Children’s Mental Health Services: A Practicum Report

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Abstract

This report provides a critical review of my field practicum experience as a Master of Social Work (MSW) student at Children’s Mental Health Services within the Saskatchewan Health Authority. The focus of this field practicum was to work within a multi-disciplinary team to provide services to caregivers and children from birth to 11 years of age experiencing mental health challenges. This 450-hour field practicum was completed over 12 weeks under the supervision of my Professional Associate, a clinical social worker. I carried a small caseload of children and their families and provided direct counselling services and initial assessments. Included in the report is a description of the agency, my practicum goals and activities, a literature review, a reflection of theories which shaped my practice with discussion reflecting on ethical social work practice. I conclude the report with a reflection on my professional growth over the 12 weeks of my field practicum placement.
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Chapter 1: Introduction

Early in my social work career, I discovered my passion for working with children. Prior to entering the social work field I would never have imagined working with this population; instead, my professional goals included working with adults who experienced mental health challenges and concerns. While working as a child and youth care worker in a group home setting, I realized the impact of mental health concerns on young children. The young children I worked with often struggled with self-regulation skills, conduct disorders, and attachment-related issues. It was apparent that their mental health difficulties impacted their daily lives and contributed to their difficulties in navigating relationships with peers, family, and group home staff. Oftentimes, their mental health challenges significantly impacted their experience at school; it contributed not only to academic challenges but also in their peer relationships. As a staff member who spent a significant amount of time caring for and being with the children, it was difficult to watch them struggle through their daily activities, routines, and lives.

Many, if not all the children were connected to mental health service providers who were able to assist the children and provide staff with behavioural management information and techniques. This experience allowed me to observe how the combination of medication, behavioural management techniques, such as consistency and attention on the part of the staff and the child’s development of self-regulation skills, could often positively impact the mental health of the children I worked with. For example, I observed that many of the children were able to live their lives with more joy and playfulness and live up to their full potential.

The experience of being a part of children’s healing and growth was powerful and created a desire to be involved further in the lives of children experiencing mental health-related challenges. This desire led to my goal of pursuing a field practicum in children’s mental health
and specifically a placement at Children’s Mental Health Services (CMHS) within the Saskatchewan Health Authority (SHA). An additional motivating factor for pursuing a field practicum within CMHS was the use of Animal Assisted Therapy (AAT) by the Pet Therapy Team. This team is comprised of social workers and a psychologist incorporating an animal in the provision of clinical services to children. I was first introduced to AAT as an approach to practice during my time working in group care. Additionally, I worked with children whose therapeutic interventions included the use of Animal Assisted Interventions (AAI). I was able to see the positive impact and value that AAT and AAIs can have on children. Although animal assisted interventions were not a focus of my actual placement experience, it is important to mention that offering this innovative approach within Children’s Mental Health Services was one of the deciding factors to pursue this placement setting. The combination of my interests in working with children with a focus in the area of mental health and the use of AAT led me to the SHA, CMHS, and my Professional Associate. My Professional Associate and her therapy dog are an important part of the team at CMHS and work to meet the mental health needs of numerous children. I was able to shadow my Professional Associate and Kona during multiple sessions with children presenting with different mental health needs. The experience of witnessing the impact therapy dogs can have on children was truly invaluable.

I completed my MSW field practicum from April 17, 2016, to July 8, 2016. This report includes an overview of the placement agency, my field practicum, and a literature review focusing on childhood anxiety, parental challenges and influences on children, and the impact of parental brain injury on children. I then discuss my practice values and ideological beliefs as well as the integration of theory and practice. I also present several therapeutic approaches that helped shape my practice. The report concludes with a discussion of ethical social work practice.
and a self-reflection on the placement experience. Ethical practice also includes ensuring that client confidentiality is respected, therefore this report does not include identifying information in the examples shared.

**Placement Setting**

My field practicum placement was in the CMHS program within the Child and Youth Program, Mental Health and Addictions Services department with the Saskatchewan Health Authority. During my practicum placement the CMHS program fell within the Saskatoon Health Region. However, in December 2017 the twelve Regional Health Authorities were integrated into one organization, the Saskatchewan Health Authority (SHA). I have chosen to use the current name throughout my report to reflect the provincial change. This reorganization was related to working towards unifying the health system and improving patient care. During this transition there were no changes to health care programs, services, facilities, or phone numbers to ensure access to health care services was not impacted (Saskatchewan Health Authority, 2018). The Health Authority has various sub-departments, including Mental Health and Addiction Services, which is also separated further into Child and Youth Program and Adult Mental Health and Addiction Services. The CMHS is a public service therefore service users are not required to pay fees as this is covered through provincial healthcare (Saskatchewan Health Authority, 2018).

A multidisciplinary team provides services to children from birth to 11 years of age (and their caregivers) who are experiencing a wide range of mental health challenges or concerns, typically identified by a parent or caregiver. Examples of presenting concerns include: aggressive or oppositional behaviour, anxiety, attachment issues, attention difficulties, depression, impacts of abuse, non-intentional self-harm, parenting difficulties, social and
emotional concerns, suicidal ideation, and trauma. The services offered include a range of assessments including: behavioural, family, psychological, social/emotional, speech and language. Additionally, therapeutic services include: behaviour management, family therapy, group therapy, individual therapy, and case management (Saskatchewan Health Authority, 2018). The team provides specialized services including Art Therapy, Play Therapy, AAT, and Neurosequential Model of Therapeutics (NMT). The team of professionals is made up of social workers, psychologists, psychiatrists, speech and language pathologists, recreation therapists, nurses, mental health therapists, and daycare behaviour consultants. Psychiatrists are available to the team for consulting purposes.

To access services, caregivers can connect with centralized intake by calling the phone number available on the SHA website. Following this first point of contact, a phone call is scheduled with caregivers to explore the concerns presented or the reason for the referral. This initial screening is useful in determining the appropriateness of services. If a referral is required to other existing programs or services, then parents and caregivers are provided with this information. Initial referrals can also be made by other service providers, such as a school social worker. After this screening information is gathered, the child’s parents or caregivers are contacted by centralized intake to ensure they are aware of the referral and obtain their observations. The team must be able to refer to other available services should they be more appropriate for an individual or family. Additionally, if parents have coverage through their employer benefits, they are often encouraged to access services available privately to limit their waiting time. There is a high demand for mental health services which can challenge existing mental health supports available in Saskatoon. However, SHA has made a commitment to triage services and ensure all those referred are seen by a psychologist or social worker within 30 days.
This requires the team to come together to assess caseload and wait list demands and address wait list times. Despite the challenges of both high caseloads and peak referral and intake times, the commitment to effective, appropriate, and timely services to meet the needs of children and families is evident.

**Practicum Goals and Objectives**

The overarching goal of the field practicum was to work with children and their families who have diverse mental health needs or challenges. More specifically, the goal of this field practicum was to gain advanced social work knowledge and practical experience in clinical counselling with children up to the age of 11.

To best meet these goals, I outlined learning objectives, which included specific activities. The objectives were intended to deepen my knowledge and understanding of the mental health challenges children and their families or caregivers experience, and to develop advanced mental health clinical experience and skills. Additional objectives included building on my existing assessment skills, developing knowledge and skills around creating case plans, and observing the use of specialized clinical interventions.

In an effort to ensure these objectives were met, I outlined four specific activities which would contribute to achieving the learning goals and objectives. The first activity involved shadowing my Professional Associate to gain a thorough understanding of the role of the clinician in this setting, which included the specific activities implemented with children, charting and proper protocol for documentation, and office routines. My intent was to carry a caseload of clients to further my knowledge of case management, and service provision. Additionally, I would provide individual counselling support to gain practical clinical
experience. Other activities included completing appropriate documentation of my clinical work, and developing initial assessment skills.

The early period of my practicum placement included developing relationships with the staff and becoming familiar with the office. Prior to beginning my practicum, and in the early days, I felt rather overwhelmed, and unsure of my knowledge, skills, and abilities. This hesitation was related to a lack of experience in this specific role; I questioned if my knowledge and skills would be sufficient in meeting the needs of the children and families I would be working alongside. However, shadowing allowed me to observe clinical processes, and alleviate some of the initial hesitation I was experiencing. I was able to observe my Professional Associate’s approach with families including her use and integration of resources. This was also helpful in learning about the questions parents typically had.

In terms of my social work practice, I have grounded my clinical work in approaches, and frameworks that I believe are ethical, relevant, and respectful of clients or services users. However, my practicum placement provided an opportunity to advance my understanding of the integration of theory in clinical practice. During my practicum placement at Children’s Mental Health Services (CMHS), I carried a diverse caseload where I was exposed to various mental health concerns that children and their families or caregivers may experience. These concerns included children experiencing anxiety, struggles related to grief and loss, and difficulties with divorce, separation, and attachment issues. It was apparent to me that, based on my caseload alone, anxiety, and related behavioural concerns contributed to a high number of referrals. These behavioural concerns typically included emotional dysregulation, separation anxiety, and avoidance. Many times these behaviours occurred in the school, and home environments, and during transitions from one activity to another. With my preliminary understanding of the
presenting issues on my caseload, and those experienced by other team members in their work with children and families, I chose to advance my understanding of these issues through my review of the literature. The next chapter presents the literature review where I explore the following issues including: children and anxiety, grief and loss, divorce and separation, and attachment.
Chapter 2: Literature Review

I begin by exploring the literature on children and anxiety. I then discuss parental influence on anxiety in children and how a parent’s temperament, their own anxiety symptoms, and child rearing can impact a child. This literature review then continues with a discussion on attachment and parenting, and the impact attachment style may have on children. I conclude the chapter with a discussion on the impact of divorce on children, grief and loss, and grief and loss associated with a brain injury when experienced by a parent as this was a presenting issue with two siblings that I worked with in my practicum placement.

Children and Anxiety

The goal while working with children who experience challenges and difficulties related to anxiety include teaching and developing skills to manage anxiety rather than curing it. Anxiety is largely understood as a safety mechanism devoted to preparing an individual for fight or flight (Colonnesi et al., 2011; Pine, Cohen, Gurley, Brook, & May, 1998). However, some individuals experience heightened anxiety which can impact their functioning, and quality of life. The degree of distress and the impact related to the heightened anxiety on children’s functioning can assist in assessing typical and atypical anxiety. It is important to distinguish between anxiety symptoms, which are responses and reactions of fear to perceived danger, and an anxiety disorder. As mentioned above, anxiety symptoms often warn us of danger but unexpected or unhelpful anxiety can significantly impact an individual’s life; an anxiety disorder may develop when anxiety symptoms persist, and become intensive and interfere with daily functioning (Canadian Mental Health Association, 2018; Bandelow et al., 2013; American Psychiatric Association, 2013). It is suggested that 70 percent of mental health problems have their onset
during childhood (Public Health Agency of Canada, 2006). As such, there is value in exploring treatment and education of mental health challenges in children.

