Counselling at Catholic Family Services: A Field Practicum Report

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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Prince Albert, Saskatchewan
July 2018
Abstract

This report outlines my practicum experience providing counselling at Catholic Family Services. The goal of my practicum was to gain global experience providing counselling support to individuals, couples and families experiencing a variety of challenges, in a not-for-profit agency setting. In addition to my overall experience, I chose to focus on three counselling methods: Cognitive Behavioural Therapy with individuals (children and adults), no-talk therapy and play therapy with children and youth. To achieve the goals identified in my practicum proposal, I immersed myself within the agency providing counselling services four days a week and completed one to five sessions daily. I worked with clients experiencing a variety of challenges including mental health concerns (anxiety, depression, and obsessive-compulsive tendencies), relationship issues, parent/child conflict, experiences with childhood and adult traumatic experiences including physical, sexual and emotional abuse, and attachment issues. I enhanced my knowledge through academic journals and articles, books, and online webinars on various theories and models in order to effectively support my clients during their sessions. These approaches included strengths based counselling, no-talk therapy for children and adolescents, play therapy, cognitive-behavioural therapy and mindfulness-integrated cognitive behavioural therapy. As a result of my practicum experience my counselling skills and confidence as a counsellor have greatly improved. I experienced growth both in my skills as a counsellor, as well as my knowledge of my personal strengths and challenges and areas of ongoing need for personal and professional development.
Acknowledgements

I want to take a moment to acknowledge the many people that have supported me through the journey of completing this paper and my Masters of Social Work. First, and foremost, my partner Mark who encouraged me every step of the way that I was capable of success and providing me with the space in our lives, when little space was available, to complete this paper.

I want to thank Eric Bailey, my professional associate, clinical supervisor and colleague who was extremely supportive throughout my practicum and afterwards, and encouraged me to find balance in my life that allowed space for completing this paper.

I would like to thank all of the professors I had throughout my master’s program that challenged me and provided me with different ways to think and look at being a clinician. I would like to thank Raven Sinclair, my academic supervisor who supported me through my practicum and writing process with encouraging emails and a “you can do it!” when that was exactly what I needed. Thank you to Randy Johner for agreeing to be my committee member and taking time out of your busy schedule to support me on this journey. Thank you to all the faculty in the MSW and Graduate studies programs for the difficult work you do ensuring this program is challenging and beneficial to students like myself.

Thank you to my friends and family for your emotional and financial support through my MSW program.

And finally, thank you to the clients I work with, who graciously let me become a part of your lives and journeys, build strong relationships with me and trust me with your stories and allowing me to celebrate along with you for your victories.
Dedication

I dedicate this paper to my closest friend, Sharon Miller who has been my biggest support throughout my social work and counselling career, as well as my Masters of Social Work degree. Thank you for challenging me to be a passionate, ethical and caring counsellor in every interaction I have with clients and for being the pillar of support in my life when doing so has felt overwhelming.
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Chapter 1: Introduction

This paper is a reflection of my experience as a practicum student providing counselling at Catholic Family Services. Prior to my practicum I chose to focus on providing counselling to children, youth and families experiencing a variety of personal and relationship challenges with the plan to utilize the counselling approaches of Cognitive Behavioural Therapy, No-Talk Therapy and Play Therapy. This report begins with an overview of my personal and professional history, the agency in which I was placed, and an overview of my placement proposal and objectives. I include a review of the three counselling approaches and their application during my practicum. This paper will also provide an overview of additional approaches and strategies that I researched and utilized throughout my practicum including mindfulness and grounding techniques. In addition to the research and skills utilized throughout my practicum, this report provides an exploration of my values, as well as the values of Catholic Family Services, the themes that emerged during my practicum, as well as the challenges I experienced. I conclude with a discussion of themes that emerged during my practicum, challenges I faced, and the implications of my learning for social work practice. I begin this report with some life experience and context that led me into the counselling field.

1.1 Personal and Professional History

I selected Catholic Family Services in Prince Albert as the agency in which to complete my practicum as I was seeking an opportunity to provide counselling in a community based organization with a long-standing positive presence in the community, that employed skilled clinicians and that provides services to clientele of all ages, religious and cultural backgrounds and socioeconomic status. Prior to my practicum, I worked for several years providing in-home
clinical services to families experiencing challenges with addiction, mental illness, parenting difficulties, behavioural concerns or parent-child conflict. I knew after this experience that I was passionate about working with children, youth and families and that I wanted to utilize my practicum experience to enhance my clinical skills and confidence in providing quality, evidence-based counselling and interventions. I am thankful that I was able to gain the experience I hoped for during my practicum with children, youth and families, while also being encouraged to accept counselling intakes outside of my “comfort zone”. I had the opportunity to build skills in new areas such as couples/relationship counselling, anxiety and depression in adult males and providing counselling to children and adults with physical and intellectual disabilities. I felt challenged by my supervisor and coworkers to research and utilize not only the counselling strategies and approaches I identified in my proposal, but also different perspectives to meet the needs of my clients.

On a personal level, I have been passionate about being in the helping profession since I was a teenager, and have always related positively to counselling since I was 15 and experienced the loss of my mother to cancer. I accessed support from three different counsellors during my teenage years and have continued to access counselling throughout my adult life when I felt I would benefit from the support. As a result, I developed a positive relationship with the field of counselling and my positive personal experience steered me towards doing my masters of social work degree, and ultimately deciding to become a counsellor.

1.2 Catholic Family Services Agency

I chose to complete my Masters of Social Work practicum at the agency, Catholic Family Services (CFS), located in Prince Albert, Saskatchewan. I selected this agency as I was interested in a field practicum at a community based organization offering counselling to members of the
community from a variety of socioeconomic, cultural and religious backgrounds. According to verbal history provided by the current Executive Director, Catholic Family Services is a not for profit agency that was opened in 1984 by the Roman Catholic Diocese of Prince Albert, to meet the need for affordable counselling in the community. The agency has undergone many changes and expansions since 1984; however has remained committed to the value that services are available to all members of the community, regardless of their ability to pay. The mission statement of Catholic Family Services is “to promote and maintain the integrity of the family. We respect the spiritual and cultural beliefs of all those we serve” (CFS, 2016, p. 8). The purpose is “to assist individuals and families, to build on their strengths and find positive ways to understand and act when faced with challenges in their lives” (CFS, 2016, p.9). Catholic Family Services offers a variety of services to the community including individual, couples and family counselling to children, youth and adults, school counselling to children in the Catholic School system, life improvement programs and re-employment programs.

At the time of my practicum, Catholic Family Services (CFS) employed seven, full-time counsellors with professional backgrounds in social work, psychology, educational psychology and marriage and family therapy (Catholic Family Services [CFS], 2017). Four of these counsellors provide counselling in the office, and the remaining three provide counselling to children within the Catholic School System in Prince Albert, Saskatchewan. Referral sources for counselling at CFS include the Ministry of Social Services, the Ministry of Justice, First Nations Child and Family Services agencies, referrals from other non-profit agencies in the community, self-referrals and a variety of Employee and Family Assistance Programs (CFS, 2017). Catholic Family Services provides approximately 2200-3000 counselling sessions per year, with approximately 500 of these sessions provided to “non-pay” clients (i.e. clients who are unable to
pay a fee for counselling services) (CFS, 2017). Clients are encouraged to call Catholic Family Services to request counselling for themselves or family members, and then are given payment options including: submitting receipts for reimbursement through their benefit plan, applying for approval through Non-Insurance Health Benefits or paying a fee for services determined from an income-based sliding scale.

The other large component of services offered by CFS is life improvement and re-employment programs. The Director of Programs at CFS is responsible for seven different life-improvement programs. The programs offered are designed to address needs identified in the community including: anger management for children, teens and adults, domestic violence in relationships, children exposed to domestic violence, children experiencing a parental separation or divorce and parent improvement (CFS, 2017). All programs are offered three times or more yearly at no, or minimal (i.e. $45.00 or less) cost to the participants. Funding for these programs come from a variety of sources in the community including the Catholic School Division, the Public School Division, the Parkland Health Region, the Prince Albert Police Force, RCMP and grants provided by the Ministry of Justice, United Way, Community Initiatives and several others (CFS, 2017).

The final area of services offered by the agency is the BRIDGES program, an employment initiative program designed to support ex-offenders released from the provincial corrections system to transition into employment and the community. The BRIDGES program is 10 weeks in length and provides participants with a variety of certificates and training opportunities, as well as access to education on mental health, addictions recovery, driver’s license training, budgeting and parenting education (CFS, 2017). Participants have access to weekly individual
addictions counselling through the program, as well as on-going support for one year from one of the full time counsellors with the agency.

1.3 Practicum Proposal

My counselling practicum at Catholic Family Services consisted of 450 hours on a full time basis from January 4th until April 10th, 2017. In my practicum proposal, I outlined three clear goals for my field practicum experience, as well as several learning objectives that would help support the achievement of my overall goals.

The first goal I identified was to gain experience providing individual, couple and family counselling at a community based organization with a focus on providing counselling to children, youth and families. The second goal I identified was to gain experience utilizing the counselling models of Cognitive Behavioural Therapy, No-Talk Therapy and Play Therapy. The third goal I identified was to learn how to effectively respond to and integrate supervisory feedback and guidance.

The learning objectives I identified that would support my completion of these goals included the objective of seeking to acquire knowledge of the current research on best practice counselling models for counselling with children, youth and families. To achieve this learning objective I conducted research and completed a literature review on best practice counselling methods with children, youth and families, consulted with my clinical supervisor and coworkers and attended online webinars. My second learning objective was to gain familiarity with the services offered within the community. As I had newly moved to the community of Prince Albert my knowledge of community resources was limited and therefore I engaged in internet research, accessed literature on community resources, consulted with agency colleagues and attended information sharing sessions hosted in the community. My third learning objective was to
develop therapeutic relationships with children, youth, couples and families. This goal was achieved by participating in counselling sessions and utilizing engagement skills to develop a therapeutic alliance including empathy, active listening, humor and play. The fourth objective was to have opportunities to develop clinical skills in providing counselling to children, youth and families. These clinical skills were developed through research, group and individual clinical supervision and practical experience during counselling sessions. The fifth learning objective I identified was to have opportunities to work within the agency offering a wide variety of services to a diverse clientele, which was achieved by completing my practicum at Catholic Family Services. During my practicum I carried a reduced caseload in order to allow additional time for research, session preparation and debriefing as well as self-care. Through individual and group clinical supervision, I had the opportunity to engage in learning about a variety of clinical skills and approaches, as well as to present case examples and receive feedback and support.

