placed in the Children’s Services Library on the third floor which did not allow for privacy while working. I was unable to make client phone calls and/or meet with children/families in this space. I was then moved to an office with another student at Youth Services on the second floor. This proved to be challenging as I felt disconnected from the Children’s Team and not a part of the Youth Team. The office also only had one phone and one computer which were difficult to share between two busy interns. Second, client office space was a challenge. The Children’s Team has three play rooms with taping equipment but it was not possible to book those rooms for every client for every session. I often booked the room and would discover another clinician using the room when my client/families arrived. I was forced to look for unused office space on a regular basis throughout my practicum placement.
Interdisciplinary Nature

I wanted to observe an assessment being completed by a registered psychologist in regards to Autism or Attention Deficit Hyperactivity Disorder. Unfortunately I did not have the opportunity to do this during my practicum placement. I asked several registered psychologists on the team and received responses regarding my request such as: ‘email me’, ‘I’m too busy’, and ‘I only work with psychology students’. I was also disappointed and angered by comments made on a regular basis about a Master in Social Work being easy and a Master in Psychology being much harder. It was challenging to see social work as the weaker discipline and psychology as the stronger discipline as I have not worked in an interdisciplinary medical setting before. Although the professions are similar the belief in many interdisciplinary settings is that psychology is much more valued than social work. I do not believe this and find myself wondering how this can change. The Saskatchewan Association of Social Workers has discussed the process of allowing social workers to diagnose. I also find myself wondering how this new role will affect the already hurting relationship between psychology and social work. It is noteworthy that interdisciplinary teams and wraparound services are essential when providing mental health treatment (Hudson-Allez, 2007; Selekman, 2010; Smith-Boydston, 2005). I cannot speak of other disciplines but social workers should “relate to both social work colleagues and colleagues from other disciplines with respect, integrity, and courtesy and seek to understand differences in viewpoints and practice… social workers utilize the expertise of other disciplines for the benefit of their clients” (CASW, 2005b, p. 13).

Practicum Ethical Considerations

This section focuses on ethical dilemmas I faced during my clinical practicum placement at Mental Health and Addiction Services. I consulted with my supervisor and used the Canadian
Association of Social Workers Code of Ethics and the Canadian Association of Social Workers Guidelines for Ethical Practice to inform decisions regarding ethical dilemmas. According to the Canadian Association of Social Workers, the “guidelines for ethical practice are not intended to be exhaustive, or entirely prescriptive, but rather are intended to provide social workers with greater clarity on how to interpret and apply the ethical values and principles in the [code of ethics]” (p. 2).

**Self-Disclosure**

The practice of self-disclosure in therapy is a widely debated topic. The term self-disclosure refers to sharing personal information between the therapist and the client (Barnett, 2011; Bridges 2001; Goldfried, Burckell, & Eubanks-Carter, 2003). In traditional psychotherapy the therapist should be a ‘blank screen’ and distant when conducting therapy (Bridges, 2001; Goldfried et al, 2003). According to Barnett (2011),

self-disclosure by the psychotherapist may be an important element of the development of the therapeutic alliance and a trusting relationship… self-disclosure promotes increased visibility that allows the marginalized client more power in the relationship than [he or] she would have with a less forthcoming psychotherapist. (p. 319)

My supervisor and I had a discussion about self-disclosure. I told my supervisor that I believe self-disclosure can be important in therapy when used appropriately. For example, I self-disclosed to two children that I worked with in my practicum placement that I came from a divorced family. This self-disclosure allowed me to gain trust with the children as we had a common experience. This experience also allowed me to empathize with my clients and their current situation. I became more convincing to the children when I validated their feelings and emphasized with their experience as I had similar feelings regarding my own parent’s
separation/divorce. Barnett (2011), Bridges (2001), and Goldfried et al (2003) explain that self-disclosure can cross a boundary without being a boundary violation; self-disclosure is a clinical technique and like all clinical techniques it must be used properly; self-disclosure can create a safe place and a reduction in fear; self-disclosure can only occur if the information being shared is a resolved issue for the therapist; self-disclosure should not shift the focus from the client to the therapist; self-disclosure should not harm the clients best interests or the therapy process; and self-disclosure should not be extensive or excessive.