According to Colonessi et al. (2011), the most common anxiety disorders in early childhood are related to separation anxiety and several different phobias which are likely to dissipate over time. Social phobia, generalized anxiety disorder, and obsessive-compulsive disorder are more prevalent in late childhood and adolescence (Colonessi et al., 2011). It is suggested that anxiety disorders prevalent during late childhood and adolescence tend to become stable and persist into adulthood (Pine et al., 1998). It is important to understand how anxiety presents in children. For example, Kelly (2005) indicates that anxiety may manifest itself as severe temper tantrums, chest pain, or even recurrent abdominal pain (p.148). Environmental factors can include traumatic events, challenging social environments, or life stressors. Some of the environmental factors I observed were related to divorce and separation, parental conflict, addiction, and a chaotic home environment. Within the assessment process, it is important to consider the impact of these environmental factors. Additional key factors include the exploration of onset and development of symptoms, medical history, school history, family psychiatric history, medications, and substance abuse in the child and family (Kelly, 2005). Children with heightened anxiety commonly avoid age appropriate situations and social interactions deemed necessary for healthy development. This can also contribute to difficulties in social relationships and school (Verduin & Kendall, 2008). However, as Mychailyszyn et al. (2011) suggest, early identification and treatment of anxiety disorders in children and youth can significantly improve current function and positively influence long-term health. To summarize, experiencing anxiety and fear is a typical part of child development; however, intervention is
necessary when a child’s anxiety response exceeds the level of threat and what is developmentally expected (Stulmaker & Ray, 2015).

In working to address anxiety in children, it is important to consider the factors mentioned which are known to impact anxiety. It is valuable to work with a multidisciplinary team which can explore and address physiological factors while developing coping and management skills with the client. Additionally, it is beneficial to work with family, caregivers, school counsellors, and teachers to ensure the child’s environment contributes in a positive manner to their wellbeing and to reduce environmental stressors. Teachers can assist in reducing anxiety for their students through simple measures such as anxiety-reducing breaks throughout the day which can settle and keep children calm (Minahan & Rappaport, 2012). Therapists, counsellors, and social workers can work to develop self-regulation skills and tool kits with strategies for clients which can positively influence their ability to cope with heightened anxiety (Minahan & Rappaport, 2012). Parents and caregivers are crucial in establishing a positive home environment where anxiety-provoking environmental factors are addressed. This often requires parents and adults to reflect on their own behaviour (Minahan & Rappaport, 2012).

**Parental Influence on Anxiety in Children**

Brown and Whiteside (2007) suggest parental characteristics, temperament, anxiety symptoms, modeling of anxious behaviour, and parental rearing behaviour contribute to childhood anxiety problems. Wood, McLeod, Sigman, Hwang, and Chu (2003) highlight three parenting dimensions that include parental control, acceptance and modeling of anxious or avoidant behaviour, which are understood to contribute to childhood anxiety. Characteristics of parents of anxious children include parents who are considered to be less tolerant of differences of opinion, those who demonstrate less respect for children’s views, and those who exhibit
judgmental or dismissive reactions (Siqueland, Kendal, & Steinberg, 1996; Viana & Rabian, 2008). Additionally, Moore, Whaley, and Sigman (2004) suggest that maternal criticism and rejection considerably impact the development of childhood anxiety. Bögels and Phares (2008) suggest that fathers may have more impact on a child’s anxiety rather than mothers. They go on to state that this is related to the typical role of a father in encouraging children to explore different situations. Anxious fathers may not encourage their children to explore in the same way, which may in turn increase a child’s anxiety. I believe that ethical practice includes service providers sharing these factors with parents and caregivers without placing blame. It is important to support parents and work from a strengths-based perspective to prevent parents from becoming discouraged and disengaged.

**Attachment and Parenting**

Another important factor to consider when exploring parental rearing behaviour, which may contribute to childhood anxiety and worry, is the parent and child attachment. It has been hypothesized that a link between attachment insecurity and childhood anxiety exists (Bowlby, 1997). Colonnesi et al. (2011) indicate a child’s repetitive experiences of distress in relation to their child-parent relationship can become a precursor of later anxiety disorders. As Bowlby (1997), Colonessi et al. (2011), and Broderick and Blewitt (2014) state, attachment theory has identified attachment as the emotional relationship which includes proximity seeking between the child and caregiver for the purposes of keeping the infant safe and assuring their survival. Broderick and Blewitt (2014) highlight four different forms of attachments: securely attached, anxious ambivalent, avoidant, and disorganized-disoriented. With the exception of securely attached, all other attachment styles are considered insecurely attached. These different styles of attachment are influenced by the early, primarily maternal, ability to meet the needs of the child.
Kerns and Brumariu (2013) report that this secure base phenomenon refers to when a child uses his or her parent as a safe haven during times of distress and a secure base from which they are able to explore their environment and the world when they are not distressed.

Balluerka, Muela, Amiano, and Caldentey (2014) suggest that children and adolescents who are deprived of affection develop the idea that they will not receive the help or support that they need. Additionally, the early experiences of trauma and neglect can lead to overall distrust in relationships with adults (Balluerka et al., 2014; Beetz, Julius, Turner, & Kotrschal, 2012; Parish-Plass, 2008). Furthermore, children who are neglected or abused are more likely to suffer insecure attachments, lack of ability to empathize, and are more likely to fail to recognize and respond adequately to distress in their own children (Parish-Plass, 2008). If parents or caregivers show a lack of sensitivity or inconsistency in meeting needs, infants will not perceive their parents as reliable and secure (Colonnnesi et al., 2011).

As Ainsworth, Blehar, Waters, and Wall (1978) suggest, children with avoidant attachment will distance themselves from caregivers when separating by not crying, ignoring the caregiver upon reunion, and resisting proximity. Ambivalent children exhibit high levels of distress during separation and seek contact upon reunion; however, they will also remain distressed despite the reunion. They often exhibit anxious and angry behaviours towards their caregivers at times of reunion (Colonnnesi et al., 2011; Moreira & Canavarro, 2015). On the other hand, disorganized children experience and understand their caregivers as frightening, and they do not develop appropriate methods of coping with this. Therefore, they show inconsistent responses to their caregivers. These children often experience a state of “fear without solution” as the caregiver is viewed as both a source of comfort and fear (Colonnnesi et al., 2011).

Likewise, children who are securely attached will perceive their caregivers as reliable and
accessible when necessary which promotes their confidence and ability to explore the world. Colonnesi et al. (2011) states further that children who are insecurely attached and avoidant are likely to perceive themselves as unworthy and unable to elicit proximity when distressed and caregivers are perceived as insensitive and indifferent, which contributes to the notion that the world is unsafe. Children who have an insecure or ambivalent attachment style can grow to perceive themselves as only able to elicit proximity and care through extreme reactions and through maximizing attachment behaviours. Therefore, children will exaggerate expressions of distress in order to increase and maintain proximity to caregivers and ensure their needs are met. These behaviours result in the possibility of children responding inappropriately in their social interactions with others (Colonnesi et al., 2011).

Sroufe, Carlson, and Shulman (1993) suggest that insecurely attached children are more likely to struggle or experience difficulty in establishing and maintaining friendships. It is suggested that these children also experience more rejection and receive less support from peers and caregivers (Kerns, 1994; Kerns & Brumariu, 2013) and have lower capacity for self-regulation and lower levels of ego-resiliency (Stams, Juffer, & Van Ijzendoorn, 2002; Verschueren, Marcoen, & Schoefs, 1996). Colonnesi et al. (2011) suggests that these characteristics contribute to making children with insecure attachment more vulnerable to developing anxiety disorders. Additionally, Kerns and Brumariu (2013) state that perhaps insecurely attached children not only experience anxiety as a result of an insecure base but also due to these difficult experiences, which also contribute to anxiety. However, Colonnesi et al. (2011) highlights that the relationship between attachment and anxiety may also vary by age and report an association between insecure attachment and anxiety that was stronger in adolescence than childhood. Moreira and Canavarro (2015) suggest that avoidant parents may also be less
mindful in their relationship with their children therefore contributing further to attachment-related challenges.

Additionally, attachment is moderately to strongly associated with anxiety disorders and difficulties in children through various age groups and in different types of insecure attachment. Brown and Whiteside (2007) suggest that parents of anxious children may contribute through anxious and over-protecting parenting, however, rejection is most strongly associated with worry and childhood anxiety disorders. Bakermans-Kranenburg, Van IJzendoorn, and Juffer (2003, 2005) demonstrate that insecure attachment can be effectively treated or addressed through family-based interventions which can contribute to enhancing parental sensitivity during infancy and childhood. Both Kerns and Brumariu (2013) and Brown and Whiteside (2007) highlight that attachment is only one aspect of what contributes to anxiety; risk factors including attachment, temperament, specific genes, and maternal anxiety may contribute to anxiety and to attachment-related difficulties. In summary, insecure parent-child attachment is a risk factor which contributes to the development of anxiety. Insecurely attached children are less likely to develop emotional regulation skills, which contributes to difficulty in social interactions, and relationships, therefore placing them at risk of challenging experiences which would contribute to the development of anxiety (Kerns & Brumariu, 2013). The next section of the literature review focuses on the impact of divorce on children.

**Divorce**

Parenting is widely understood to be challenging and difficult yet rewarding. While parenting styles and values are diverse and could be based on cultural or theoretical values, it is apparent that children can be negatively influenced by the challenges experienced by their parents. For example, fighting between parents and reports of negative behaviours exhibited by
children are moderately correlated, particularly when the conflict is related to the child’s externalizing behaviours such as aggression, noncompliance, and delinquency (Cummings, Goeke-Morey, & Papp, 2001). A study by Hart and Kelley (2006) states that mothers who experience greater degrees of work-family conflict and parenting stress also report more internalizing and externalizing symptoms in their children. This suggests that mothers who experience greater work-family conflict and challenges also face additional stress in their parenting role, view their children as difficult, and are more likely to see internalizing symptoms such as anxiety, worry, and sadness, and externalizing aggression, and non-compliance symptoms in their children.

It is apparent that divorce impacts not only the two people involved in the separation but each individual family member and the family as a unit. During my practicum placement, I worked with parents who were recently divorced. Many were concerned about the possibility of potentially long-lasting negative impacts of the divorce on their children. Collardeau and Ehrenberg (2016) and Demo and Acock (1988) suggest that it is important to recognize that divorce has unique and different consequences for children. The consequences vary along different dimensions of wellbeing: characteristics of children, such as age and time of disruption, and characteristics of the family, such as socioeconomic history, degree of conflict, and parent-child relationships, all influence the impact of divorce on children. Wallerstein and Lewis (1998) highlight an important difference between the adult and child experience of divorce and suggest that unlike the adult experience, a child’s challenges or suffering does not peak at the time of separation and then level off. Rather, the impact increases over time and is different within each developmental stage.
Immediately following the separation, children are known to suffer loneliness and a significant loss of parenting. In early adolescence, children may experience a lack of sufficient supervision and may be required to adjust to new step-parents or step-siblings. In young adulthood, they may experience fear that their own adult relationships will fail similarly to their parent’s relationship (Wallerstein & Lewis, 1998). This does not indicate that children of divorced parents will be unhappy or unsuccessful adults, it simply suggests that they experience unique and difficult challenges throughout their developmental stages. Children may also experience and exhibit behavioural and adjustment problems which present themselves in anxious reactions, depression, phobias, irregularities in eating and sleeping, development of negative attitudes towards marriage, differences in sexual behavior, and decrease in self-esteem (Reid & Crisafulli, 1990). Witnessing the end of their parent’s relationship has the potential of creating doubt in children around the security of their relationship, attachment, and bond (Kobak & Madsen, 2008).