I will begin this paper by providing a literature review on the three different counselling approaches I utilized during my practicum, Cognitive Behavioural Therapy, No-Talk Therapy and Play Therapy.
Chapter 2: Theory

This chapter provides a review of the four therapeutic approaches I utilized during my practicum, Cognitive Behavioural Therapy, Mindfulness-Based Cognitive Behavioural Therapy (MiCBT), No-Talk Therapy and Play Therapy. Cognitive Behavioural Therapy, No-Talk Therapy and Play Therapy were approaches I originally identified in my practicum proposal to focus on, however MiCBT became an approach I used frequently throughout my practicum and therefore is discussed in this section as well. Completing a literature review on these approaches allowed me to gain an understanding of the basics of each; including the populations that benefit from each approach, how to implement the approach effectively and strategies to utilize within the counselling setting.

2.1 Cognitive Behavioural Therapy

One of the goals I identified in my practicum proposal was to become acquainted with evidence-based practices for counselling with children and youth in order to provide effective services to my clients. One of the therapeutic approaches determined as effective in working with children, youth and adults is Cognitive Behavioural Therapy (CBT), which has proved particularly effective for anxiety and depression for both children and adults (Drewes, 2009). CBT focuses on changing maladaptive thoughts and behaviours, and looks at the interaction between a person’s cognitive process, their emotional experience and their behavioural response (Lyneham, Rapee, Sburlati & Schniering, 2014). Cognitive Behavioural Therapy has been found to be effective in treating Generalized Anxiety Disorder; however, the traditional form of CBT as practiced with adults is inappropriate to utilize with children and adolescents (Drewes, 2009). It is vital to adapt traditional CBT practices to be developmentally sensitive to children and adolescents (Drewes, 2009). It is important to note that CBT emphasizes the importance of the
relationship between the therapist and client in order for the client to achieve success during therapy (Dattallio, 2010). Drewes (2009) identifies the three core components of CBT to include: (1) psychoeducation around depression, anxiety and maladaptive thinking, (2) supporting the client in learning skills to identify their maladaptive thoughts, and develop skills to challenge these thoughts (i.e. cognitive restructuring), and (3) assisting the client in developing coping skills. Although traditional CBT with adults involves a high level of talk therapy paired with worksheets and homework, children and adolescents may respond more favorably to the kinds of experiential techniques used in play therapy as opposed to traditional CBT (Drewes, 2009). Therefore, this section will outline the core concepts of CBT and adaptations noted to be beneficial in treating children and adolescents.

Psychoeducation about depression, anxiety and maladaptive thoughts is identified as a core concept of CBT, as individuals often attend therapy expressing a desire to feel better without fully understanding their current challenges, or the importance of changing the way that they think (Lyneham et al. 2014). Psychoeducation with adults includes providing information in the counselling setting verbally or through handouts, as well as providing assigned reading when appropriate (Dattallio, 2010). Drewes (2009) identifies that creative or play based psychoeducation on anxiety, depression and CBT is a more developmentally appropriate and engaging approach for children and adolescents. Suggested strategies include the use of puppet shows, index cards with brief descriptions of labels, the use of photographs or drawings and therapeutic stories (Drewes, 2009). An important concept of this stage of treatment is also acquainting the child or adolescent to the CBT model utilizing a developmentally appropriate visual and an example from the child’s life.
Negative thoughts (also known as maladaptive thoughts or negative automatic thoughts), through the lens of CBT, are noted to be one of the key features of depression and anxiety; and the presence of negative thoughts are seen to play a role in maintaining these conditions. In order to achieve success, individuals must learn ways to identify, manage, and reduce these maladaptive thoughts and replace them with positive thoughts and new behaviours (Lyneham et al. 2014). This process is defined as cognitive restructuring and is the second phase of CBT. One strategy noted to be beneficial in CBT with both adults and children is to utilize examples provided by the client of situations in which they experienced distress. By examining the situation with the client, counsellors are able to implement the thoughts, behaviors and feelings into a diagram often called the maintenance cycle (Lyneham et al. 2014). One of the challenges for clinicians is to assist the client in identifying which thoughts they had in the distressing situation that led to the resultant emotion and caused the behavioural response. This task can be challenging for adults, however younger children in particular may not have the skills required to learn the cognitively based techniques traditionally used in CBT (Drewes, 2009). For younger children, the use of play concepts that demonstrate a cycle or cause-and-effect experience similar to the core CBT concept can be beneficial (Drewes, 2009). Drewes (2009) provides examples of these including the use of dominoes arranged in a circle, three individuals standing in a circle connected by yarn and interactive metaphors or stories (i.e. good coach vs. bad coach to demonstrate helpful vs. unhelpful thoughts). As previously mentioned, children and adolescents benefit from learning about cognitive restructuring when paired with exploration of emotion words, and physiological experiences related to emotions (Lyneham et al. 2014). A well-known strategy during this phase is *thought diaries* since individuals often have difficulty identifying their thoughts after the event has occurred. The use of images by children and adolescents in
their thought diaries can also be valuable in understanding their thoughts and emotions (Lyneham et al. 2014).

Once children and adolescents have gained an understanding of the impact their thoughts and emotions have on their behaviour clinicians will engage them in a process referred to in MiBCT as “decentering”. Decentering is “the ability to observe one’s thoughts and feelings as transitory events in the mind that do not reflect reality, truth or self-worth” (Baer, 2010, p. 35). One of the strategies utilized in the decentralizing process is to have clients ask themselves questions that explore how thoughts are invalid or irrational. Several questions have been identified as helpful in supporting individuals to find flaws in, or evidence against their maladaptive thoughts. These include, “what would you say to a best friend if they had this thought?”, “Has there ever been a time when you were in a similar situation and not been worried or upset?” and “What do you think your best friend/mom would say if you told them about this thought?” (Lyneham et al. 2014, p. 164). This process is noted to be powerful in promoting individuals understanding of their maladaptive thoughts, however is significantly more advantageous when paired with behavioural experiments and coping strategies.

Behavioural experiments or the implementation of coping skills is the third component of CBT once negative thoughts have been identified and clients have the skills to challenge such. Behavioural experiments are described by Lyneham et al., (2014) as the process by which the child can reflect upon the cyclical nature of their thoughts, emotions and behaviours. Children are encouraged at this phase to use their problem solving skills to break the cycle, and additional coping skills are introduced (Lyneham et al. 2014). Coping skills can be taught to children and adolescents through interactive activities, handouts and role-plays (Drewes, 2009). Children can
also be encouraged through the use of the visual maintenance cycle to identify the weakest part of the cycle between thoughts, feeling and behaviours.

Some of the core strategies that have been determined as effective with children and adolescents include self-monitoring of symptoms, participation in pleasurable activities, cognitive restructuring and social skills training (Drewes, 2009). These techniques parallel those used with adults however differ in that they are made more engaging for children and presented in a simplified manner. Mindfulness has been identified as an effective strategy to implement with both children and adults and therefore the following section will explore integrating CBT and Mindfulness.

2.2 Mindfulness-Integrated CBT

I identified the use of CBT with children and youth as one of the therapeutic approaches I planned to utilize during my practicum. As my practicum evolved, I learned that the use of CBT was effective in treating those with anxiety and depression; however, I felt the need to introduce additional strategies to meet the needs of my clients, particularly children and youth, by including play and mindfulness strategies into traditional CBT. As a result, the following will provide an overview of the concepts of Mindfulness-Integrated Cognitive Behavioural Therapy. There is increasing evidence that the use of mindfulness interventions is effective in treating a large number of mental disorders and provides clients an increased ability to manage stress (Chiesa & Serretti, 2010). Mindfulness as conceptualized by Kabat-Zinn (2015) is described as the “awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to what is unfolding moment by moment” (p. 1481).

Mindfulness-Integrated Cognitive Behavioural Therapy (MiCBT) is defined by Cayoun (2011) as:
a systematic therapy approach that integrates mindfulness meditation with core elements of cognitive and behavioural methods for the purpose of teaching clients to internalize attention in order to regulate emotion and attention, and externalize these skills to the context in which their impairment is triggered or maintained (p. 11).

Mindfulness meditation is shown to increase calmness, therefore decreasing general reactivity and shown to benefit those with depression, anxiety, psychosis and anger issues (Cayoun, 2011). Training in mindfulness focuses on assisting clients in being able to “turn towards” instead of “turn away” from difficulties (Lau & McMain, 2005). It is important to note that for the purposes of this paper a general overview of MiCBT is provided, along with identification of which concepts I utilized during my practicum. MiCBT is a flexible, four stage integrative model. The stages include the personal stage, exposure stage, interpersonal stage and empathic stage (Cayoun, 2011). Stage one involves mindfulness meditation training and is taught to help clients bring their attention inwards and promotes deep levels of awareness and acceptance (Cayoun, 2011). This stage is intended to equip clients with an increased sense of self-control in handling their thoughts and emotions and learning to regulate their attention and emotions (Cayoun, 2011). The second stage, exposure, is the first externalizing phase and introduces various exposure procedures first in imagery and then in practice to decrease avoidance and increase self-confidence (Cayoun, 2011). The third stage is the interpersonal stage and requires further externalizing by decentering attention from self to others. By gaining an understanding of others’ way of communicating, combined with assertiveness and other social skills we learn to prevent our reaction to others’ reactivity (Cayoun, 2011). The fourth stage is the empathic stage which involves teaching empathic skills grounded in the bodily experience of
the present moment. It involves developing self-compassion and compassion towards others, forming a connection to ourselves, and others (Cayoun, 2011).

One of the key strategies utilized in phase one, the personal stage, and one that I found critical to introduce to clients was progressive muscle relaxation (PMR). PMR is described as one of many beneficial meditations used in mindfulness that also includes mindful stretching and mindfulness of breath-body-sounds-thoughts (Lau & McMain, 2005). The central tenant of PMR is to systematically tense and release muscle groups throughout your body, holding tension for 5-7 seconds, and then relaxing the muscle group paying attention to the difference in feeling throughout your body (Blum, Hood & McCallie, 2006). In exploring the body, clients also engage in tensing and relaxing their muscles in order to experience the tension we feel when stressed or anxious, countered by a relaxed muscle for awareness. Another strategy I found useful for clients was the introduction of calm breathing, or the “mindfulness-with-breathing” technique through mindfulness scripts read in sessions, listening to recordings online or videos and using phone applications with guided mindful breathing. Through mindful-breathing clients learn to feel natural breath in order to develop some control over racing thoughts (Cayoun, 2011). Through practice the client is able to develop the skills to detect intrusive thoughts without identifying with them, and eventually preventing the usual reaction to the thought by not engaging with it (Cayoun, 2011).