**Boundaries**

I attended a wedding during the summer and one of the families that I worked with was also at the wedding. The family approached me and was very friendly throughout the event. The mother tried adding me on Facebook the day after the wedding. I did not accept her friend request. Although I risked hurting her feelings I had to follow our professional guidelines. At the next counselling appointment, I explained to the mother that it was not appropriate to be friends online due to our clinical relationship. The mother appeared to understand my dilemma/decision. I also informed the mother that she did not have to worry about confidentiality of her information as social workers “respect the importance of the trust and confidence placed in the professional relationship by clients and members of the public” (CASW, 2005a, p. 7). I offered to transfer the file to another counsellor if she had any concerns. She stated that transferring the file was not necessary and that she was not concerned with a breech in confidentially although we knew mutual people. I recognize that I may unexpectedly see this client at a future event due to mutual people we know but would handle it again in a professional manner. *The Canadian Association of Social Workers Guidelines for Ethical Practice* states that social workers should “maintain appropriate professional boundaries throughout the course of the professional relationship and
after the professional relationship” ends (CASW, 2005b, p. 11). I have explained to the family that I will never approach them first in a public setting to ensure their privacy/confidentiality.

Conflict of Interest

My friend sought services through Children’s Services for herself and her two children after leaving her partner due to domestic violence. She and her children had consistent contact with a clinician for approximately six months before stopping services. The services were discontinued because my friend returned back to her partner. My friend asked me to look into her file and see what the clinician had wrote about her returning back to her partner. I informed my friend that this was a conflict of interest as the file was not assigned to me. I informed my friend that viewing the file would be unethical on my part as the information in the file was designed for professional use and not for personal use. I informed my friend that she could contact the clinician and request to see a copy of the file if she wanted to. The Canadian Association of Social Workers Guidelines for Ethical Practice states that social workers “discuss with clients their rights and responsibilities… [such as] the client’s right to view professional records… their right to obtain a second opinion… and to seek avenues of complaint” (CASW, 2005b, p. 5). The issue has not been discussed further with my friend after my recommendation to her.

Practicum Recommendations

This section focuses on recommendations to both the Saskatoon Health Region and the Government of Canada after the completion of a practicum placement in a mental health setting. This section also discusses why the recommendations set forward should concern the profession of social work. These recommendations are based on my personal observations and are in no way meant to detract from the daily work being done by the Saskatoon Health Region and the Government of Canada.
First, the name Mental Health and Addiction Services is problematic and may be a barrier to service. The terms ‘mental health’ and ‘addictions’ are often associated with struggle and can be stigmatizing. The problem is that people living with mental illness often internalize stigmatizing labels that are widely endorsed in our society and as a result they believe that they are less valued because of those labels (Corrigan, 2004; Hewitt, 2005; Sartorius, 2007). The choice in name may deter clients from reaching out from services. The Saskatoon Health Region should consider changing the current name to something friendlier and non-stigmatizing. The Saskatoon Health Region should also consider the appearance of the current building. For example, Children’s Service is very plain and is not visually appealing to children and families.

Second, the current office hours may be a barrier to service. The office is currently open from 8:00 am to 4:30 pm Monday through Friday. Some clinicians currently flex their time to accommodate appointment times for clients who are unable to meet within that time frame. The Saskatoon Health Region should consider extending the hours or having one night a week where the office is open later such 9:00 pm. The clinicians could rotate bi-weekly or monthly on the evening shift to accommodate clients needing later appointment times.