Spigelman, Spigelman, and Englesson (1991) indicate that children of divorced parents also exhibit higher levels of hostility, aggressiveness, and anxiety problems than children of married parents and suggest that this is a result of the children’s exposure to mutual aggressiveness and conflict between their parents both before and after the divorce. The findings from a study by Wallerstein and Lewis (1998) also suggest that it would be valuable to involve or consult children when the court and legal systems determine dual residences. For example, these authors suggest that the children in their study did not want their living arrangements made without their input. Additionally, the lack of change or evolution of the court orders with the children’s developmental stages often caused challenges for these children (Wallerstein & Lewis, 1998).
Dion and Dion (1996), Lester (1995), and Hiller and Recoules (2013) suggest that divorce rates are consistently related to the level of cultural individualism within society, such that the higher a society’s individualism is, the higher the divorce rates are. More collective cultures view divorce more negatively and tend to place more emphasis on family unity and self-sacrifice, therefore influencing a lower divorce rate (Afifi, David, Denes, & Merrill, 2013; Dong, Wang & Ollendick, 2002; Diener, Gohm, Suh & Oishi, 2000; Inglehart & Bakar, 2000; Singh & Kanjirathinkal, 1999). Other contributing factors to divorce rates include religious values, birth of children, economic factors, and divorce law (Furtado, Marcen & Sevilla, 2013). It is important that service providers recognize these cultural differences and meet the needs of their clients appropriately.

During and after divorce children require the emotional support, attention, and affection of both parents (Mosier, 2013). As Miller (2012) suggests, the way in which parents express their feelings regarding the situation and their behaviour in the presence of their children influence the impact that separation has on children, including how the children feel about that separation and how they feel about themselves. The impact of the separation can often continue to influence children well into adulthood. Therefore, parents’ behaviour and attitude play a crucial role in their children’s abilities to process and respond to the separation. It is beneficial to the child if parents are able to resist discussing the divorce when they are emotionally volatile or speak negatively about the other parent, and discussions surrounding the divorce should be done to ensure the child is reassured that both parents’ love for the child will continue (Mosier, 2013). Additionally, if the news of the divorce comes from both parents, it reduces the blame and reassures the children that both parents will continue to love and care for them.

Furthermore, it is suggested that parents should refrain from sharing the details of what led to the
separation. While children are likely to express interest in knowing the details, sharing details with children can create more confusion and, depending on the age of the children, the details could influence more challenges for the children. Perhaps most importantly, parents must reassure children that they are not responsible for the separation and divorce (Mosier, 2013). Additionally, it is valuable to maintain as much stability in routine as possible.

To summarize, through maintaining some stability in children’s routines, allowing children to process the divorce at their own pace, reassuring children that they are loved by both parents despite the divorce, and through supporting children’s self-esteem parents can continue to support their children’s wellbeing through a separation and divorce (Mosier, 2013). Divorce is understood to be a trauma in the lives of children and viewing the divorce through a grief and loss lens can help support children and their parents.

Grief and Loss

Whiting (1986) and Dyregrov (2008) suggest that a loss may occur in any circumstance or experience which takes away something that is significant and/or familiar to a child or adult. Losses children experience can include the loss of relationships, skills or abilities, the loss of objects, or the loss of a special person. The grieving process can include different reactions including physiological changes such as a loss of appetite or lack of sleep, sorrow, distress, or guilt (Fleming, Belanger, & Kathleen 2011). Protecting children from these typical yet traumatic losses is neither feasible nor supportive of their growth. Instead, parents, caregivers, teachers, and therapists or service providers should support children through these experiences and support the growth of skills and abilities to cope with further losses they may experience in life. According to Dyregrov (2008) and Whiting (1986) when supporting children through these
losses, particularly death, it is important to consider the age and developmental stage of a child as a child’s understanding of death and grief vary by age and developmental stage.

Other important factors which influence children’s responses to loss and grief include familial and cultural responses to loss and grief (Favazza & Munson, 2010; Rosenblatt, 2008). Values and beliefs around loss and grief vary in the different cultures and religions across the world; it would be valuable for service providers to have a general understanding of the different cultural views while recognizing their client or service user may hold different values than the culture or religion they identify with. As Favazza and Munson (2010) and Parkes (1972) highlight, an important aspect of grief and loss is that it takes time to sort through the various emotions which arise while grieving and often unexpected triggers will start the process all over again.

It is largely understood and accepted that there is no right way of grieving; however, parents and caregivers should seek supports when a child’s response is maladaptive and results in the child acting out or misbehaving. Parents can instead work to help their children develop healthy methods of coping with grief and loss which includes honesty and an explanation of death. How a parent discusses grief and loss can impact a child’s response (Favazza & Munson, 2010; Servaty-Seib, Peterson, & Spang, 2003). Similar to divorce, a method of supporting children through grief and loss is maintaining consistency in their routines as this will provide a sense of security to the child (Favazza & Munson, 2010). Service providers can promote healing by allowing children to share their stories and respecting the child as an expert of their own experiences. The storytelling process can include the use of art and play to allow children who may not have words for their emotions to express what they are experiencing (Scaletti & Hocking, 2010). Favazza and Munson (2010) report that young children experience various
losses associated with death, change, and transitions as well as direct loss in life events in their families and through their relationships at school. Furthermore, children are exposed to loss indirectly through books, stories, and film. All these losses create opportunities for the adults in children’s lives to support them through these emotionally challenging times and allow children to develop the skills necessary to address and cope with losses further along in life. The following portion of the report focuses on grief and loss associated with brain injuries as this is related to my work with two brothers and their parents.

**Grief and loss associated with acquired brain injuries.** Acquired Brain Injury (ABI) is described as a chronic condition which can cause impairments to cognition, emotion, social and physical functioning (Kieffer-Kristensen, Siersma, & Teadale, 2013). These impairments can cause a great deal of distress not only to the individual with the injury but also to the family and friends close to them as they often require various supports to cope and manage in their daily lives (Kieffer-Kristensen, Siersma, & Teasdale, 2013). An ABI is often seen as a negative stressful life event which can cause long-term strains, uncertainties, and ambivalent feelings within the family and often requires family members to redefine their relationships and roles (Kieffer-Kristensen & Teasdale, 2011). There is a gap in the literature in the area of the impact of an ABI on children, however, Kieffer-Kristensen, Teasdale and Bilenberg (2011) find that school-aged children with a parent with an ABI have significantly elevated post-traumatic stress symptoms when compared to a control group of children living with a parent with another chronic condition or illness.

Rolland (1997, 1990) suggests that illness profoundly affects all members of the family and the family unit as well. Age and developmental age influence a child’s ability to process their parent’s illness or injury; Visser, Huizinga, Hoekstra, van der Graaf, and Hoekstra-
Weebers (2006) found that younger children were less psychologically impacted than adolescents who responded more emotionally to parental illness. Butera-Prinzi and Perlesz (2004) found that isolation, depression, and aggression following an ABI were the most distressing consequences for children whose father had a brain injury. It can also be a traumatic experience for children to see their parent severely injured in a hospital setting (Leclere & Kowalewski, 1994).

As Kieffer-Kristensen et al. (2013) suggest, families must deal with the challenges of invisible injuries. These injuries largely involve the impact of the injury on the parent’s behaviour and mood, which can result in social stigma and isolation as children’s peers may have challenges understanding the complexity of an ABI (Kieffer-Kristensen et al., 2013). The findings of a study conducted by Pessar, Coad, Linn, and Willer (1993) suggest that children affected by parental ABI choose not to invite peers to their home and participate in fewer leisure activities.

The challenges associated with an ABI may also result in parental stress, depression, and marital problems, which may also impact a child’s psychosocial wellbeing (Kieffer-Kristensen et al., 2013). Armistead, Klein, and Forehand (1995) introduce the term disrupted parenting which refers to reduced parental support or less nurturing of the child. Disrupted parenting may occur due to altered family routines, fewer efforts at discipline, parental absence, depression, stress, and marital conflicts between parents (Kieffer-Kristensen et al., 2013).

This chapter explored the literature related to my experience with CMHS. Anxiety was the challenge most children presented with. While some degree of anxiety is typical and necessary for survival, many of these children experienced heightened levels of anxiety which impacted their daily life. Childhood anxiety is impacted by environmental, genetic, and
neurohormonal factors. As discussed, environmental factors include traumatic events and challenging social, environmental, or life stressors. Some of my direct practicum experiences included clinical practice with children of parents going through a separation or divorce, children experiencing loss, and specifically grief and loss associated with parental brain injury. Another key piece explored in this report is attachment and parenting and the significance of maladaptive attachment on a child. It is suggested that untreated childhood mental health can have a negative impact on the individual, in some cases well into adulthood. Therefore, families and service providers have a critical role in supporting children in their healing journey. The following chapter will explore the theoretical frameworks that shaped my social work practice while in my practicum placement.
Chapter 3: Theoretical Frameworks

Ensuring that practice is ethical and effective is critical for social workers. Therefore, it is important to remain reflective, knowledgeable of current theoretical and practice approaches, and understand how to meaningfully integrate theory into practice. This chapter explores how theory shaped and guided my practice during my practicum placement. As a social worker and social work student, I have developed an eclectic theoretical framework which I believe is holistic, ethical, and meets the needs of clients. Humanism is the essential and foundational value of my practice as a social worker. This view refers to respecting and recognizing an individual as the focus of all societal decisions (Fromme, 2010; Hardy, 1981). A society rooted and built on humanism would recognize the universal nature of human need and actively work towards ensuring that the environment promotes physical survival, mental health supports, self-respect, dignity, love, a sense of identity, the opportunity to use one’s intellect and, lastly, happiness (Fromme, 2010; Hardy, 1981).

Over the years, critical and feminist theories and an anti-oppressive perspective have helped me understand the impact of social structures, the value in recognizing and understanding oppression, and the ongoing impacts of colonization. I believe that these theoretical frameworks allow me, as a social worker, to be critical of the structures I work within while working anti-oppressively to support individual clients. For example, critical theory ensures that my practice does not become one that places blame or responsibility on those who experience the oppression or victimization (Mullaly, 2007). Instead, with the understanding of the impact of social structures on individuals, systems can be navigated to better serve clients and their needs. Additionally, I believe that these frameworks and approaches ensure that social workers are practicing in a way that best meets the needs of an entire person rather than the treatment of a
specific challenge. I fundamentally value working with the whole person rather than focusing on one challenge. The theoretical frameworks that encompass the values mentioned above shaped my practice during the 12-week field practicum placement and will be discussed further in this report. These include: critical theory, structural social work, anti-oppressive perspective, feminist theory, and family systems theory. I conclude the chapter with a discussion of integration of theory into practice with examples of experiences during my 12-week field practicum placement.

Critical Theory and Structural Social Work

Critical theory focuses on moving from a society characterized by exploitation, inequality, and oppression to one which is free of legal, social, or political restrictions and domination (Campbell & Baikie, 2012; McDowell, 2015; Mullaly, 2007). Critical theory suggests that in order for emancipation to occur individuals must first recognize what imprisons the human mind and be committed to the development of objective knowledge through understanding the world as it really is (Mullaly, 2007; Sabia & Wallulis, 1990). Social work practice is often with marginalized populations. Therefore, an important responsibility that I carry in daily practice is seeking and working towards changing existing social, economic, and political institutions which continue to marginalize specific groups of people (McDowell, 2015).

There are two views of critical theory: modernist and postmodernist. With the increased domination of nature by the scientific revolution, which promised relief from scarcity and natural disasters, the modernist view developed to work to create rational forms of organization and the use of rational thought. The goal of these rational thoughts and beliefs was to liberate people from irrational beliefs rooted in myth, religion, and superstition while releasing people from the arbitrary use of power (Harvey, 1989; Mullaly, 2007). Modernists seek to free people from the
beliefs which suggest that everyone and everything belongs to a predetermined place within society and the universe and that no action can change that (Mullaly, 2007). Modernist thinkers detach themselves from the notion of the universe and instead examine it, explore the elements which contribute to it, and understand how it works, explaining it, controlling it, and using it to benefit all peoples (Howe, 1991).