Stage two of MiCBT involves combining the core mechanisms of mindful-meditation with exposure to distressing situations through imagery and practice. The goal of this stage is to prevent clients from avoiding situations that relate to their goals and living life to their values (Cayoun, 2011). Cayoun (2011) identifies that research in behaviour therapy has shown an equivalence between experiencing in imagination and experiencing in reality. Therefore when
we can support our clients in exposing themselves to fears through imagination we prepare them for similar experiences in person. The technique utilized by MiCBT during this phase is “bi-polar exposure” that includes guided self-imagery of traditionally avoided situations (Cayoun, 2011, p. 118). Bi-polar exposure is related to the concept “systematic desensitization” however focuses on empowering the client to manage the physical sensations they experience when exposed to a distressing situation, rather then desensitizing to a particular stimulus (Landau, Mealiea & McGlynn, 1981). The increased focus on physical sensations allows the client to gain control over their physical reactions and therefore these strategies can be utilized in a variety of situations (Cayoun, 2011). The goal of this practice is to desensitize the client to distressing situations before they proceed with real-life exposure.

Stage three involves expanding on the previous stages, while moving attention from the self towards others through decentering (Cayoun, 2011). The goal of this stage is to help prevent reacting to others’ reactions, which is achieved through “experiential ownership”. Through “experiential ownership”, clients learn to take responsibility for their current experience and relinquish responsibility for the experiences of other people (Cayoun, 2011, p.126).

Stage four involves supporting our clients in developing empathy in order to appraise, understand and accept the difficulties of others (Cayoun, 2011). This process was traditional labelled as the “Loving-Kindness Meditation” in mindfulness teaching traditions. Through engaging clients in this compassion-based meditation they increase feelings of warmth and caring for themselves and others (Leppma & Young, 2016).

In addition to the use of mindfulness and CBT, I felt that many of the children and youth that I saw could benefit from alternatives to traditional counselling and therefore I conducted research on the approach no-talk therapy.
2.3 No-Talk Therapy

In order to be prepared to support children and youth with varied levels of engagement in counselling, I researched and found no-talk therapy as a beneficial approach that minimizes the conversational components of counselling for children and youth. No-talk therapy was conceptualized by Martha Strauss in 1999 and is based on the concept that many children who attend counselling are unable to engage in traditional counselling which focuses on verbal communication. No-talk therapy closely aligns with strengths-based approaches in focusing on a child’s strengths and successes as kids do not usually want to talk about the bad things that have happened to them (Franklin, 2015). One central tenant of no-talk therapy is that the children referred for therapy will often not respond to typical engagement strategies such as active listening and supportive reframing, however continues to stress the importance of a therapeutic relationship for children and teens to experience success in counselling (Hanna, Hanna & Keys, 1999). No-talk therapy stipulates that other models of therapy, particularly cognitive therapies, focus on following a regimented structure and therefore no-talk therapy focuses on providing children and adolescents with a tailored counselling experience based on their needs (Strauss, 1999). Straus (1999) identifies the five principles of successful no-talk interventions with children. These include: children develop a positive relationship with the healing professional in a safe place, other services are provided due to the complexity of the children and their required supports, the peer group is recognized as an area for support and efforts are made to develop social skills, therapy is tailored to the developmental stage of the child or adolescent and that family members are involved in treatment to the extent that they are willing and able (Strauss, 1999, p.26).
Straus (1999) identifies that in order to understand how to best support the children and adolescents we see, we must have an understanding of their “developmental runways” (p. 12). Strauss’ use of the word “runway” is a synonym for the many words we use to describe a child’s journey, path or experience of moving through physical, cognitive, emotional and social development (p. 12). This concept also ties to the importance of entering the therapeutic relationship without expectations of the child, and seeing each child as an individual therefore ensuring the counsellor does not make assumptions about their development based on their age (Robinson, 2011).

In assessing physical development we must look at what current experiences the child is going through physically (i.e. growth spurt, puberty, tall or short for their age, over or underweight) and how this is affecting their self-esteem and how the adults and peers in their lives treat them (Strauss, 1999).

When exploring cognitive development with the children we work with, a primary component is acknowledging that children rarely possess the cognitive skills to describe their experiences and emotions, and therefore traditional talk-therapy counselling approaches are not beneficial (Strauss, 1999). Areas to pay attention to in children’s cognitive development include development of concrete operational thoughts and formal operational thoughts, egocentric thinking and problem-solving skills (Strauss, 1999). Research indicates that 95% of brain development occurs before age five or six, with the second largest wave occurring between age 11 to approximately 24 (Roaten, 2011). As a result, many of the children seen by no-talk therapists will be experiencing significant cognitive development and adjustments that occur related to such.
When looking at emotional development for children it is critical to acknowledge the developmental timeline related to experiencing, expressing and regulating emotions (Strauss, 1999). When children have difficulty expressing their emotional experience in words in therapy, they may be struggling to recognize their feelings, put their feelings into words and understand the meaning of these feelings. The development of understanding mixed emotions is also one to be paid attention to, with many children not being able to comprehend until 12 years or more that they can experience two, incompatible emotions at once (Strauss, 1999).

The final component of development that requires attention is social development. Many of the children we see in therapy have past social experiences that will frame how they approach the relationship with their counsellor, and often times this framework is not positive (Strauss, 1999). As a rule, social development has not progressed smoothly for kids who are referred to therapy and they are often disengaged from typical ways of interaction (Strauss, 1999). Two components of social development that require recognition and support within the counselling relationship is children’s and teens need to be recognized and to find a place where they can belong (Ballou, 1999). Therapy provides these children with an opportunity to achieve success socially if the therapist is attuned to the current social development of the child and ways to support development in this area (Strauss, 1999).

Kids who have a history of success are more likely to feel confident that they can overcome a challenge when encountered with one in the future (Strauss, 1999). Our role as therapists is to provide children with opportunities to experience success and therefore increase their confidence. Aligning with Carl Roger’s client-centered counselling approach, no-talk therapy is non-directive counselling (Robinson, 2011). Two experiences can create confidence in children: authentic approval from significant others and competence in domains of importance to them.
(Strauss, 1999). The areas identified as generally important for children include school achievement, peer acceptance, good behaviour and physical attractiveness (Strauss, 1999). It is our job as meaningful adults in the child’s life to celebrate their successes in these areas and encourage the other adults in their circle of support to do the same. We can provide opportunities in therapy for children to gain mastery over domains of importance to them including drawing, reading, writing and playing games.

Another central tenant of no-talk therapy is the concept of “the circle of adults”. This concept is founded in the idea that lasting change cannot be achieved for a child without involving the rest of the family or supportive adults in the child’s life, and the untapped resources in the community (Strauss, 1999). A child’s nuclear family of their first social system and their most solid foundation and each child has resources within their environment that can help develop their strengths (Ballou, 1999; Xie, 2015). The limitations of individual therapy are many and therefore we must recruit others within the child’s formal or informal support system to pick up where we leave off (Strauss, 1999). No-talk therapy is flexible in how this team of adults is formed and what level of structure is given to their involvement however emphasizes the importance of knowing who is involved with the child’s life in a meaningful way and involving them in supporting the child (Strauss, 1999). This approach is consistent with an ecological approach to counselling in ensuring that the individuals and systems within a child’s system are included and support the child (Dishion & Stormshak, 2001). Opportunities for community involvement can also benefit the children we work with including youth organizations, organized sports or physical activity, youth volunteer opportunities, mentor programs, church-based programs, friends and family and work training programs (Strauss, 1999). Our role as
counsellors can be to identify the need for this community involvement, refer or enroll children and encourage parents or caregivers to ensure attendance.

One of the aspects of no-talk therapy that I adhere to and believe has guided my work in a meaningful way is how Strauss (1999) describes the characteristics of a no-talk therapist. Strauss states that the following characteristics are crucial to being an effective child therapist. These traits include having genuine positive regard for the children we work with; being in-touch with the more childlike parts of ourselves; being enthusiastic and acting as the child’s cheerleader; displaying warmth and kindness to children and allowing children to know we are imperfect. Effective qualities also include utilizing our inherent parental instincts, having a high level of frustration tolerance, advocating for the children we work with, providing sincere and thoughtful empathy and being flexible, fun and creative (Strauss, 1999). Roaten (2011) identified that adolescents are more likely to engage in the counselling process if it includes interesting, stimulating, brain engaging activities (p.305). Recognizing the importance of incorporating creativity into counselling I conducted a review on the counselling approach of play therapy.

2.4 Play Therapy

The third approach identified in my practicum proposal was the utilization of creative strategies or play therapy with children and youth. Child-centered play therapy (CCPT) is based on the belief that the relationship between the child and the therapist is the single best predictor of healing for children experiencing difficulties (Crenshaw & Steward, 2015). Landreth (2012) defined play therapy as:

A dynamic interpersonal relationship between a child and a therapist trained in play therapist procedures who provides selected play materials and facilitates the development
of a safe relationship for the child to fully express and explore self through play, the child’s natural medium of communication, for optimal growth and development. (p. 11)

CCPT was developed in the 1940’s and is noted to be one of the longest standing forms of therapy today (Crenshaw & Stewart, 2015). CCPT is based around Carl Rogers’ person-centered theory and follows the basic concept that a person’s perception of their experiences represents reality for that individual. Specific to play therapy is the belief that children are born into the world viewing interactions in a unique and personal way that is apart from others perceptions (Crenshaw & Stewart, 2015). A child develops their sense of self through interactions with significant others and their perception of these interactions (Crenshaw & Stewart, 2015).