Third, there are currently 8 full-time and 3 part-time in office clinicians working at Children’s Services. They consist of 1 Registered Psychiatric Nurse, 4 Master Social Workers, and 6 PhD Psychologists. The policy at Children’s Services is that a child or a family should be seen within 30 days after an intake is completed. The intake is fairly general and includes identifying information and the presenting problem(s). Surprisingly, children and families are currently waiting more than 60 days after an intake is completed to be seen. The Saskatoon Health Region should consider hiring more clinicians to bring down this wait time so they can
meet the needs of clients. The Saskatoon Health Region could conduct research on how many clinicians would be required to keep the waitlist at a minimum and/or a reasonable wait time. The Government of Canada could determine what a reasonable wait time is. For example, they could conduct research on wait times within provinces and territories and could set a standard based on national averages.

Fourth, the Saskatoon Health Region should consider who is primarily accessing services. It is apparent that people currently accessing services are white middle class people. The families that I worked with during my practicum placement included 9 Caucasian and 1 Aboriginal. I was rather surprised by this and recommend that the Saskatoon Health Region target groups who are not accessing services and in more need such as people in poverty or visible minorities. The creation of a drop in counselling center in the core neighborhoods may target hard to reach clients. The creation of cultural programs may be beneficial to target First Nations. The process of partnering with settlement agencies may be beneficial to target newcomers and ethnic minorities.

**Canadian Government**

Mental Health is a without a doubt a human rights issue and it has been neglected in Canada for decades (Kirby, 2008; Manion, 2010; Thompson-Prout, 1999). First, “everyone has the right to equal access to public services in his [or her] country” (United Nations, 1948, p. 2). The lack of clinicians is currently creating long wait times and this does not allow access to services in a timely manner. Second, the “widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of children” (United Nations, 1966, p. 3). The statistic mentioned earlier that 25% of children and youth in Canada
suffer from either mental health problems and/or a mental health diagnosis is alarming. The mental health of children and youth who are the future of this country are being neglected. The following recommendations related to mental health should be considered, implemented, and/or continued by the government:

- to increase the proportion of health spending that is devoted to mental health from seven percent to nine per cent over the next ten years
- to refocus spending on improved planning, program delivery, program outcomes, program evaluation, and overall education
- the government should require federally/provincially funded mental health agencies to encompass a full continuum of wellness (biological, psychological, social, and emotional)
- the government should require federally/provincially funded mental health agencies to encompass a full continuum of services (medical, clinical, community-based, and school-based)
- the use of technology to reach people (radio, tv, internet)
- to engage young people to promote change
- to engage families to promote change
- to decrease stigma for individuals and families associated with mental health
- to decrease stigma among health care workers associated with mental health
- to complete ongoing research on mental health (what is working versus what is not working)

(Kirby, 2008; Manion 2010; Mental Health Commission of Canada, 2012).
The recommendations set forth to both the Saskatoon Health Region and the Government of Canada should be of concern to the profession of social work as

- social workers believe in the obligation of people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity and to afford them protection from harm…

- social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand choice for all persons…

- social workers analyze the nature of social needs and problems, and encourage innovative, effective strategies and techniques to meet both new and existing needs and, where possible, contribute to the knowledge base. (CASW, 2005a, p. 5-8)

**Conclusion**

This paper was an in-depth examination of a 450 hour clinical practicum with Children’s Services at Mental Health and Addiction Services within the Saskatoon Health Region. The clinical practicum focused on assessment skills, therapy skills, and reflection skills. The paper illustrated examples of therapy being used at Children’s Services. The paper then discussed practicum challenges and practicum ethical considerations. The paper lastly focused on recommendations regarding mental health as they relate to the Saskatoon Health Region and to the Government of Canada. My placement and this paper have reminded me that beauty is in the eye of the beholder and so are differences.
References


Mental Health and Addiction Services. (no date). *Child and youth programs* [Brochure]. Saskatoon, SK: Saskatoon Health Region.