Fraser (1985) suggests that the postmodernist view calls for a complete break from the notion of Enlightenment. Postmodern social theory has a range of perspectives which influence the politics and views which emerge from them. One end of the continuum is understood to be conservative and individualistic; at the other end of the spectrum are those who have taken and built upon the postmodern analyses and criticisms of modernity and attempted to revitalize critical social theory (Dickerson, 2010; Mullaly, 2007; Weinberg, 2008).

Postmodernists largely reject the modernist view that modernism created and influenced material and social progress for some populations, primarily due to the notion that it also contributed to the exploitation, impoverishment, cultural destruction, and death of others. The negative impacts to other populations occurred through imperialism, colonialism, economic development, and warfare. It is important to note that modernist knowledge and universal truths often reject experiences and different knowledge generated by women, Non-Europeans, and marginalized populations (Leonard, 1994). Ife (1997), Mullaly (2007), and Dickerson (2010) highlight the postmodernist claim that different realities exist at any one time and that these realities are constantly being defined and redefined by different people within different contexts and there is no one correct answer or best way of understanding them. Another foundational difference between the two perspectives is that power is not entirely located within the state, rather power is found in different systems, locations, contexts, and social situations. Many of
these contexts, systems, and locations include the work of social workers (Mathias, 2015 Mullaly, 2007).

Harvey (1989) indicates that the power differentials and influences vary within locations and a single overarching theory cannot explain the impact of power differentials; this aligns with the existing and above-mentioned postmodernist values. In order to address the micro-level oppression marginalized individuals experience, the postmodernists call for a multi-faceted and pluralistic attack on individual systems and practices which can challenge and address capitalism without creating an opportunity for a new form of capitalism to emerge (Harvey, 1989). As Anderson and Gerhart (2012) highlights, a postmodernist approach to clinical work includes creating a collaborative relationship between service users and service providers which contributes positively to a non-pathologizing environment. Additionally, another important core value is the idea of otherness; postmodernism emphasizes the importance of every group’s right to speak for themselves, in their own voice and language, and have that voice accepted as legitimate (Harvey, 1989).

A critique of the postmodernist rhetoric is that it fails to confront the realities of the political economy and global power. The failure to recognize that globalization of capital accumulation is being used to marginalize and subjugate the very groups and populations that postmodernists are concerned about suggests that they are overlooking the very population they seek justice and change for (Mullaly, 2007). Another critique identified by Ife (1997) suggests that postmodernism does not account for structural oppressions such as race, class, and gender as the postmodern perspective embraces the idea that power is held by many rather than concentrated in the hands of a few. Furthermore, by identifying differences, it creates an
environment which fails to unite and create solidarity among different groups experiencing the commonality of oppression, regardless of the source.

While both modernist and postmodernist critical theory differ in various values and beliefs, I believe there are valuable aspects to both which contribute positively to my social work practice. At their core, both challenge the current social structure and suggest there are methods for creating meaningful social change. I value the postmodernist view that alternative versions of society are the reality for different groups of people. This allows for the various experiences that individuals face to be honoured and respected and it prevents overgeneralization of experiences and encourages services providers to truly listen, respect, and honour the experiences of clients or services users. This was, and continues to be, an important part of my daily practice and work with clients – I worked hard to ensure that families were leading our time together. This included goal planning together, making time to hear what their feedback was, and ensuring that everyone was recognized as the expert of their experience.

**Structural social work.** Structural social work recognizes that there are pervasive structural issues of oppression and domination in relation to class, gender, and race (Mullaly, 2007). It recognizes that in all forms of oppression there is a power differential, there are consequences of oppression, and the hegemony of the view of the dominant group is supported and reinforced by social systems and institutions. The postmodernist values remind social workers that despite the oppression experienced by many, the ways in which oppression is experienced and the impact will be felt uniquely by different groups of people (Baldwin, 2011; Lavalette, 2011; Mullaly, 2007).

The modernist values of solidarity are important within structural social work as well. It is valuable for groups of people to come together to address oppression and create social change.
I believe that in order for me, as a social worker, to ensure my practice aligns with these critical social work theoretical values, I must root my practice in both modernist and postmodernist values. I work to remain reflective of my practice and ensure that I recognize and respect the influence of race, gender, class, power differentials, and how oppressive systems may impact the daily lives of the individuals I work alongside, while also adhering to my responsibility as a social worker and working towards creating meso- and macro-level change. In daily practice, this often involves recognizing and highlighting the practices which continue to oppress individuals and to address and change those practices.

**Anti-Oppressive Perspective**

Oppression occurs at three levels: the micro or individual level, the cultural level, and the structural level (Dominelli, 1996; Mullaly, 2002; Thompson, 1997). Mullaly (2007) highlights that these three levels are interdependent, interactive, and mutually reinforcing. Oppression at the personal level includes thoughts, attitudes, and behaviours that depict negative pre-judgements of a particular subordinate group; this includes stereotypes and may be overt or covert. Oppression at the cultural level refers to those values, norms, and shared patterns of thought and action combined with the consensus of what is right, normal, and acceptable, which all contribute to the belief in a single superior culture (Burke & Harrison, 2002; Mullaly, 2007). These values and ideas contribute to presenting the dominant culture as the norm, therefore, sending the clear message that all others should conform to it. Oppression at the structural level refers to how social institutions, laws, policies, and social processes and practices all work together in favour of the dominant group and at the expense of the subordinate groups. Oppression at the structural level is where oppression is given its formal legitimation (Danso, 2009; Mullaly, 2007).
Similar to the different levels of oppression there are different ways in which oppression presents in people’s experiences; these different forms include: exploitation, marginalization, powerlessness, cultural imperialism, and violence (Mullaly, 2007; Young, 1990). Exploitation refers to social processes where the dominant group is able to accumulate and maintain status, power, and assets from the effort and labour of the subordinate groups; working-class people, women, and people of colour primarily experience exploitation (Mullaly, 2007).

Marginalization largely affects racialized people, old and young people, many single mothers and their children, people with disabilities, unskilled workers, and Indigenous peoples (Mullaly, 2007; Rush & Keenan, 2012). The marginalization of these groups of people excludes whole groups from meaningful participation in society and the labour market, which contributes to material deprivation (Mullaly, 2007; Young, 1990). Cultural imperialism has been identified by feminists and black liberation theorists and refers to the dominant group universalizing its experience and culture and identifying it as the norm. Ethnocentrism of the dominant group results in the projection of the dominant group's experience and culture as representative of all humanity (Mullaly, 2007; Young, 1990). Lastly, all oppressed groups suffer systematic violence due to their place in subordinate groups. Violence refers to physical attack, harassment, ridicule, or intimidation which stigmatizes members of the subordinate groups. The oppression of violence extends beyond direct victimization and refers to the constant fear that violence may occur due to one’s group identity (Burke & Harrison, 2002; Mullaly, 2007).

To summarize, oppression is the result of unequal power across social divisions (Burke & Harrison, 2002). Social workers or service providers often work with people who are members of these subordinate groups. It is critical that as social workers and services providers we have an understanding of the impact of these different levels or forms of oppression experienced by
the vulnerable people we work alongside (Burke & Harrison, 2002; Thompson, 1997). Healy (2005) suggests that anti-oppressive theorists urge social workers or service providers to be alert to the social divisions impacting the lives of service users. In addition to having a thorough understanding of the impact of oppression, social workers must also work to address these oppressions and ensure their practice is anti-oppressive at every level. Social workers must also be aware of their privileged status and must work to remain critical and reflective of their practice to prevent replicating oppression within their practice setting (Burke & Harrison, 2002).

The anti-oppressive approach highlights the structural influences of service users’ challenges and urges social workers or service providers to facilitate service users’ critical consciousness and collective responses to the root causes of the challenges and problems they experience (Healy, 2005). Dominelli (1996) suggests that anti-oppressive practice aims to provide more appropriate and sensitive services by responding to and addressing the needs of people regardless of their social status. The anti-oppressive approach is person-centered and based on an egalitarian value system concerned with reducing the effects of structural inequalities. Within this approach, social workers or service providers work to empower service users by reducing the negative effects of hierarchy in their immediate interactions and in the work they do. Additionally, anti-oppressive practice calls on social workers and service providers to explore and consider how the membership of specific disadvantaged group influences and impacts their current challenges (Burke & Harrison, 2002). This includes a critical analysis of major social divisions such as race, class, and gender (Healy, 2005). Dalrymple and Burke (1995) also indicate it is important to consider the power of language and the way in which it impacts service users. Anti-oppressive practice calls for service providers to
work in partnership with service users, allowing individuals the right to make decisions in their lives which contribute to their own empowerment (Dalrymple & Burke, 1995).

**Feminist Theory**

Feminists draw attention to the fact that women experience a different social reality than men (Lee 2001; Mullaly, 2007). It is understood that the state plays a central role in the domination of men and the subordination of women, which contributes to the demands that the existing ideological and theoretical framework be revised to account for the role of the state in maintaining the dominant patriarchal and heterosexual relations which largely comprise Western society (Mullaly, 2007; Poorman, 2003). Woodward (1997) suggests that feminist critique primarily focuses on the ways in which the gendered nature of social institutions and practices has been ignored and gender neutrality has been assumed in traditional social science literature. The literature has also failed to recognize the ways in which issues that are particularly important to women who are marginalized are excluded from the focus of social welfare. While all feminists may agree on the existence of gender inequalities, there are fundamental differences regarding the perceived causes and methods of addressing and effecting social change (Mullaly, 2007). The three schools of feminism include liberal feminism, socialist feminism, and radical feminism.

First-wave feminism of the 19th and early 20th centuries used liberation language to demand equal opportunities and civil rights. The primary focus at this time was social issues and gaining the right to vote (Kemp & Brandwein, 2010). The second-wave feminists emphasized reforming existing institutions in their efforts to seek equality and civil rights (Mullaly, 2007). Williams (1989) highlights that liberal feminists reject the notion that biological differences between men and women influence gender inequality; instead, there should be accommodations
for women as they bear children and the state should provide women with contraception, abortion, maternity leave, and publicly funded daycare. Liberal feminists largely focus on creating change in social institutions and practices through changes in sexist values, norms, and ideas. The largest critique of liberal feminism is that there has been little done to address or challenge the structural oppression, such as classism, patriarchy, and racism in society, which directly contributes to the subordinate status of women (Mullaly, 2007; Reichert, 2006; Saulnier, 2008).

Socialist feminism analyzes women in society through a Marxist lens (Mullaly, 2007). Williams (1989) writes that classical Marxism has largely overlooked or ignored the significant oppression of women. Socialist feminism also emphasizes that biological differences do not influence the behavioural differences between men and women; these differences are the result of the social constructs of gender (Williams, 1989). Socialist feminists focus their efforts on women’s groups and organizations fighting to improve health, housing, income security, child and elder care, and employment services for women (Williams, 1989). A large area of focus for socialist feminists is the interrelationships between capitalism and patriarchy with an analysis of women’s dual role. The concept of dual role refers to women’s participation in the public sector and their responsibilities in the home, including caring for children.