The therapeutic process of CCPT begins with the development of a therapeutic relationship between the counsellor and child, and the counsellor’s ability to provide a safe environment and relationship for the child is the primary concern of therapy (Crenshaw & Stewart, 2015). CCPT is non-directive and therefore gives children autonomy; however, the counsellor is an active, engaged participant in the counselling process (Crenshaw & Stewart, 2015). CCPT is focused on the child, not the problems of the child. In adapting Carl Rogers’s six conditions for therapeutic change, Ray (2011) applied these conditions to CCPT and defined the following conditions as key to therapeutic change for children. These conditions include a relationship between the child and counsellor; the child must be in a state of discomfort demonstrated through anxiety or vulnerability; and for the counsellor to experience therapist congruence, unconditional positive regard and empathic understanding towards the child (Crenshaw & Stewart, 2015). In order to display unconditional positive regard and empathic understanding, the therapist must have reached a state of congruence, which is defined as “the ability to feel free to be him-or-herself within the therapeutic relationship” (Crenshaw & Stewart, 2015, p. 6). Unconditional positive
regard is the therapist’s ability to show warm acceptance of the client’s experience and empathic understanding is the experience of entering the child’s world as if it were his or her own without losing their sense of self (Crenshaw & Stewart, 2015).

The general structure of CCPT is the following eight basic principles: (1) the counsellor develops a warm, friendly relationship with the child; (2) the counsellor accepts the child for who they are; (3) the counsellor develops a sense of permissiveness to allow the child to feel free to express thoughts and feelings; (4) the counsellor is attuned to the child’s feelings and reflects those back, gaining further insight; (5) the counsellor reflects the child’s ability to solve problems; (6) the counsellor does not direct the child’s behaviour of discussion but follows the child’s lead; (7) the counsellor does not attempt to rush therapy and accepts the natural progression and (8) the counsellor sets limits only as required to anchor the child to reality or make the child aware of responsibilities within the relationship (Crenshaw & Stewart, 2015, p. 8).

2.5 Chapter Summary

The three therapeutic approaches discussed in this chapter were Cognitive Behavioural Therapy, Mindfulness-Integrated CBT, No-Talk Therapy and Play Therapy. All three represent effective approaches to counselling that focus on the existing strengths and successes of the client, and utilize the positive therapeutic relationship as a catalyst for the client to achieve further success in their lives. The use of creativity and play are emphasized in all three approaches as beneficial when working with children, youth and families. The counselling methods discussed aligned well with both my personal values, as well as the values of Catholic Family Services therefore resulting in a positive experience for the agency, the clients and myself.
Chapter 3: Ideology and Values

This chapter examines the values of the agency in which I completed my practicum, as well as my personal ideology and values. The chapter concludes with a discussion on my experience as a practicum student navigating similarities and differences between my values and those of Catholic Family Services. I was pleased to have the opportunity to complete my placement at Catholic Family Services as the values of the agency closely align with my personal and professional values as detailed below.

3.1 Values of Catholic Family Services

Catholic Family Services is an agency with a longstanding positive presence in the city of Prince Albert. Institutional history provided by the current Executive Director indicated that the agency began with counselling services provided by two Catholic Nuns to church and community members. Over the past 34 years, Catholic Family Services has evolved to employ four master’s qualified clinicians and delivers services to individuals and families from the community, as well as surrounding cities, towns and First Nations reserves. In addition to counselling services, the agency now runs a variety of educational and support programs. Catholic Family Services strongly values the employment of highly trained professionals, who are members of their governing body and adhere to the ethics of the agency and their professional code of ethics. Catholic Family Services values that services are available to all individuals and families regardless of their race, cultural background, gender, religious background, sexual identity and income. Catholic Family Services’ mission statement supports this in saying, “We respect the spiritual and cultural beliefs of all those we serve” (CFS, 2016, p.8). Fee for services are determined utilizing a sliding scale based on individuals’ income, and individuals who are unable to pay are never denied services. Catholic Family Services believes
that the individual values of each client served are respected and all clients experience acceptance and understanding from staff and counsellors. Catholic Family Services values confidentiality and all client information is kept strictly confidential with the exception of limitations resultant of duty to report mandates (CFS, 2017). Catholic Family Services believes in seeing the strengths in the clients served and reflects this in the agency purpose saying, “The purpose is to assist individuals and families, to build on their strengths and find positive ways to understand and act when faced with challenges in their lives” (CFS, 2016, p.9). The values of Catholic Family Services closely align with my professional values of treating clients with respect and from a strengths-based perspective. The agency values also align well with my personal ideology and values of providing counselling from an ethical, client centered approach. As a result, it became an excellent learning opportunity for my practicum.

3.2 Personal Ideology and Values

My personal and professional values are that all individuals have the right to respect regardless of their gender, race, age, ethnic background, ancestry, religion, sexual identity or relationship status, gender or socio-economic status. I am passionate about providing counselling from an ethical and strengths-based perspective. Ensuring I provide quality services to my client’s means, that I am a registered member of the Saskatchewan Association of Social Workers (SASW) and adhere to the SASW, Social Work Act (2015) and the Canadian Association of Social Workers (CASW) Code of Ethics (2005a) and CASW Guidelines for Ethical Practice (2005b). When faced with challenges during my practicum I sought to make decisions for my clients that reflected the six values of the Guidelines for Ethical Practice (CASW, 2005b) which include Respect for Inherent Dignity and Worth of Persons, Pursuit of Social Justice, Service to Humanity, Integrity of Professional Practice, Confidentiality in
Professional Practice and Competence in Professional Practice. The CASW Guidelines of Ethical Practice outlines that social workers have an ethical responsibility to their clients, to ensuring decisions made are in the best interest of the client and that clients do not experience discrimination based on any of their individual traits or preferences (2005b). My professional values provide a framework with which I determine how to provide services to the clients I serve and therefore have become a part of my personal ideology.

As a social worker and counsellor, I have developed my professional values through my personal and professional experiences, primarily as a clinician working with families. Because of this professional experience, my values reflect providing support to the whole family system whenever possible, rather than an individual member of the family, as well as connecting the family to community or wraparound supports. It is my personal and professional value that children do best when we are able to educate, and support the whole family system bringing about more widespread and long-lasting change for the child. As a result of these beliefs my counselling with children and youth aspires to involve parents, caregivers, siblings and extended family members whenever possible and ethical, and therefore these values closely align with the beliefs of No-Talk Therapy and the concept of “the circle of adults” (Strauss, 1999).

Being a social worker practicing from a strengths-based perspective is something I have felt passionate about since I began practicing. Strengths-based counselling is a belief in the inherent good of our clients, an ability to see their strengths and capacity for growth and a commitment to identify and build on clients’ strengths (Saleeby, 2012). Providing services from a strengths-based perspective aligns with the CASW Guidelines for Ethical Practice (2005a) as it dictates, “Social workers promote the self-determination and autonomy of clients, actively encouraging them to make informed decisions on their own behalf” (p.4). This definition mirrors my belief
that every client has his or her own individual strengths, history of successes and ability to grow. My professional approach to counselling is to provide services to children and adults focused on their strengths and successes from the past, as well as looking forward to the future rather than focusing on the current challenges (Dybicz, 2011). Through my research and practice, I believe that I was able to incorporate or adapt the three main approaches I utilized throughout my practicum to align with my values of supporting clients through a strengths based perspective. My placement was successful in supporting me to achieve my practicum objectives.
Chapter 4: Achieving Practicum Objectives

This chapter will outline my original practicum proposal goals and how each goal was achieved by identifying and discussing the specific objective related to each goal. The three goals of my practicum were: 1) To gain experience providing individual, couples and family counselling at a Community Based Organization with a focus on providing counselling to children, youth and families; 2) To gain experience utilizing the counselling models of Cognitive Behavioural Therapy, No-Talk Therapy, and Play Therapy; and 3) to learn how to effectively respond to, and integrate, supervisory feedback and guidance.

4.1 Goal One

The first goal identified in my practicum proposal was to gain experience providing individual, couple and family counselling at a Community Based Organization with a focus on providing counselling to children, youth and families.

4.1.1 Objective One

As part of being successful in achieving my overall goal of providing counselling, the first objective I identified was to acquire knowledge of the current research on best practices models for counselling with children, youth and families. As a result, I began researching counselling approaches approximately four months before my practicum and continued this research throughout. My research focused on the approaches of Cognitive-Behavioural Therapy, No-talk therapy and creative and/or play interventions. As detailed throughout this report, there were several books that led my research and guiding me through the experience. These books included: Play Therapy: A Comprehensive Guide to Theory and Practice (Crenshaw, D.A. & Stewart, L.A. (2015)), No-Talk Therapy (Strauss, M. (1999)) and Evidence-Based CBT for Anxiety and Depression in Children and Adolescents (Lyneham et al. 2014). In addition to these
books I supplemented by research by searching on the University of Regina library database for online journals and articles. I completed internet searches for tools and resources to supplement the books and articles, as well as watching videos when available.

4.1.2 Objective Two

The second objective I identified was to gain familiarity with the services offered within the community that can provide further support to children, youth and adults. This objective was achieved by completing online research of community supports, reading community support handouts or pamphlets, consulting with my supervisor and colleagues and attending community education seminars. Knowledge of community supports was gained experientially as clients attended counselling and required different supports and referrals and therefore research was required.

4.1.3 Objective Three

The third objective I identified in my proposal was to gain experience working within a community based organization offering a wide variety of services to a diverse clientele. In order to achieve this objective I completed my practicum at an agency that employs counselling generalists where all counsellors are required to see a variety of different client groups, as well as clients with an assortment of different challenges. I expressed openness to my supervisor in taking referrals from a variety of funding resources, as well as from all backgrounds and family compositions. As a result, the three and a half months of my practicum were comprised of providing counselling to individuals, families and couples from varied backgrounds and with varied challenges and strengths. Due to my professional history working with children and families, I received the majority of clients in this category (i.e. approximately 60%) however also
engaged in counselling with a smaller portion of individual children and adults (approximately 30%) and couples (approximately 10%).

4.1.4 Objective Four

The fourth objective identified was to have opportunities to engage in building therapeutic relationships with children, youth, couples and families. As highlighted throughout the report, the therapeutic relationship as the primary goal and best indicator for success in therapy, identified in all of the therapeutic approaches I chose to study for this practicum (i.e. CBT, No-talk therapy and play therapy). Lyneham et al. (2014) stipulate that “evidence-based treatments assume that a strong relationship with the child and parent is critical” and that a client’s motivation throughout the treatment process is largely dependent on the bond they have developed with the counsellor (p. 63). As a result, I was aware that building therapeutic alliance would be my primary goal and not to move forward with counselling until this was achieved. In developing relationships with clients of all ages, it is vital to carefully consider the client’s cultural background and how this may influence forming the alliance (Lyneham, et.al, 2014).