Williams (1989) suggests that socialist feminism draws attention to women’s dual role and demands the reorganization of the sexual division of labour and an end to divisions between paid and unpaid labour. This brings attention to the notion of sexual division of labour where women are responsible for caring as it is considered their natural work and men have the breadwinner role in the family (Mullaly, 2007).
Radical feminism suggests that women as a group or class are oppressed by men as a group or class (Robbins, Chatterjee, & Canda, 1998). Patriarchy is considered the primary source of women’s oppression both at the micro and macro levels (Carr, 2003; Mullaly, 2007). Radical feminists define patriarchy in two ways: male power and control over women’s sexuality and male power and control over women’s reproductive capacity (Williams, 1989). Mullaly (2007) suggests that male domination of women is maintained by force and the risk of male violence. In relation to women’s reproductive capacity, radical feminists highlight that due to biological processes of childbirth, women are forced to rely on men for long periods of time; this has resulted in and contributed to the emergence of patterns of male domination and female subordination. According to Firestone (1970), radical feminists suggest that in order to address and abolish patriarchy, it is necessary to relieve women of their biological reproductive role as much as possible, ensuring women have access to family planning, abortion, 24-hour childcare centres, and artificial reproduction.

The primary focus of feminist theory is on gender and the limitations caused by patriarchy; central to feminist beliefs is that all people have the right to access basic human rights, free from domination (Turner & Maschi, 2014). Lee (2001) highlights that empowerment is an essential aspect of feminist theory, suggesting that feminist theory seeks to increase personal, interpersonal, and political power of oppressed and marginalized populations for micro- and macro-level transformation and change. A large critique of this paradigm is the lack of focus or attention on the experiences of people of colour. Black feminists have referred to the above-mentioned feminist perspectives as “white feminism” (Mullaly, 2007). Feminists of colour have argued that gender similarities with middle-class white women are less powerful and meaningful than the ethnic and class differences which separate women of colour from white
women (Crenshaw, 1989; hooks, 2000). Although the initial focus was on middle-class white women, with the increased involvement of women of colour in the development of self-in-relation theory, feminist theory has become inclusive of all women (Collins, 1991; Brown, 1998; Kabeer, 2009; Maschi et al., 2011). This point raises the importance of intersectional feminism, which recognizes the experiences of minority women, including the experiences of trans women. As a woman of colour, the feminist perspective is often a focus of mine. In practice, my focus is to ensure that I am honouring and respecting the challenges women experience. This is in line with Rowbotham’s (1989) view which acknowledges that oftentimes the burden of parenting and ensuring the health of children falls on the woman.

**Family Systems Theory**

Bowen (1966) suggests that the family movement began in the early- to mid-1950s and developed from an effort to explore more effective treatment methods for those with severe emotional challenges. With the development of child analysis and the beginning of the child guidance movement, it became standard procedure for social workers or a second therapist to work with parents or caregivers in addition to the primary psychotherapy with the child. Traditional individual theory focuses primarily on the individual through the medical model lens of pathology and concepts of etiology and the treatment of the illness in the individual (Bowen, 1966). An individual’s behaviour or diagnosis is understood to be influenced by the structure, organization, and patterns of the family system (Dore, 2008; Miller, Ran, Keitner, Bishop, & Epstein, 2000; Steinglass, 1987). Family systems theory understands the family as a system with a variety of subsystems; systems function at all levels of efficiency from optimum functioning to total dysfunction and failure (Bowen, 1966; Broderick, 1993). The functioning of any system is dependent on the functioning of the larger systems of which it is a part as well as the subsystems.
An important aspect of family dysfunction that needs to be acknowledged is that there is typically over-functioning in another part of the family system; an example of this is when a family member is ill, the other family member will automatically over-function to compensate for the dysfunction (Bowen, 1966; Brooks & Ronen, 2006; Franck & Buehler, 2007; Hughes & Gullone, 2008; Richmond & Stocker, 2008). The over-functioning individual often views their over-functioning as necessary to compensate for the poor functioning of the other. Temporarily, this is not concerning, however, chronic dysfunction and over-functioning is concerning (Bowen, 1966). Bowen (1966) highlights that families do not often seek help or intervention until the flexibility of the system is lost or an individual is severely impaired. Recovery and balance begin with the slightest decrease in over-functioning or dysfunction (Bowen, 1966).

Bowen (1966) indicates that the therapist also fits into the family structure and concept. He goes further, highlighting that in his observations the more the therapist learns about a family, the more the family learns about itself. The therapist can be understood as the expert in understanding family systems and can provide help, structure, and guidance in the family’s efforts to restore itself to functioning equilibrium (Brown, 2012). The overarching goal is to help family members become system experts who have a strong understanding of the family system, which allows the family to readjust itself without outside expert involvement if the family system is ever stressed again. This prevents over-reliance on the therapist to fix or address the concerns, which may not authentically address the concerns or allow the family to develop long-term skills (Bowen, 1966; Howe, 1991).

According to Bowen (1966), the central concept of family systems theory is the undifferentiated family ego mass, which refers to the idea of the emotional oneness that exists at all levels, from the family where it is most intense to the family in which it is minimal. The
symbiotic relationship between a mother and child is an example of a more intense version. The degree to which any specific family member may be involved depends on their basic involvement in the family ego mass with specific patterns of emotional responsiveness (Bowen, 1966).

At times of stress, the process can involve the entire nuclear family, a spectrum of extended family members and non-relatives, which includes service providers (Bowen, 1966). In periods of calm, the process can remain within the family. The term undifferentiated family ego mass is considered more utilitarian than accurate. Clinically, the best examples of the relationship within an undifferentiated family ego mass are reflected in intense versions of symbiotic relationships. Emotional closeness can be so intense between some family members that they can know one another’s thoughts, feelings, fantasies, and dreams. These relationships are cyclical; there is a phase of calm, comfortable closeness that can shift to anxious, uncomfortable closeness with the incorporation of the self of one by the self of the other. Then there is a phase of distinct hostile rejection in which the two can repel one another. In some families, the relationship cycles through these phases frequently and in other families the cycle stays fixed for longer periods of time. Bowen (1966) notes that during an angry-rejection phase family members can reject one another for years or even life. Bowen (1966) highlights that there are three major theoretical concepts in the family systems theory. The first is related to the degree of differentiation of self in a person. It is valuable to note that the opposite of differentiation is the degree of undifferentiation or ego fusion. Furthermore, an attempt has been made to classify all levels of human functioning on a single continuum: at the most intense end, undifferentiation and ego mass dominate and there is little differentiation of self. Here individuals are understood to live in a feeling world where they are dependent on the feelings of
those about them (Bowen, 1966). Much of their energy goes into maintaining their relationship system, loving or being loved or reaction against the failure to get love. These individuals struggle to differentiate between a feeling system and an intellectual system. Individuals at this end of the spectrum typically have resilient personalities, lack their own beliefs and convictions, and adapt quickly to the prevailing ideology (Bowen, 1966). They typically go along with the system that best complements their emotional systems. At the other end of the scale, the differentiation of self represents the highest level of functioning. These individuals are principle and goal-oriented people who are sure of their beliefs and convictions but are never fixed in their thinking; they are able to hear other viewpoints and discard old beliefs in favor of new (Bowen, 1966). An important concept is the family progress process by which parental problems are transmitted to their children.

Bowen (1966) suggests that after marriage they fuse together into a new family ego mass with obliteration of ego boundaries and incorporation of the two pseudo selves to form a common self. Each partner uses the mechanisms used in their families of origin in their interactions with one another. For example, the individual who used separation and physical distance as a means to create distance will tend to run away in the marriage (Bowen, 1966). The future of the new family ego mass will depend on the spectrum of mechanisms that operate within the family ego mass and the others outside their relationships within the extended family system (Bowen, 1966). Spouses utilize the following three major mechanisms to control the intensity of the ego fusion: marital conflict, dysfunction in one spouse, and transmission of the problem to one or more children. Marital conflict is rooted in the concept that each spouse fights for an equal share of the common self (Bowen, 1966). A typical pattern in a brief period of conflict is that one spouse will reluctantly give in to relieve the conflict. Another response is that one spouse volunteers to
be the one no self in support of the other spouse who they become dependent on, which puts the
dependent spouse in a vulnerable position and at risk of physical, emotional, or social illness
(Bowen, 1966). The transmission of the problem to one or more children is a very common
mechanism for dealing with family ego mass problems. There are families with intense marital
conflict and no impairment of the children, which suggests that marital conflict itself does not
cause problems in children. When there is a significant degree of ego fusion, there is also
borrowing and sharing of ego strength both within the nuclear family and the family of origin
(Bowen, 1966).

The foundational effort of this therapeutic method is to help individual family members
towards a higher level of differentiation of self (Bowen, 1966). An emotional system requires a
balance of a certain amount of being and self to the welfare and wellbeing of the others.
Imbalance can occur when one family member moves toward a higher level of differentiation of
self. Bowen (1996) goes on to summarize that the basic building block of any emotional system
is the triangle. In calm periods, two members have a comfortable emotional alliance and the
third is in the outsider position which moves toward developing a favourable connection or
rejection. In tense situations, the outsider is in a favoured position and both of the emotionally
over-involved individuals will make efforts to involve the third in their conflict. As tensions
increase, there is increased involvement from outside members (Bowen, 1966).

The triangle occurs when emotional tension builds in a two person system and focuses on
a third person shifting the tension in the triangle (Bowen, 1966; Franck & Buehler, 2007). A
triangled child is one of the most challenging circumstances in psychotherapy. Bowen (1966)
identifies that his optimum approach to any challenge within a family is to begin therapeutic
work with the husband and wife together and to continue with both for the entire therapeutic
process and relationship. This process of working with both parents with a symptomatic child improves family communication, resulting in symptoms dissolving and, eventually, the end of the therapeutic involvement. A conflictual marriage is an example of a circumstance where a service provider would only work with one parent; this clinical situation is one where the emotional system is fairly immersed in dysfunction before they access support (Bowen, 1966; Franck & Buehler, 2007).

Attachment theory and family systems theory each have the capacity to shape therapeutic work with children and families with children who present with significant behavioural concerns (O’Gorman, 2012). Secure attachment can be reflected in stability in children as they understand that their caregiver is accessible and will be able to meet their needs appropriately and as necessary. With anxious and disorganized attachment, the children typically expect reliable insensitivity; in other words, they expect their caregivers will not respond appropriately or within a reasonable time (O’Gorman, 2012). As a child grows and their needs change, their caregiver must remain accessible, reliable, predictable, and sensitive to the needs at that developmental stage and maturity level. In the event that a child presents with significant behavioural concerns, the behaviours can be viewed as a symptom; attachment and family systems theory would support the conceptualization of these symptoms in the context of significant attachment relationships. Furthermore, attachment theory places emphasis on the description of a child’s behaviour with reference to parent-child interaction. Attachment theory additionally recognizes possible associations between internalizing and externalizing behavioural concerns and insecure or disorganized attachment classifications (Fonagy, 2001; Wallin, 2007). On the other hand, family systems theory contextualizes the child and their behaviour with reference to the larger family system, thereby suggesting that behavioural concerns are rooted in the current functioning
of the family and a shift in one part is likely to impact other parts. Isolating a child’s symptoms to an extent that little emphasis is placed on the quality of caregiver-child interactions runs the risk of a child being held responsible for being the agent and sustainer of change in their family. This responsibility on a child can be both overwhelming and unrealistic.

**Integrating Theory and Practice**

Integrating theory into daily practice is a critical aspect of ethical social work practice. This section includes specific examples of ways in which I integrated and based my practice on theory and literature.