Due to my history of providing clinical services to children and families I felt more at ease developing these relationships, realizing that I already had many engagement skills in my skillset that were effective. When building relationships with children, strategies I found successful included identifying and praising strengths (i.e. unconditional positive regard); use of reflective and validating statements; expressing genuine interest in the client and their experiences and engaging children and families in play and fun. I also found it effective to provide a warm and comfortable environment for counselling; showing my clients my humanness and imperfections and instilling hope for the future (Strauss, 1999; Lyneham et al. 2014). Despite feeling confident in the skills I possessed, I always remain aware of the fact that one of the greatest strengths in
developing relationships is the ability to tailor treatment to each individual and family you work with (Lyneham et al. 2014).

In developing relationships with individuals and couples, I found that conditions that fostered positive engagement were warmth, empathy, genuineness and humor (Shebib, 2007). I was pleasantly surprised with the effectiveness of my engagement skills translated from in-home clinical services with families to an office setting with children, individual adults and couples.

4.1.5 Objective Five

The fifth objective identified in my practicum proposal was to have the opportunity to develop clinical skills in providing counselling to children, youth and families from a strengths-based perspective, utilizing Cognitive Behavioural Therapy, No-Talk Therapy and Creative or Play based interventions. Providing counselling from a strengths-based perspective requires the counsellor to place their focus on identifying the client’s resources, skills and goals, and to search for strengths and solutions, rather than pathology and problems (Sharry, 2003).

Counselling from a strengths-based perspective aligns with the approaches utilized throughout my practicum and was a critical component of my identity as a counsellor. At this time I will highlight some of the experiences I had implementing these counselling approaches including the strategies I found to be effective and meaningful for clients

4.1.5.a Cognitive Behavioural Therapy

Throughout my practicum experience I had the opportunity to work with many children and adults experience anxiety and/or depression and this presented as one of the primary referral concerns for individuals and families. The first task I approached was to build a positive therapeutic relationship with the individual child or adult experiencing anxiety and/or depression (Lyneham et al. (2014). With adults, relationship development was generally achieved through
talking, allowing them an opportunity to share their experiences with me, while receiving my undivided attention, active listening, reflection to ensure understanding and empathy. Operating from a strengths-based perspective, I also spend time during relationship development exploring the areas of the individuals’ life that are going-well and the successes they have had in the past and present (Saleeby, 2012). With children, relationship development involves engagement in play or art based activities exploring their image of themselves, their family system, their social supports and likes/dislikes. Building a therapeutic alliance with adults can often be achieved in one session, however children occasionally require two or more sessions, paired with engagement activities at the beginning of each session.

Following the development of a therapeutic alliance, I developed an assessment on which therapeutic approach I felt would likely benefit the client. Developing an assessment included spending time exploring areas of concern or discomfort for the client, exploring their desired outcomes from counselling and goals for the future, and interviewing parents or caregivers when working with children. If I determined through my assessment that the child or adult was likely to benefit from Cognitive-Behavioural Therapy I would generally proceed at this time with the first step identified in Mindfulness-Integrated CBT, which is that of working on the clients’ personal experiences and calm-breathing and progressive muscle relaxation. The decision to integrate the first step of MiCBT is related to my experience that delving directly into psychoeducation regarding anxiety, depression and CBT (i.e. the first step in traditional CBT) is beneficial however can leave some clients feeling overwhelmed. As a result, I first focused on supporting the client in developing strategies to achieve relief from their anxious or preoccupied thoughts, and physiological symptoms related to such. In order to achieve this, I often introduced the idea of mindfulness-meditation or grounding techniques. I utilized a variety of approaches
depending on the age, developmental stage, engagement level and learning style. For children I frequently use short videos on mindful-breathing (i.e. 4-7-8 breathing) or short, interactive breathing activities (i.e. imaginary blowing up a balloon, blowing on a pinwheel or practice breathing with a stuffed animal on your belly). One of the other tools that I utilized with children is the book “A Handful of quiet: Happiness in Four Pebbles” (Hanh, 2012) which guides children through simple drawing, pebble or breathing meditation’s that can easily be replicated at home. In addition, I have also found it effective to read stories with, or to children such as “King Calm: Mindful Gorilla in the City” (Miles & Sweet, 2016) that focus on the concept of mindfulness.

For adults I utilized strategies such as mindful-breathing recordings, mindfulness-based phone applications such as “Breathe” and “Calm” and deep breathing and progressive muscle relaxation scripts. When willing, I engaged clients in relaxation exercises while in the office, or send them home with homework to try the different available strategies until they find one effective for them.

The second stage of CBT that I engaged clients in is psychoeducation around anxiety and/or depression followed by engaging clients in exploratory activities around their anxiety and discussing the concept of “self-talk”. When working with adult’s psychoeducation can resemble providing them with educational handouts or hosting discussion in the counselling room of their understanding of anxiety and/or depression. When working with teenagers I have often found it beneficial to complete activities from the workbook, “Beyond the Blues: A workbook to help teens overcome depression” (Schab, 2008) that explores the different causes of depression including family history, chemical imbalances and experiences of traumatic events throughout their life. When discussing CBT with youth it is critical to avoid the use of jargon and developmentally inappropriate language (Lyneham et al. 2014). The use of metaphors such as
developing “tools for a toolbox” and appropriate therapist self-disclosure are also noted to be effective in working with children and youth (Lyneham et al. 2014). In working with children, I often utilize activities, or variations of activities suggested by Drewes (2009) including cause-and-effect games (i.e. dominoes), modeling (i.e. teaching a puppet or doll about their difficulties) and reading stories about children who have difficulty regulating emotions such as “David and the Worry Beast” (Guanci, 2007).

Once clients have gained an understanding of anxiety and depression I move forward with bringing awareness to maladaptive, or negative thoughts, and the impact that such has on their emotions and behaviours. Both adults and children often struggle to identify their maladaptive thoughts in the counselling room as the situations have occurred several hours or days earlier (Lyneham et al. 2014). Using an example of a time where the clients’ symptoms of anxiety or depression became overwhelming and applying this information into a visual diagram showing the relationship between their thoughts, feelings and behaviours has shown to be incredibly effective with the clients I have served. For the purposes of my counselling sessions, I utilized a simple triangle diagram, with thoughts, feelings and behaviours identified as the three sides, drawn spontaneously with the client as I have found the use of a more formal tool unnecessary. In working with children, I have found it effective to modify language from maladaptive thoughts to “positive vs. negative thoughts”, “sunny vs. cloudy thoughts” or “helpful vs. unhelpful thoughts”, accessing suggestions from the child on what language they connect to most. I have also found and developed several interactive tools where children are required to work with the counsellor to sort thought examples into negative or positive piles, or match a positive thought with a negative one. Depending on the age and developmental stage of the child,
I have also drawn a simplified version of a CBT triangle illustrating the impact negative thoughts had on their behavior.

In introducing the concept of cognitive restructuring with clients I have found it beneficial to use situations or thoughts they have previously identified and work through thought challenging questions or activities in the counselling setting related to those. In working with children and youth, I modify language from cognitive restructuring to “changing our negative thoughts” or a simplified phrase easily understood by the child. One of the key strategies effective in cognitive restructuring is that of questioning or challenging our negative thoughts, or finding evidence to prove or disprove these thoughts. Lyneham et al. (2014) identified several beneficial thought challenging questions including: “what advice would you give your best friend if they had this thought?” “what do you think your best friend/mom/sister would say if you told them you had these thoughts?” or “if you were in this situation tomorrow, what do you think you would say to yourself?” (p. 165). In addition to these questions, I have found it helpful to spend time with adult and teenage clients exploring the idea of the “evidence” supporting or refuting the thought and whether the thought is true, partly true or entirely untrue (Sudak, 2012). One effective strategy in introducing cognitive restructuring for children is asking the child to identify several positive memories or “best days” in their lives, either verbally or having them draw pictures depicting these. Then exploring with the child questions such as “was everything perfect about this day?” and the idea that days and situations are rarely all good or all bad and dispelling the myth that perfectionism equals happiness (Drewes, 2009). Role-play and interactive play can also be effective at this stage, using negative thoughts the child has previously shared, announcing them yourself and then requesting the child tell you why that thought is wrong, and then switching roles until a strong, effective challenging statement is developed (Drewes, 2009).
Once clients have developed an understanding of maladaptive thoughts, and strategies to dispute or challenge these, focus in treatment includes troubleshooting difficult situations, homework for the clients including mood logs or thought diaries and supporting the client through their journey.

4.1.5. b No-Talk Therapy

The second approach that I utilized throughout my practicum was no-talk therapy developed by Martha Strauss. I was familiar with no-talk therapy from reading the book several years ago and attending training put on by Ms. Strauss in 2015. I had utilized strategies and approaches suggested in the book throughout my work to date however had not attempted to adhere to the model with rigor. This ultimately became a challenge for me as a counsellor and my adherence to this model of counselling was met with both success and difficulties. Therefore, in reviewing my completion of this goal, I will identify the components of this approach I was successful and unsuccessful in using in my practice and my analysis of why I believe this occurred.

The first component of no-talk therapy is to provide children with an opportunity to develop a healing relationship with a trustworthy adult in a place they perceive to be safe (Strauss, 1999). Following the suggestions of the book, my engagement strategies when using this approach include being fun and enthusiastic, such as playing games, coloring, drawing, and doing crafts. Sharing my childhood memories when appropriate such as some of my favorite activities and memories, as well as challenges I experienced. I also treated children with warmth and kindness, celebrating their successes and progress and empathizing for the pain and heartache. I developed relationships through sharing my imperfections, such as my messy desk drawer or mismatched socks, and was flexible and creative when my plan for the session needed to be modified or discarded in order to play, share frustrations or cry (Strauss, 1999). Through these strategies, I
found that I built strong, trusting relationships with many children, including some I thought I would never be able to reach.

One of the other central tenants of no-talk therapy is to celebrate successes for the children we work with (Strauss, 1999). Operating from a strengths-based perspective makes this tenant an area I am confident in. I frequently recall my first social work supervisor telling me that no matter what house or situation I walked into, my first instinct should be to scan for strengths. As a result of my experience and training, the first question I generally asked children when they come into my office is a variation on “what is going good right now?” or “what has been the best part of your week”. Beginning sessions this way frames them in a positive manner and encourages both myself, and child to focus first on success. I continue to focus on strengths throughout my sessions and therapeutic relationships, finding opportunities in play and crafts to celebrate achievement, and reframing parental concerns or frustrations to see the growth or areas to praise. My work with parents and caregivers often focuses on seeing positive in their children, and assigning homework such as identifying what the child already does well, and praising progress, no matter how small.

No-talk therapy also places focus on collaboration and accessing the support available for the child outside of the therapy relationship. No-talk therapy stipulates that the best chance of lasting success for the children we work with is through involving their community of supports, recognizing that even long-term therapy relationships rarely last longer than a few months or year (Strauss, 1999). In the past, I have strongly believed in the role of social workers and counsellors connecting children to formal and informal supports and would often utilize this as a primary intervention to families experiencing crisis. Despite these beliefs, in reflecting upon my practicum, I acknowledge that I was not always successful in achieving this. When children were
living with their parents, I ensure that parents attend the first session without the child in order for me to gain an understanding of the child and family situation, and provide the parents with suggestions and support. During this time, I will often inquire about the child’s involvement in extra-curricular activities as part of my assessment. On occasion, afterwards, I have followed up with parents to provide suggestions of community groups or activities I believe would be beneficial, however note, that this is an area I did not place enough focus. An additional challenge I have faced is the high number of referrals I receive from children in foster care or group home placements. These children presented as challenging at times, due to their frequent movement from placements and historical experiences making them hesitant to attach to myself or other supports. I acknowledge that my focus in working with children was too narrow at times, and that involving the formal and informal supports in my counselling process likely would have proved beneficial for many of these children.

Another concept crucial in the no-talk therapy concept is that of “no-problem therapy” under the basis that children are uncomfortable discussing their problems, often fear they are in trouble and are confused by our intentions asking these questions (Strauss, 1999, p. 132). The concept of deliberately avoiding the discussion of problems can be challenging for therapists and parents alike. Parents often doubt the efficacy of therapy when the therapist does not yet know “the problem” (Strauss, 1999, p. 137). No-talk therapists are required to undertake a difficult task of balancing their own need to achieve outcomes, the expectations of the parents or caregivers and following a counselling model that works best for the child. As a novice counsellor this area was particularly difficult for me. I introduced the idea to all parents that I would spend much of my sessions engaging in play, crafts and games with their children and received responses ranging from acceptance and understanding, to insistence that therapy is expensive and time consuming.
and therefore time should focus on achieving outcomes. At times I pushed children into discussing problems earlier than they were ready and experienced the “consequences” of such including them shutting-down, becoming angry and refusing to return. At times of course, the outcome was not so bleak, and children were comfortable discussing problems and together we developed and implement solutions. In reflecting upon my counselling experience, I recognize the importance of being assertive with parents, recognizing my knowledge and experience as a trustworthy guide, and requesting that parents allow trust in this process as well.

Utilizing the no-talk approach the following recommendations are made to terminate counselling effectively. Strauss (1999) recommends utilizing softer language including the word commencement or graduation to describe the end of a counselling relationship. No-talk therapy describes that a rite-of-passage ceremony involving the important people in the child’s life can be a positive and memorable termination. In addition to these Strauss (1999) recommends “open-door” terminations in which the child is invited to return at any time or describing that a “vacation” or “extended vacation” from counselling will be taken and therefore returning to therapy will not be seen as a failure or disappointment. When counselling cannot end in a planned manner for any number of reasons (i.e. sudden move, child does not return etc.), Straus (1999) recommends sending a good-bye letter or email to celebrate successes and share contact information. During my practicum, I experienced a variety of termination scenarios including planned terminations due to a move or completion of therapy, planned breaks or “vacations” from therapy and unplanned terminations due to the child not returning. When planned terminations occurred I avoided the use of the word “termination” and often spoke with the children about the progress made and therefore were going to take a break from counselling, which often followed a process of distancing appointments further and further apart. When
children moved or were unable to “leave the door open” to counselling, I completed termination activities such as collages to commemorate our experience together, exchanging handmade bracelets or art and providing the child with a journal with favorite memories and encouragements for the future. Unplanned terminations were frequent during my practicum and I faulted in following through consistently via letter or email however, on the occasions where I was successful found positive outcomes including receiving email updates or asking for referrals for on-going support.

4.1.5.c Play Therapy

The third approach I utilized during my practicum was that of play therapy or creative approaches to therapy. Due to my belief that all children and youth benefit from the integration of some level of play in their counselling experience, this was an approach frequently used in collaboration with other counselling approaches. The use of play in counselling is centered on the belief that the relationship between the counsellor and child is the primary healing factor, and that the use of play allows the opportunity for children to develop a safe relationship (Crenshaw & Stewart, 2015). Play is a child’s natural medium for communication and therefore they are able to express themselves and their feelings with more ease and openness, creating opportunities for development and growth (Crenshaw & Stewart, 2015). It is important to note that there are several different specific theories of play therapy, and becoming a “Registered Play Therapist” requires lengthy training and supervision, and therefore distinguish that I practiced counselling with the incorporation of play and creativity and not as a “play therapist”. Some of the key components of play therapy that I adhered to during the use of this strategy included: providing a safe relationship and environment conducive to the child’s growth, being non-directive in play allowing the child autonomy and self-sufficiency while being an active participant alongside the
child (Crenshaw & Stewart, 2015). Play therapy believes that children will naturally strive
towards growth and independence and therefore structure in play is not required. In order to
provide a safe environment for children I set up my office in a warm, child friendly manner with
toys, colouring materials and games displayed and within reach for children. I allowed children
the freedom to choose activities within the counselling setting and would often allow children
independence within these activities (i.e. allowing them to draw or make whatever they chose out
of playdough). I aimed to provide children with a variety of options for play that lacked structure
(i.e. blocks, playdough, colouring materials and cards) allowing children to guide the play in the
direction they chose.

Another key component of play therapy is for the counsellor to communicate with the child
their empathic understanding and unconditional positive regard (Crenshaw & Stewart, 2015).
Unconditional positive regard is warm acceptance of all aspects of the client’s experience
without judgment or evaluation and involves the therapist’s trust in the child’s ability to move
forward (Crenshaw & Stewart, 2015. The provision of unconditional positive regard, closely ties
to my personal values of being strengths based and therefore was easily incorporated into my
counselling. It was with ease that I found strengths within the child’s play and creativity and
acknowledged and celebrated achievements such as building a tower out of blocks or finishing a
snowman out of playdough.

Specific objects or toys suggested for play therapy include real-life toys to play out actual
experiences, acting-out/aggressive toys for creative expression and toys for creative expression
and emotional release to allow for unstructured and expressive play (Crenshaw & Stewart,
2015). Due to being new into the profession, I relied on already available or affordable options
for toys. I had available to me problem solving toys and purchased stress balls and fidgets that
allowed for squeezing, hugging and opportunities for emotional release. I had a couple of dolls available for real-life toys, and also encouraged children to draw and make “paper-dolls” themselves of important people in their lives that were used for acting out real-life experiences. Acting-out and aggressive toys I utilized included stress balls and sensory balls, playdough and blocks with the ability to build and then break such.

I also incorporated different games that I discovered explored coping strategies and impulse control including Jenga, Uno and Dinosaur Dice. At times, I found it beneficial to incorporate more structured creative strategies, particularly for older children or adolescents and therefore I utilized activities such as Jenga was corresponding questions about feelings, having children and teenagers draw pictures of their families and drawing feelings wheels.

4.1.6 Objective Six

The sixth objective identified in my practicum proposal was to have opportunities to engage clients in on-going community resources and engage in the termination process with counselling clients. As previously discussed, I had several situations that arose that led to termination of the counselling relationship including the client moving, the client and I agreeing that goals had been achieved and therefore termination could occur and clients not returning for counselling.

In situations where the client moved, and this was known for one or two sessions prior to termination I focused on connecting the client to on-going services in their new community. This included counselling when available, or providing them with information on how to access support from local non-profit or government agencies when required. The termination process with these clients was structured and included the completion of a termination activity with children and teens including an arts-based activity done together, discussing the successes and growth in counselling and providing the client with a small memento to recall their experience in
counselling. With adults, termination included a reflection on their growth during counselling and completion of a feedback survey regarding their experience.

With children and adults, where it was agreed upon by myself and the client, that goals had been achieved, and therefore termination should occur, this was also done in a structured and supportive way. With most clients I was able to have them leaving counselling feeling positive about their experience, and also willing to return if they feel they need to in the future. I avoided the use of words such as “termination” or “closing your file” and instead state that “the door is left open” and they are welcome to return at any time. Often times I felt that clients would benefit from a “check-in” several weeks or months later and therefore suggest this and encouraged them to book this session prior to leaving in order to feel connected still to the counselling relationship. At times, I felt that these clients would benefit from connection to an alternative form of counselling including support groups or couples counselling when working with individuals.

Termination with clients who do not return to counselling was something I experienced often during my practicum. On occasion, I would recognize that this had occurred and reach out to ensure that all was well and that they were aware they could return should they desire. However, more often I was unaware until the time came to close the file that the client had not returned and therefore no formal termination process occurred.

4.1.7 Objective Seven

The seventh and final objective identified in my practicum proposal was to provide a critical analysis of counselling services at Catholic Family Services and become familiar with clinical social work in a non-profit organization. This objective was achieved through completing my
major practicum hour requirements at Catholic Family Services and by completing this practicum report.

4.2 Goal Two

The second goal of my practicum was to gain experience utilizing the counselling models of Cognitive Behavioural Therapy, No-Talk Therapy and Play Therapy. This goal was achieved through providing individual and family therapy accessing skills and strategies from these approaches as detailed in the previous section of this report, titled “objective five”. My experience providing counselling from these approaches was challenging yet beneficial and I gained the skills necessary to feel confident utilizing these approaches within a counselling setting.

4.3 Goal Three

The third goal identified in my practicum proposal was to learn how to effectively respond and integrate supervisory feedback and guidance. The role of both individual and group supervision was critically important to my success during my practicum.