**Critical Theory and Structural Social Work.** The focus of critical theory is moving from a society characterized by exploitation, inequality, and oppression to one which is free of legal, social, or political restrictions and domination (Campbell & Baikie, 2012; McDowell, 2015; Mullaly, 2007). Both modernist and postmodernist perspectives recognize that social change cannot occur without the involvement of the marginalized or oppressed groups of people (Mullaly, 2007). This challenges me as a social worker to ensure my practice is addressing power differentials and is providing an environment that is empowering for clients or service users. I reflected on this principle in practice through the rapport-building process as well, during which I verbalized my respect for their experiences being unique to themselves, that I was not the expert of their experiences or challenges and, instead, we were there to work together on the goals that were important to them and their families. This aligns with the postmodernist approach to clinical work which includes creating a collaborative relationship between service users and service providers therefore contributing positively to a non-pathologizing environment (Anderson & Gerhart, 2012). It was my experience that this approach helped address any power differential as clients provided me with constructive feedback, which allowed me to shift or
shape practice to better meet the families’ needs. For example, with one of the young girls I was working with we moved from having her caregiver in the room for the entire time to only having her join us at the end. This was a suggestion from the caregiver and proved to be more effective in rapport-building and the child was more open and honest.

Structural social work recognizes the pervasive structural issues of oppression and domination in relation to class, gender, and race (Mullaly, 2007). I remain reflective of my practice and ensure that I recognize and respect the influence of race, gender, class, power differentials, and how oppressive systems may impact the daily lives of the individuals I work alongside. Working within the health care system, it is clear that the system can be oppressive for service users with wait times, language barriers, and limited understanding of cultural diversity and impacts on individual health, particularly with mental health. Therefore, it is critical that service providers recognize the ways in which systems can create barriers or oppress services users and work towards addressing the harmful practices and systemic barriers. I was a part of various meetings within the organization where front-line staff and management spent time working to develop clear and manageable methods of improving access to services, wait times, and high caseload management, which impact the delivery and quality of services. The largest barrier that clients and staff experienced was the long wait time. The agency was dedicated to serving clients within 30 days of referral, which typically included an assessment and perhaps an initial session. However, the challenge staff experienced was scheduling these assessments while serving their existing clients. Some children, due to the nature of their needs, required more intensive work and more frequent visits. The challenge then became either scheduling new assessments and preventing long wait times or scheduling children for frequent and timely appointments.
The staff often came together with management to brainstorm and explore different methods of addressing these challenges, and there were adjustments to team systems and processes during my placement. These changes included the teams reviewing the list of children waiting for initial assessments to assess which members had the space to integrate the children. This was an adjustment to their prior process where each team was assigned a few new children every month regardless of their caseload or absent team members. These attempts at addressing wait times align with critical theory values of moving from a society characterized by exploitation, inequality, and oppression towards one that more free of these barriers (Mullaly, 2007).

Throughout my practicum it was important to reflect on barriers from a structural social work perspective, for example, understanding a child’s and family’s socio-economic status, the gender of the parent accompanying children to appointments, and their ethnic background. While I certainly did not gather information about income, I did explore if they had additional health benefits through their employer. Those who had additional health benefits were encouraged to access support through that coverage if they preferred as they would not face the same wait times, which in this case does place those children and families at an advantage particularly in comparison to those who did not have any additional health benefits.

Additionally, exploring race or cultural background helped me to not only explore their cultural values but also allowed me to explore how race or culture may have impacted their access to services. Rapport-building also meant addressing the power differential between service users and me. It was my experience that people were able to give me feedback or information about what their best hopes or goals of accessing services were when they were asked directly. The open sharing also created an environment where they were more in control
or leading the use of services. Addressing micro-level power differentials, I believe, gives service users more confidence and opportunity to address power differentials they might experience in other systems. For example, the mother who came from a collective culture where familial problems were addressed within the family. Additionally, she was hesitant to access services as she was worried about service providers’ assumptions about her due to culture or her perceived language limitations. This made me reflect on how people of diverse backgrounds might feel more comfortable. More diversity in service providers could positively impact more comfort, but I also believe staff addressing the differences in a respectful manner would honour a person’s experience and create an opportunity to discuss their relationship with their culture and its impact on their day-to-day life. This open dialogue could also prevent service providers from making assumptions.

**Anti-Oppressive Practice.** As discussed in the literature review, oppression occurs at three levels which are interdependent, interactive, and mutually reinforcing (Dominelli, 1996; Mullaly, 2002; Mullaly, 2007; Thompson, 1997). The three levels of oppression include: micro or individual level, the cultural level and the structural level. Much of my anti-oppressive practice during this practicum was focused on the micro or individual level.

Ensuring daily anti-oppressive practice included reflecting on my practice, personal values, thoughts, and responses to service users. It is valuable to validate experiences of service users and explore their relationships and views of their position within disadvantaged groups. In my experience, service users may not identify and place themselves in these disadvantaged groups; it is valuable to explore why they identify differently or do not see themselves as disadvantaged. Additionally, it is helpful to acknowledge and honour where an individual is in their journey and to refrain from imposing one’s individual values on them.
A large part of working anti-oppressively in my practicum setting was remaining non-judgmental of parents in their parenting and as individuals. I also honoured where people were in their journey and used this as a starting place for our work together. Helping service users navigate through traditionally oppressive systems was also an important helping role. At its very foundation, an anti-oppressive practice means respecting individual experiences, recognizing and challenging the barriers to certain groups of people, and actively working to address and eliminate some of the barriers individuals face. A key aspect of anti-oppressive practice also became ensuring the environment I worked within was a safe space for service users. Creating this safe space included ensuring the service users were aware that the space was free of judgement. At times, this meant asking permission before asking invasive questions; it included explaining the intent behind the questions and explicitly stating that there was no right or wrong answer.

**Feminist Theory.** Feminist theory impacted the ways in which I understood and worked with children and families in my field practicum. The majority of the time mothers or female caregivers accompanied children to their sessions at the office with the responsibility for their wellbeing falling on them. Many times we worked to include the children’s father in the services provided. In families where the parents were a unified pair this was less problematic, but in families with more disharmony this was more of a challenge. As service providers we worked to address this imbalance by including both parents in goal planning and responsibility for implementing change in the home. Understanding the dual roles and implications of the division of labour on caregivers gave me a greater understanding of the challenges they experienced.

The feminist perspective also gave me more insight into the young girls who accessed services. This allowed me to develop a better understanding of how societal factors impacted
their challenges. In some cases it was related to body image and self-esteem; in others it was anxiety and a stress response to parental challenges.

During my practicum at CMHS, I often tried to work with both parents during sessions with their child or children. Each service provider varied in their practice with children and families; some included parents in all sessions they had with children and others did not. I opted to include parents in each session as it was evident to me that family challenges, over-functioning or dysfunction, impacted the entire family and working together felt more productive in addressing the concerns. Many times, both parents were unable to attend, but where parents were more of a unified front, I felt that it continued to work well. In situations where both parents were unable or unwilling to be a part of sessions, we worked with the parent present and their relationship with the child or children. It was particularly challenging when one adult refused to be a part of the process. I worked to continue to try to engage that part while working with the parent and child that attended.

Another factor that I was conscious of was the gender of the caregiver that attended the initial assessment and follow-up appointments. I only had two fathers attend initial assessments and neither attended follow-up appointments. Often times the mothers or female caregivers explained that it was related to both parents being unable to take the time off work. While this is absolutely valid, I did reflect on how the parents may have come to the decision of who would take the time off to attend appointments and the impact it might have on the woman’s employment. This made me reflect back on the dual-role women play as Mullaly (2007) discussed and the idea that women are responsible for the caring role in the family. To address the lack of paternal involvement I did take the time to call some fathers to hear their feedback and explore their perceptions of their children’s needs. However, I remained reflective in how
much weight I placed on each parent’s feedback and tried to ensure that it was as balanced as possible; I did find myself leaning towards what the women stated. Perhaps this was related to internalized ideas of who knew the needs of a child better or who was simply more present.

**Family Systems Theory.** As noted in the literature review, Bowen (1966) suggests that the functioning of an individual within the family relies on the functioning of the larger family system. The parent who did not experience the brain injury appeared to be over-functioning to compensate for their partner’s illness or dysfunction and they sought out therapeutic support and intervention when it was clear that this dysfunction was not temporary and the overcompensating behaviour was difficult if not impossible to maintain in a healthy manner long term.

This parent struggled with guilt around their true feelings for their partner. Lezak (1998) suggests that guilt of further traumatizing children and fear of social isolation make it difficult for spouses to consider divorce despite the personality changes following an ABI which can complicate the process of reestablishing a satisfactory marital relationship. This parent certainly reported that the largest contributing factor to their consideration for separation and divorce was the personality changes. They shared that their spouse’s inability to control the personality traits contributed to their guilt. Kieffer-Kristensen (2013) states that the impact of the parental ABI depends largely upon family factors and the level of functioning in the healthy parent; this highlights the importance of validating emotions and supporting all family members and the family as a unit.

The children had to redefine their relationship with their parent with the brain injury as they were unable to care for them in the same way they once did. Kieffer-Kristensen et al. (2013) highlight that the redefining required by an individual’s impairments causes distress to their family and friends and often requires redefining relationships. The children often shared
that this parent used to be the one who took them to their extracurricular activities but was no longer able to do so independently. Additionally, the children struggled with the guilt of not actually wanting this parent to be there because of their new functioning levels and how that impacted them socially; the children did not want to be worried about their parent’s potentially embarrassing behaviour.

The children also shared with me the trauma of seeing their parent in the hospital and how the equipment and environment made them afraid. Bilenberg (1999) highlights that school-aged children with a parent living with an ABI have significantly elevated PTSD diagnoses in comparison to children of parents living with chronic illness. The children were also observing changes in their parents’ relationship and expressing anxiety regarding the possibility that their parent without the injury might separate or divorce the parent with the injury and what that might mean for their relationship with the parent with the injury. Rolland (1997, 1990) shares that illness often profoundly impacts all members of a family and the family unit itself.

In my experience, the stronger the bond between families and me, the more difficult it became to end the relationship. The family with two children also made me reflect on the views of collective cultures on divorce. As discussed earlier in this report, collective cultures view divorce more negatively, placing greater emphasis on self-sacrifice (Singh & Kanjirathinkal, 1999). While I may never fully understand their experience with their culture, because I believe that is unique from one person to the other, acknowledging how collective cultures view divorce did lead to more clarity around the parent without the injury’s struggles and internal conflict around making a decision around separation and divorce.

**Attachment Theory.** In working with a young child, I began to explore the relationship between attachment and their presenting concerns. Balluerka et al. (2014), Beetz et al. (2012),
and Parish-Plass (2008) highlight that early experiences of trauma and neglect can impact a child’s level of trust or distrust of adults. It was clear that no adult involved in the child’s life had a clear understanding of the degree of neglect or trauma she may have experienced; it was likely what we knew was simply a small glimpse of what she may have experienced. We were aware that her parent showed a lack of consistency in meeting the child’s needs, which impacts attachment (Colonnessi et al., 2011). To best meet this young child’s needs, I followed up with them on a weekly basis. The child often struggled to stay on task and was somewhat defiant and controlling of play. However, they did respond well to cues and redirection.