Throughout my practicum experience I engaged in once-weekly individual supervision with my professional associate. This individual supervision was one hour per week and focused on exploring my practicum goals and steps being taken to achieve such, as well as case consultation and exploration. Throughout the first month to six weeks of my practicum, clinical supervision focused on developing confidence in my skills as a counsellor, integrating theory into practice and problem-solving challenges and celebrating successes. My supervisor provided me with praise and encouragement to feel confident in the skills I already possessed, and provided me with suggestions and strategies when I felt I was skill deficient in an area. My supervisor’s approach was strengths-based, reassuring and encouraging and therefore I felt supported and
non-defensive to feedback allowing me to easily integrate suggestions into my practice. On one-occasion, I sought supervisor guidance when I felt that a couple I was working with needs went beyond my capabilities and I received support to transfer this file to another, more seasoned counsellor. On other occasions, my supervisor gently pushed me to continue working with clients, reaffirming my skills and confidence I would achieve success.

The second component of clinical supervision was once monthly group supervision. This supervision was led by my professional associate and included the four-generalist counsellors and the three school counsellors employed at Catholic Family Services. This supervision involves a combination of structured and unstructured time, including education by counsellors who recently attended or participated in workshops or on-going education opportunities, followed by case consultation and self-exploration questions. Education provided by my colleagues included information on Emotionally-Focused Therapy and crisis support training.

The case consultation component required each counsellor to come prepared to discuss a difficult case that they felt they would benefit from support from the group. Due to time constraints, generally one or two cases were discussed at each supervision session. I found the process of bringing a case to discuss incredibly beneficial as it allowed me the opportunity to receive feedback from counsellors with backgrounds in psychology, marriage and family therapy, social work and addictions degrees. I experienced a consistently supportive and non-judgmental environment from the other counsellors and therefore felt comfortable asking questions and integrating feedback. Group supervision concluded by each counsellor answering the questions: what impacted you today, how are you feeling and, what are you doing for self-care coming up. These questions conclude the group supervision by focusing on individual growth, self-reflection and self-care.
4.4 Chapter Summary

This chapter has reviewed my practicum goals and objectives in detail. I first outline my practicum goals and then the objectives utilized in order to achieve these goals. I was able to successfully achieve the goals of my practicum through researching counselling methods, experiential learning in the counselling setting and by accessing individual and group supervision.

Through the process of achieving my practicum goals and objectives several themes emerged as relevant to my practicum experience.
Chapter 5: Emerging Themes

This chapter explores the themes that emerged during my practicum experience and how they impacted me personally and the counselling I provided to my clients.

5.1 Mindfulness

Throughout this report, the theme of mindfulness has appeared several times. Prior to beginning my practicum, I had become aware of the concept of mindfulness through university courses, as well as minimal knowledge through research. Once I began working with children, youth and adults experiencing a variety of challenges including anxiety and depression, emotional regulation, experiences of trauma, anger management and relationship issues that all involved feeling heightened emotionally.

Through experience, I learned that those heightened emotionally were unable to utilize the calm, problem-solving part of their brain (Pederson, 2015) and therefore they were experiencing distress in their personal relationships with partners, friends and children, as well as issues at work and interacting with the public. I found that I was unable to talk about underlying concerns, or use strategies I knew to be effective until I had supported these individuals in learning strategies to settle their physiological symptoms and slow their thinking patterns. In researching emotional regulation or calming strategies, my search brought me to resources on mindfulness, and found that simple mindfulness practices like calm breathing and progressive muscle relaxation became a strategy I used in almost every counselling relationship. With children, I found that the basic concept of mindful-breathing, with the assistance of visuals was often enough to provide them relief from symptoms they described as “butterflies in their stomach” or “their heart beating out of their chest”. With children, the concept was often new and novel and
through role-play and practice, I saw many children begin to use strategy for anger, anxiety and hyperactivity.

When exploring the idea of mindfulness with adults I generally encountered two responses. The first response was often that this was a new concept to them and they were enthusiastic to implement anything that would provide them relief from their physical and mental symptoms. The second response was that they had heard of the concept but were not interested due to believing it was a form of meditation or yoga and would not be effective for them.

With clients enthusiastic and willing I would often engage in strategies within the counselling session, at times when they were emotionally regulated as practice, and at times when things became heightened and they would benefit from slowing down. I provided homework to these clients including daily progressive muscle relaxation, often for sleep issues, and use of basic grounding techniques when overwhelmed. These clients often reported immediate relief from using the strategies and I was then able to integrate concrete strategies such as CBT at this time.

For clients who presented as unsure or resistant to the idea of mindfulness I often shared with them alternatives to calm breathing and progressive muscle relaxation such as guided meditations on the internet, or phone applications that had guided meditative walks or simple grounding techniques observing your environment. My experience was that through sharing my personal experiences with mindfulness and encouraging these individuals to find a form of mindfulness that worked for them, that most eventually found peace in slowing down at least once a day, observing their environment or breath and recognizing the physical symptoms in their body.

5.2 Mindfulness and Me
As previously mentioned, prior to my practicum placement I had little experience or exposure to the idea of mindfulness. I recall having two or three presentations throughout my master’s program in which people explored guided meditation however; it was not a concept that resonated with me. My opinion of mindfulness changed greatly when I began to see the effectiveness it had with my clients, but also for myself. Going through the practicum experience was one that was difficult and anxiety producing at times. I was nervous before first sessions and felt overwhelmed at times bearing witness to the stories shared with me. I noticed my sleep patterns became unhealthy and I was often bouncing my leg while writing notes or driving home. On one particular day, I received a call from a client who disclosed a traumatic incident just as I was leaving work. While driving home I realized I was experiencing significant signs of anxiety including a racing heart, difficulty sitting still, a churning stomach and difficulty taking deep breaths. Once I got home, I recognized that I needed to do something to calm myself down, and therefore turned to the guided meditations I had suggested to a client. That night I participated in some form of mindfulness for over an hour until I could feel my body and mind settle. I began using mindfulness strategies before sessions when I felt myself becoming nervous, taking two or three deep breaths and experiencing instant relief. I began using grounding techniques during sessions if a client’s story connected to me on a personal level and I felt my mind wander or body respond to the memory. I began using a guided meditation each night to fall asleep that wiped away the stress of the day and allowed me to sleep peacefully.

5.3 Chapter Summary

Mindfulness played a significant role in my practicum placement. Through my work with children, youth and adults I learned that many individuals benefit from practicing mindfulness for a variety of personal challenges and the implementation of simple mindfulness techniques
can significantly impact an individual’s well-being. As a result, I can say, that mindfulness has had a huge impact on both my personal and professional life, and it helped me to address the challenges that I faced in my practicum placement.
Chapter 6: Challenges

During my practicum placement I experienced a number of challenges as a professional and in my personal life. These challenges, as well as the attempts I made to navigate such, are detailed in this chapter.

The first and most prominent challenge I experienced during my practicum placement was adhering to the confidentiality and conflict of interest components of my Code of Ethics. The following section provides a discussion on my experience with this.

6.1 Confidentiality and Conflicts of Interest

One of the first and most prominent challenges I experienced in my practicum was the experience of living and being a counsellor in a small city, and the issues around confidentiality and conflicts of interest that arise because of this. The CASW Guidelines for Ethical Practice (2005) state that “Social workers inform clients when a real or potential conflict of interest arises, and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary” (p.11). During my social work practice prior to my practicum, I was working in Regina and with a large amount of clients that travelled to be a part of the program from different cities and provinces. As a result, I rarely saw clients outside of work or after our involvement was over. Upon beginning my practicum in Prince Albert, I knew very few people in the city and therefore felt issues around conflicts of interest would not occur. At Catholic Family Services, one of the forms completed at the time of intake is titled “Clients Rights and Responsibilities” which outlines the clients right to confidentiality, as well as our agency’s policy that I will not acknowledge them should I see them in public. These policies ensure the client’s right to keep their attendance at counselling confidential from friends at family members. Unfortunately, I learned quite quickly that my few connections to Prince Albert through my partner and
stepchildren meant that I encountered clients regularly at their school, on their sports teams, in their friend circles, at their workplaces and in social settings. At times, I was able to easily avoid conflicts of interest, such as when referrals were sent for friends of my stepchildren, and therefore I could flag this and have the child be seen by another counsellor. Other situations presented as greater challenges for me, such as discovering that my stepchildren were friends with an existing client of mine, and having this friend come up to speak with me at school concerts or events. In addition, I experienced having my stepchild join a sports team that an existing client of mine was on and was, therefore, seeing them several times a week at practices and games. I also encountered situations where I found out after the counselling relationship had begun that a client worked with my partner. Finally, I joined a sports team myself, and then found out that an existing client of mine was also on the team. In situations where conflicts of interest arose once the counselling relationship was established, I followed the guidelines of ethical practice and discussed these conflicts with the client, allowing them the opportunity to explore with me what decision would be in their best interests and comfortability outside of the counselling relationship. In situations where I discovered I would be seeing a child client repeatedly at my stepchildren’s sporting events, I ensured that they were aware their confidentiality would be maintained at all times and provided them with options that included: seeing another counsellor, taking a break from counselling until the activity was over and continuing counselling if they felt comfortable. In the situation where I had joined the sports team, I discontinued my involvement and apologized to the client at the next session for the conflict for them.

In addition to concerns regarding conflicts of interest, I struggled with the concept of confidentiality and working with children. The CASW Guidelines for Ethical Practice (2005b)
outlines that “Social workers who have children as clients determine the child’s capacity to consent and explain to the child (where appropriate), and to the child’s parents/guardians (where appropriate) the nature of the social worker’s relationship to the child and others involved in the child’s care” (p.4). CASW does not clearly outline a specific age in which children have the right to the same levels of confidentiality as adults (i.e. 16 or 18), and in researching there is not an age established by the Advocate for Children (Advocate for Children and Youth, 2012). In our society, there is an expectation that parents and guardians have the right to full access to their children’s medical and school records and therefore parents occasionally come to counselling with this same expectation (Webb, 2011).

Upon beginning my practicum, I asked my supervisor about what age children have the right to exclusive confidentiality from their parents and what the agency’s position is on this. In speaking with him, as well as my colleagues, that there was agreement that any client over the age of 16 was able to attend counselling without parental consent and had full rights to confidentiality, however I received varied answers regarding children under the age of 16. Within my agency, some counsellors indicating children over the age of 12 had a choice in this matter however they shared everything for children younger than 12 and some indicating that children of all ages had the right to total confidentiality with the exception of duty to report items. The CASW Guidelines for Ethical Practice (2005b) state, “Social workers may wish to reserve the right to disclose some information provided by a young child to parents when such disclosure is in the best interest of the child. This should be declared prior to the first session with a child” (p.7). In following the CASW guidelines, I determined that guidelines around confidentiality would be a discussion with children of all ages and their parent or caregiver at the time of intake allowing an opportunity for both child and parent expectations to be discussed.
With young children, I identified that the sharing of information that gave parent the opportunity to support the child at home would be beneficial, however non-essential information need not be shared. In order to reassure children with concerns regarding confidentiality I initiated the practice of reviewing with all children any information I planned to share with parents prior to doing so, in order to get their consent. In addition to ensuring all children were aware of the information that would be shared, I also provided them with the opportunity to share this information themselves or participate in the conversation with the parents and myself. With children between the ages of 10-16, I presented the opportunity for the child/youth to express their desires related to confidentiality. At times this resulted in them identifying that they did not want any information shared with their parents. In these situations, I respected the wishes of the child, however within our therapeutic alliance continued to explore how inclusion of their caregiver could benefit them and their home situation. In situations where I counselled a child who was living in a group home, emergency receiving home or foster home, I allowed them greater control on the limits of confidentiality based on the level of connection they had with their current placement or caregiver.

I encountered one situation in which a minor client expressed to me at the time of intake that they desired complete confidentiality from any information being shared with their parent/caregiver. The client shared with me that they had had past experiences where a therapist had shared information with the caregivers, which they had disclosed to the therapist in confidence and it had severed the individual’s trust in the therapeutic relationship. As a result of the client’s experience I agreed to confidentiality with the exception of issues related to harm to self or others. Over time, the client and I worked together to develop ways of sharing information with their caregivers that was within their comfort level. These included writing letters, sharing
information I provided, hosting a phone call in my office and ultimately, after developing a list of things that would be discussed, they agreed to have the caregivers participate in a session.

6.2 Confidence

The second challenge I experienced in my practicum was related to confidence. As a new counsellor, I struggled with several negative beliefs related to how clients would perceive me that greatly impacted by ability to feel confident within the counsellor role. These beliefs included that clients would expect their counsellor to be older than I am; that clients would expect their counsellor to have more education or experience than I do; and that clients expected a counsellor to have different life experiences then I do. As a result of these notions, I often approached new counselling relationships feeling insecure and prepared to receive feedback that reflected my insecurities.

In taking new referrals I frequently advised my supervisor that I did not feel confident taking clients whose issues were complex such as trauma, or that I was best-suited to counsel children as I had background in these areas and not in counselling with individuals or couples. As a result of having a reduced caseload, I also took on the responsibility of completing phone intakes with new clients. Part of this process is to inquire whether the client has a preference in seeing a male or female counsellor. At this point in the intake, clients will occasionally share other preferences such as seeing the counsellor with the most experience, or seeing a counsellor who is older than them. These conversations led to reinforce my beliefs that I would not be a desired counsellor for many, while discounting the individuals who asked for someone young who they felt would connect well with their child or teenager, or the many individuals who expressed no preference due to feeling all counsellors were qualified.
I shared my concerns and thoughts with my supervisor, who encouraged me to reflect on my research and training. My supervisor challenged me to rely on what I know, that forming a therapeutic alliance was one of the greatest determinants of success in counselling, not the counsellors degree, years of experience or life experiences. I was required to rely on the CBT strategies I knew to be effective with clients including thought challenging questions and examining the evidence. I challenged irrational thoughts that all clients desired someone who was older or more experienced, with questions such as “what would I say to a colleague if they said that to me?” and “what evidence do you have that proves or disproves that thought?” I sought critical feedback from clients who were children, youth and adults on whether they felt listened to, understood and supported in their counselling relationship with me. Results of which showed my skills were beneficial to not only children and teens, but also adults both younger and older than I. When clients asked questions at the time of intake regarding my education, years of experience or personal life I answered honestly and found that the majority of clients asked out of interest, rather than a concern that I was unqualified. On occasion I still encountered a client who expressed a desire to see someone with specific criteria I did not meet (i.e. older, married, many years’ experience counselling) however my confidence grew and therefore I was able to prevent myself from internalizing this as a flaw with me and rather recognized it as a preference of theirs.

6.3 Self-Care

The area of self-care is something that has been emphasized throughout my social work education and career to date. According to Eckstein (2011) self-care is a broad term referring to any actions or experiences that enhance or maintain a counsellor’s well-being. My experience with self-care while in my education centered on identifying and understanding your emotions,
stress-levels and ways to manage such. In my practice prior to my practicum I admit that self-care was frequently spoken about and yet rarely practiced. When I did engage in self-care it was primarily reactive such as taking a bath after a particularly hard day, or engaging in individual counselling after a death of a client, however I struggled to implement any regular self-care practices and therefore frequently felt impacted by my work.

When beginning my practicum I consciously made the decision to establish a new way of treating myself in order to be the most effective counsellor I could be. At this time I ventured to implement basic self-care strategies that I knew to be beneficial in maintaining well-being including eating a balanced diet, exercising on a regular basis and getting enough sleep (Adamson, Bradley, Kress & Whisenhunt, 2013). I noted these strategies to be valuable, particularly in their absence, acknowledging I would find it difficult to remain focused and attentive after eating fast-food or staying up later than usual.

What I did not anticipate however, was that engaging in counselling appeared to be impacting me emotionally much more than I expected. I noticed within a month that I was more irritable on a daily or weekly basis than usual, was quick-to-tears in my personal life and was often having a hard time distancing myself from work in the evenings, feeling preoccupied with client situations or remaining emotionally impacted by difficult stories. I recognized at this point that continuing down this path was both detrimental to me and my relationships, as well as to my clients. Research indicates that self-care is required to prevent counsellor burn-out and when counsellors experience impairment as a result of lack of self-care they have a less ability to provide quality care to their clients (Adamson et.al, 2013).

What I realized at this time, was that basic self-care, and reactive self-care would no longer be enough for me to be in a counselling role. I began to attend individual counselling focused on
my experiences as a counsellor, and need for increased self-care. I was referred to the book “Rising Strong” by Brene Brown and encouraged to do further research on what self-care could mean for me. In reading “Rising Strong” I learned of my own experience with vulnerability and fear, and my belief that showing such to the world meant I couldn’t or shouldn’t be in the helping profession. I grappled with my own experiences of self-doubt and shame and recognizing that by denying or disowning my difficult stories in order to appear more whole or acceptable, I was actually preventing myself from achieving wholeheartedness (Brown, 2015). I began to integrate Brown’s theories into my life including recognizing the power of vulnerability, acknowledging my need for support in my own journey and knowing the strength is asking for help and knowing you are imperfect (2015).

Through my own personal exploration, as well as with the support of my counsellor, I have begun to integrate self-care in a meaningful way into my life. Self-care to me means taking care of my basic needs (i.e. eating well, sleeping enough, movement), but also means incorporating creativity into my life as a form of expression and spirituality. Self-care for me means knowing my limitations and being brave enough to set boundaries when they are met. Self-care also involves a network of support including my counsellor, my friends and family and my colleagues.

6.4 Chapter Summary

The challenges I experienced in my placement included difficulties with confidentiality and conflicts of interest, difficulties feeling confident in my counselling role and difficulties establishing and maintaining appropriate self-care. I learned a great deal from the challenges I experienced including that counselling is a difficult yet beneficial career choice that involves a great deal of personal and professional reflection on an on-going basis. Going forward in my
counselling career I am aware of the need to prioritize self-care including exploring my confidence as a counsellor, and maintaining adherence to the professional Code of Ethics, while recognizing areas requiring my discernment and professional judgement.

The challenges I experienced during my practicum led to significant personal and professional growth and ultimately made my placement a positive experience with positive implications of this practicum on my future as a social worker.
Chapter 7: Conclusion

This chapter concludes my discussion about my field practicum experience as a practicum student at Catholic Family Services and provides final thoughts regarding my future as a social work practitioner and reflections regarding the future of social work practice. This report provides an overview of the agency Catholic Family Services, their services and values. It provides an overview of the counselling approaches Cognitive Behavioural Therapy, No-Talk Therapy and Play Therapy, as well as my experience implementing these approaches into my counselling role as one of my practicum objectives. In addition, my goals for my practicum placement included gaining experience providing individual, couples and family counselling within a Community Based Organization to children, youth and families and learning how to effectively integrate supervisory feedback and guidance. These goals were achieved through the 450 hours spent at Catholic Family Services engaged in counselling, individual and group supervision. I outline the seven practicum objectives identified in my practicum proposal and how these objectives assisted me in reaching my overall practicum goals. I discuss my personal and professional values and how these both align and conflict with those of Catholic Family Services at times. This report also includes a discussion on the themes that emerged during the practicum as noteworthy in my counselling and my personal experience. Finally the report explores the challenges I faced during my placement and how these were navigated for an overall positive experience. I conclude this report by discussing how this experience will impact my future as a social worker.

The experience of being a practicum student at Catholic Family Services, as well as the process of completing this paper were an invaluable experience for me. I feel thankful for the opportunity to devote significant time before and during my practicum to research, which ignited
a passion in me to continue growing my skills and knowledge. My practicum experience inspired me to continue developing my skills in providing counselling from a strengths-based approach to children, youth and adults and served as a reminder of the passion I have for helping children and families. I feel inspired to continue growing my skills in providing play and arts based interventions to children and youth and recognize the benefit that unstructured, play based counselling can have for children. I feel inspired to continue building my skills in providing CBT to children, youth and adults, and believe in the central tenants of identifying and modifying maladaptive thoughts.

My practicum experience provided as a significant learning opportunity for my own emotional well-being and health. I can happily say that I now understand more about myself, my emotions and my self-care needs than I did when I began this process, and I look forward to continuing that growth through self-exploration, reading and counselling. My practicum experience taught me the importance of practicing self-care as a preventative strategy, and recognizing that in order to have a long and successful career as a social worker, proper self-care is required.

Lastly, I learned a significant amount about counselling from a variety of approaches, and significantly enhanced my repertoire of counselling skills through my field practicum. I would recommend a counselling and therapy placement to any individual seeking to gain increased theory, skills and knowledge about counselling and looking to provide therapeutic services to individuals within their community in the future. My experience at Catholic Family Services was overwhelmingly positive and I know my practicum experience was enhanced through the support and supervision I received.
References


Xie, H. (2013). Strengths-based approach for mental health recovery. *Iran J Psychiatry Behav*
Sci: 7(2), 5-10.