An example of a challenging situation I experienced was in my work with the parent of a two-year-old child. This parent’s parenting style appeared to contribute significantly to their daughter’s insecure attachment. The parent valued attachment parenting, which for their family largely involves the child being in close proximity to the parents at all times, nursing on cue and sharing a family bed. While the positives and limitations of each parenting style can be debated at great length, it was apparent in this family that the child was unable to self-soothe to any extent and this was causing a great deal of stress and anxiety in the parent and their other child. The child was distressed whenever they were not in direct contact with their parent, had a great deal of separation anxiety, and upon reunion was often more clingy than before the separation. This parent was not willing to consider how this parenting style might be contributing to the child’s challenges and ultimately made the decision to seek supports for themself rather than the child. As Kerns and Brumariu (2013) suggest, insecurely attached children are less likely to develop emotional regulation skills. The lack of emotional regulation skills can impact their ability to navigate social interactions, which can in turn impact their anxiety levels. During supervision with my Professional Associate, we discussed how the challenges these parents were
experiencing with the child were related to parenting style, which the parent was not open to adjusting or changing. My Professional Associate and I met with the parent to explore if my Professional Associate was able to suggest different strategies. As noted above, children with ambivalent attachment exhibit high levels of distress during separation and seek contact upon reunion. However, they will also remain distressed despite the reunion (Colonnesi et al., 2011). This child exhibited all of the above, along with an inability to self-soothe. My Professional Associate and I hypothesized that this was a result of the child never self-soothing and the parents always providing the soothing. As the child’s parent was unwilling to consider this as a reliable cause for the behaviour, they made the decision to seek mental health supports for themself to support them through this challenging time.

To summarize, these theoretical approaches can be understood to meet the needs of the whole individual. They acknowledge how different systems oppress and marginalize certain groups of people while equipping social workers with the knowledge and skills to begin to address problematic practices and systems. The approaches mentioned above challenge social workers to remain aware and critical of the systems we work within and our individual practice. With this increased awareness, service providers can ensure the service users are not oppressed in the same ways they may have been in the past. Additionally, when social workers work to honour all aspects of a person, it allows for healing of the whole individual versus treating the isolated concern.
Chapter 4: Practicum Experience

My practicum at CMHS began with familiarizing myself with the agency and shadowing my Professional Associate. During my MSW education, I met my Professional Associate and her therapy dog, which led to my MSW practicum placement. I was able to explore some of the tools, games, and intervention techniques that were utilized with children while in session. With experience I was able to increase my confidence and skills. I was able to quickly make observations and highlight themes, one of which of was parental guilt in relation to their child’s mental health.

Over the course of my social work education and work experience I have observed that many parents carry guilt related to their child’s mental health challenges. Therefore, it is important to highlight the value of sharing the factors which contribute to anxiety while still acknowledging the parents’ strengths and dedication to their children. Doing this can contribute to a positive working relationship and meaningful change. The patterns of modeling anxious behaviours and anxiety symptoms in parents themselves were present and apparent in my involvement with many of the parents I worked with. I worked from a strengths-based approach and shared how anxious behaviours were potentially being modeled. The strengths-based and anti-oppressive approaches focus and draw on a person’s strengths and assets, which allows an individual to build on their goals and existing skills to address the challenges they may be experiencing (Duncan & Miller, 2000). This approach and reflective practice also required that I highlight the ways in which the child was succeeding and the ways in which the parents were positively impacting the child. It also included encouraging the parent to take care of themselves and connecting parents to their own therapeutic supports.
Initial Assessments

One of my first tasks during this initial period was shadowing initial assessments and completing one with the support and supervision of my Professional Associate. In preparation, I reviewed the documentation both individually and with my Professional Associate to understand the significance of the questions. I completed my first assessment with my Professional Associate present. I was initially confident in the process of completing the assessment as I was familiar with this process as it was a part of my previous role in an acute-care setting. In an acute-care setting, social work assessments are limited to the current circumstances, crisis management, and specific details relating to addressing barriers to discharge from hospital. However, this assessment was more challenging than those that I had completed in the past as I was required to shift my focus from circumstances or barriers to completing the assessment through a clinical lens.

The assessments completed at CMHS were much more thorough than the social work assessments I had completed in acute-care settings and went back to pregnancy, pre-pregnancy parental relationships, and other stressors with the goal of better understanding the whole individual. It is my understanding that this assessment was developed by the CMHS to ensure adequate and relevant information was gathered to best meet the needs of the child’s family. Often details around the pregnancy and pre-pregnancy parental relationship created an image of the family and shared the family dynamics and complicating factors, including developmental milestones. While this was a shift from my previous practice experience, I was able to observe the value of focusing on relationship and rapport building versus information gathering. Being able to shift my practice and see the positive impacts of this allowed me to develop confidence and better meet the needs of the whole person versus focusing on the presenting issue. During
these initial assessments parents and caregivers often asked questions regarding whether or not their child’s behaviours were typical or atypical and what factors may contribute to the atypical behaviours. I observed that the assessment period was often an emotional time for parents, families and caregivers. To ensure ethical practice the initial assessment process often included validating parents’ emotions, struggles, challenges, resiliency, and commitment to their children’s wellbeing. Hearing parents’ stories contributed positively to relationship development, rapport establishment, and the development of trust. As a service provider honouring the stories of the people I work alongside is ethically important to me.

One particularly challenging assessment was when the actions of a parent of a six-year-old derailed the interview and assessment. It was my impression, through reflection with my Professional Associate, that this parent was more focused on sharing their knowledge and discussing their educational background. This parent would often answer or direct their responses to my Professional Associate even though I was asking the questions. During my debrief with my Professional Associate, I was given feedback to focus on the relationship and rapport building with the parent rather than information gathering. My Professional Associate shared that there was a great deal of value in building that relationship initially as the information missed could be gathered at a later date. While I may have understood the value of this theoretically, it was initially much more challenging to integrate this into practice. In reflection, this was likely related to a lack of confidence in my skills and the focus on exploring what the presenting concern was. However, with practice and more confidence, I was able to be more present in the initial assessment process and it became evident that with rapport building as the focus, the information gathering occurred more naturally and effectively.
Creating an open, honest, and safe space is a critical aspect of developing rapport and trust during the assessment process. As such, children were not present during the initial assessments. This allowed parents and caregivers to openly share the challenging behaviours or concerning characteristics without fear of hurting the child’s self-esteem and self-worth. It also allowed parents to express their honest responses to the behaviours. In my experience, both at CMHS and previous work experience, people can be hesitant to accept childhood mental health challenges. I found during this initial assessment process that many parents struggled to accept childhood mental health challenges, either due to guilt and feeling that they somehow directly caused the challenges their children were experiencing or a lack of knowledge or awareness of mental health. Although it was evident that many parents were struggling to accept the challenges their children were experiencing, there was a great deal of value in recognizing that, despite their internal struggles in accepting their child’s mental health challenges, they were still accessing resources and help. I believe that establishing rapport and trust with parents and caregivers facilitates and contributes to rapport and trust with their children as this can be challenging in cases where rapport and relationship have not been established with parents. I worked with one parent who was rather disengaged, which seemed to create rapport challenges and weaken the service user/service provider relationship. Incidentally, I also struggled with their child in this regard.

As my practicum progressed, I was also able to see the different tools and exercises that my Professional Associate utilizes that can facilitate the conversations necessary to explore how the children were feeling and the development of skills to address these concerns. These tools included popular games altered to include exploratory questions, apps created to discuss childhood anxiety, and activity books.
There was a point where my Professional Associate and I structured our days to create a shift from mere shadowing to doing more of the tasks myself, and I completed initial assessments independently. One assessment was completed with one parent instead of both parents together. The children, ages nine and 11, have a parent who had suffered a brain injury that significantly impacted their conduct, personality, and behaviour. I met with both parents separately to ensure that both could be honest about their observations and challenges. Another child’s parent did not support the child in therapy and felt that it was unnecessary. The parent shared that while they believed that intervention was unnecessary, this was not something they stated to the child and that if their child found the experience valuable, then they would continue to support it. During reflection and supervision with my Professional Associate, I discussed my observation that often the concerning behaviour identified by the parents was also something that they often exhibited. This was particularly evident with the family where the parent had suffered a brain injury. This highlighted that often children’s behaviours are identified as the concern while the reality is that the parents or the family as a unit require work.

Early on in my practicum, I struggled with the confidence or comfort to suggest that other family members might require or benefit from intervention or supports for themselves as well. However, over time, I did direct two parents to adult mental health to access supports for themselves. In one case, a parent accessed supports for their eight-year-old child who was experiencing increased anxiety. During a session I was discussing the typical reactions or physiological impacts of anxiety and how people might respond to those feelings in the body. As we continued in the conversation, I asked the child to reflect and share if they have ever had those feelings or reactions and they shared that they felt that it had happened a few times but they felt like it happened all the time for her mom. The parent shared that that was an eye-opening
experience for them and made them reflect on their own mental health. As this parent processed this, we were also able to discuss connecting them with adult mental health supports. They shared that while they had met with service providers in the past, they were unable to connect and create relationships with them as they struggled with expressing their honest feelings.

A great strength of the family mentioned above was the childrens’ healthy or non-injured parent’s determination to be healthy and stable as well as having familial supports. I was able to support the children in their journey towards healing through creating a space where they could share their feelings and thoughts without judgement. I also worked with the parent without the injury on strategizing how to establish and maintain routine and structure in the home to reduce the impact of the strained spousal relationship on the children, and how to minimize the injured parent’s impact on routine and structure (Mosier, 2013). We created a safety plan that involved respite care for the parents. The children also began to journal their feelings and shared them with one parent when ready. The parents did a remarkable job of ensuring their children heard that they were loved. Lastly, in a very structured way, we began to reintroduce the parent with the injury to the aspects of their lives that they had been isolated from and created activities that they could do together.

Another unique experience and learning opportunity was when I completed an assessment where I felt that the child did not require intervention and the information the parent gathered from other services provided by the referring agency seemed to meet the needs of the child. It was my impression that at the time the child seemed to have appropriately dealt with the death of his father for the time being. This challenged my perception that all individuals can benefit from being a part of a therapeutic process. However, it was also apparent that both the
child and the parent were in a positive space and were aware of the resources available should there be a need in the future.

**Engagement**

Similar to the initial assessment, engagement relies on the involvement of parents or caregivers. It is suggested that engagement is especially critical when working with children (O’Reilly & Parker, 2012). This was somewhat challenging for me personally as I do not have children or spend time with children in my family. I relied on the support and guidance of my Professional Associate to organize age-appropriate activities. As time went on my confidence in this area did grow. Often during these activities children shared more authentic feelings and details about their lives which were not directly linked to the presenting issue. Sharing details around favourite shows, favourite colours, snacks or treats created rapport, promoted engagement, and allowed the therapeutic process to begin. The family I mentioned above required being creative, trying alternative approaches, structuring sessions differently, and establishing clear and strong boundaries. The experience reminded me of and solidified the importance of creativity and innovative ideas within clinical work and in particular clinical work with children. I also experienced that rapport and relationship-building time varies between children and families; some children required multiple sessions before I felt that they began to open up. It was my impression that some of this was related to the value they placed on the interventions, their presenting challenges, and their past involvement with mental health services. My Professional Associate provided me with a great deal of information and resources, which allowed me to explore and try different things with families to see what might work best for them at that given time.
Therapeutic Intervention

As I began to schedule follow-up sessions with the children, I maintained my focus on engagement while exploring the challenges they may have been experiencing. Similar to the engagement aspect, ongoing therapeutic interventions must be engaging, entertaining, and fun. Without the entertaining and fun piece, children are quick to report that they are bored; linked to boredom is the importance of considering attention span. It was my experience that children with attention-deficit challenges require extra consideration. As I grew more familiar with the work and more confident, I was able to develop age-appropriate, engaging activities, which were enjoyable yet linked to the therapeutic work and goals. I played family Jenga with the set of siblings and their parent without the injury. This allowed me to get a better understanding of their family, but it also allowed them to share things with one another that they may not have otherwise. During this experience, it became clear that they were learning new things about one another and sharing more genuine feelings with one another, as well as some family dynamics. Over the next few weeks, the goal was to continue to use the games and tools available to create more open communication and explore their perception of the implications of their parent’s accident. These implications included the children exhibiting various behaviours related to the loss of the parent they once knew. Both children indicated that while the accident did not result in the death of their parent their before parent died and the person that their parent is now is completely different. They expressed that while they see their parent in their everyday life, they feel that the changes resulted in a complete loss of who their parent was to them.

During this time, I was also able to explore and utilize different tools and resources available to help children develop insight into the impacts of anxiety on their body. Multiple children that I either observed or worked with in my practicum placement reported these
physiological symptoms. Many times this allowed for or created the opportunity to discuss how anxiety could be felt within one’s body. In this case, my Professional Associate would often share literature, videos, and electronic games that educated children and parents on the physiological impacts of anxiety. This allowed clients to begin to understand the factors that might impact their increased anxiety or anxious responses. Naturally, much of this insight varied due to their cognitive abilities and ages and stages of childhood development. Environmental, genetic, and neurohormonal influences are understood as factors which contribute to the development of anxiety disorders (Kelly, 2005).

I completed one priority assessment during my time at CMHS. A priority assessment is completed if the presenting concerns suggest a child and family cannot or should not wait the usual wait time. Intake noted complicated family dynamics as the six-year-old was in kinship placement after concerns about parental neglect. The child was reported to have difficulties managing her anger, was aggressive, and showed some signs of self-harm, including scratching. In my assessment, it was also evident that, despite their challenges, the client was strong, resilient, sweet, and funny.

Engaging this young child was challenging and I took the time to meet with the caregiver to discuss what their experience or challenges with behaviours were after a few weeks of working with the child. The caregiver provided me with feedback surrounding the sessions with the child, the growth and challenges they were experiencing at home, and lastly the future plans. I shifted my practice somewhat with the child. As the child would often ask her caregiver to answer my questions, I had her caregiver stay in the waiting room instead of participating in the sessions. The child responded well to this; she did ask to stop and check in with her caregiver but often quickly returned. I again attributed this to the need for reassurance that their caregiver
would be there, connecting back to challenges with insecure attachment and their age. Considering the potential impact on attachment, my rapport and trust building with the child, they was always welcome to check in with their caregiver during our time together. After the shift to independent sessions and the opportunity to check with their caregiver they were more engaged and open with their thoughts and feelings. This experience validated the importance of following the lead of families, recognizing and respecting them as experts of their experience, and the value of flexible practice. Work with this family also meant spending time with the caregiver, primarily to help them work towards creating a more secure attachment in their relationship and validating that they, as the caregiver, would be there for the child as needed.

The degree of parenting advice caregivers sought was rather unexpected. I was uncomfortable with the idea of parents looking at me as the *expert* and the idea that my knowledge of typical versus atypical behaviour at various ages and a range of presenting issues must be strong. In my preparation for sessions, I often reviewed resources that my Professional Associate provided and had open and honest discussions with her regarding my knowledge, limitations, and preparations. The time spent with my Professional Associate and reviewing literature prior to sessions was helpful in that I was able to contribute to sessions with families and share the resources that contributed to my understanding or recommendations. I was able to refer parents to resources I had explored, allowing them to review the literature and resources available. However, I always remained reflective of my practice and worked hard to ensure that my ideological values reflected my practice.

Another key shift for me was documentation. This was again a shift from my previous work experience and required some consultation with my Professional Associate. This shift was similar to the initial assessments. The information gathered was documented to provide each
detail of current life circumstances but required reflection and analysis of presenting concerns. This resulted in me taking more time to complete documentation than expected and I was reminded by my Professional Associate that scheduling time for documentation was important and appropriate and to schedule fewer children and families a week. This provided me with a more balanced schedule that met the expectations of the role.

Throughout my time at CMHS, my Professional Associate and I continued to work together closely with opportunities for me to shadow her and scheduled regular supervision. This gave me the opportunity to share my assessments with my Professional Associate and my plans for moving forward.

I worked hard to ensure that my practice respected and honoured the parents’ or caregivers’ and children’s wishes, knowledge, and goals. There were times when ensuring non-judgmental practice was particularly challenging. Much of the work done with a parent who highly valued attachment parenting included validating and acknowledging their challenges and difficulties despite my perceptions and personal and professional opinions of their parenting style. During this time I continued to respectfully encourage and suggest healthier and more balanced parenting options. Eventually, the parent and I were able to come to the agreement that while the child was indeed experiencing challenges and difficulties, the true essence of the work we were doing was parenting skills and parental supports. I provided the parent with information regarding adult mental health services and parenting support services available in the city. I was unable to follow up and see the result of the parent seeking supports elsewhere due to the end of my placement; however, I am confident that our work created an opportunity for the parent to seek supports for herself.
I learned during my time at CMHS that parents were more open to the idea of seeking supports for their children than they were in seeking supports for themselves. I worked with various parents where during reflection or check-in sessions, without the children present, the parents would disclose that the experience had created an opportunity for reflection and they were now aware that they may too require or benefit from mental health supports.

Another valuable aspect of my practicum placement was the opportunity to spend time with other service providers at CMHS, including one who was able to share her knowledge and utilization of Bruce Perry’s Neurosequential Model of Therapeutics. She provided me with different videos, which I was able to watch before sitting down to discuss the approach. Another task that was valuable to my learning was being able to spend a morning with a social worker at St. Mary’s Wellness Centre. She shared the details of their holistic approach to service delivery. This centre has an in-school pediatric clinic and a great fitness area for the children and speaks to the benefits of bringing together services for families in need. I was also able to join my Professional Associate and be a part of a consultation with the Catholic School Board social workers. It was valuable to see the strengths of different views in case planning and the potential positive impacts on children. Additionally, it was valuable to see how schools may work towards meeting the needs of students with challenging behaviours and needs; this was an area where I had little knowledge and the consultation experience allowed me to understand what school social workers experience to a greater degree. This knowledge was an asset during my practicum placement as it allowed me to connect with school social workers to gather collateral information about the children and families I worked with. This included discussion around transitions as these can be difficult for children. Some children benefit from flexibility during times of transition with extra cues and warning around changes.
Ending the Service User and Social Worker/Service Provider Relationship

The last few weeks of my time at CMHS included closing the files of the children and families I worked with, referring them to other services, and referring them to my Professional Associate for ongoing support when that was necessary. In my experience as a social worker, ending the client and social worker relationship creates mixed feelings and emotions in both clients and service providers. I often feel relief and excitement that a client is succeeding and no longer requires services; on the other hand, there are feelings of sadness and disappointment in no longer being involved in the lives of people you worked alongside and grew to care for. In this practicum setting, the most challenging endings were with parents who relied on or appreciated the support of attending sessions. In those cases, there was a shift from when the services were directed and served the needs of the children to either serving the needs of the parent or providing comfort to the family. While this was important in their life and served a purpose, it does not meet the mandate for CMHS and did not serve the children directly. As a student, I had the time, ability, and flexibility to support parents and families beyond the purpose of the sessions. I observed that other service providers did not have the same luxury. With caseload and time pressures, service providers refer out and encourage people to access other groups and services offered by Mental Health and Addiction Services.

Ending the client and social worker relationship became an additional area of growth for me. In my previous practice experience, there were clear end times to the social worker and service user relationship as outlined by policy. Ending the relationship in this setting required having difficult conversations with family members and encouraging them, when appropriate, to seek ongoing supports elsewhere and to encourage them to reflect and recognize their own skills and abilities to highlight their capacity to meet their own needs.
To summarize, my greatest growth as a professional was in the application of knowledge and the ability to understand client experiences and to utilize available techniques and tools to work through their experiences. I entirely acknowledge that my skills, knowledge, and experience may be limited in comparison to the professionals I had the opportunity to work alongside; however, the opportunity to utilize and develop skills with consistent and close supervision was invaluable. I was able to take skills I had developed in previous education, in practicum experience, and experience as a social worker and apply them to a new environment I was entirely intimidated by. Specific areas of growth included my ability to complete initial and ongoing assessments. These assessments included the opportunity to sit down with families, reflect on growth, and the possibility of discontinuing services. I often had reflection time with caregivers and parents separate from the children, over the phone, by email, or in person, followed by conversations with my Professional Associate and lastly conversations with the family together. During this process, a long-standing belief of mine was challenged. I grew to value the significance of rapport and relationship building. Early in my practicum I was focused on information-gathering which did not yield the same answers and exploration of challenges as when I took the time to develop rapport and relationship with children and families. It became apparent that oftentimes this development of rapport and relationship allowed children and caregivers and families to be more open and honest with me and the process, which allowed for more effective practice and services.

**Ethical Social Work Practice**

Ethical social work practice in my practicum setting included adhering to the Social Work Code of Ethics (Canadian Association of Social Workers, 2005), ensuring that my practice was meeting the needs of the service users, and not causing harm to service users. I reflected on
my skill set, consulted with my Professional Associate, and remained reflective of practice throughout. This allowed me to ensure that I was considering client needs and that meeting their needs fell within my skill set. If intervention beyond my scope of knowledge or abilities was required, I was able to refer clients to more appropriate services. Ethical practice for me also includes ensuring I reflect on the individual as a whole. This includes not pathologizing an individual and working to develop an understanding of how their ethnicity, cultural background, sexuality, religion or spirituality, and family structure might impact their life or shape who they are.

Additionally, I worked to ensure that I was meeting children and families where they were at. This including working with children to ensure they were comfortable and felt safe and working with parents in an ongoing manner to reflect on time spent together during sessions. Reflecting on time together helped ensure that children, parents, and families felt heard, honoured, and respected as the experts of their experience. A key aspect of this with children was respecting children's boundaries, for example, if they did not want to play the game or activity suggested.

A simple but important aspect of ethical practice that felt particularly important while working with children was discussing confidentiality. This included telling children in clear and age-appropriate language the limitations on confidentiality and also providing examples. One example included sharing with the children that if I were to see them in the community, I would not say hello first to respect their confidentiality. I believe that spending the time to develop an understanding of how the above-mentioned factors might impact a person contributes to respecting them as a whole person as well as their inherent dignity and worth.
Chapter 5: Conclusion

My journey through social work education and early practicum placements gave me the opportunity to explore different areas of focus and, ultimately, I came to the realization that I have a passion for working with children. I also grew to develop a better understanding of the mental health challenges children, adults, and families can experience. The primary goal of this practicum placement was to develop my social work knowledge and practical experience in clinical counselling with children up to the age of 11. During my time at the CMHS, practicum activities included: initial assessments, developing engagement skills, developing knowledge of therapeutic interventions, and ending the therapeutic relationship.

In this report, I have presented a review of the literature which was completed during and after my practicum placement. The literature review includes a focus on children and anxiety, parenting influences on anxiety in children, attachment and parenting, divorce and grief, and loss associated with brain injuries. The areas of focus were determined by the experiences I had with children accessing services at CMHS. During this practicum period, I was challenged to reflect on my personal practice and explore further what it means for me as a social worker. I was able to explore resources and literature and develop knowledge and skills to help me move towards helping children and families address concerns they identified.

This experience of working alongside families in a clinical setting has allowed me to develop my initial assessment skills, my clinical intervention skills, my ability to integrate theory into practice, and lastly to meet the needs of the children and families I had the honour of being involved with. I was able to establish that my practice is rooted in critical theory and structural social work, anti-oppressive social work, feminist and family systems theory. The values and beliefs of these frameworks allow for practice that acknowledges and recognizes the challenges
individuals experience while honouring and maintaining that they are the experts of their experiences and life. This practice ensures that I adhere to and honour the Social Work Code of Ethics and maintain ethical practice at all times and work towards helping individuals and families make positive changes if they wish to.
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