Counselling in Child and Youth Mental Health: A Field Practicum Report

A Field Practicum Report
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Abstract

This report discusses my clinical experience and integration of theory and practice while completing a Master of Social Work field practicum. The practicum was completed at Youth Community Counselling (YCC) with Mental Health and Addictions Services (MHAS) in Saskatoon within the Saskatchewan Health Authority (SHA). The objective of my practicum placement was to gain graduate level practice experience with youth diagnosed with complex mental health issues via individual counselling and family therapy sessions. The therapeutic framework integrated into my practice with individuals and their caregivers included Trauma Informed Care (TIC), Cognitive Behavioural Therapy (CBT), and Solution Focused Brief Therapy (SFBT), from a Strengths-Based Perspective (SBP). The report begins with my learning objectives, practicum activities, and my direct practice learning experiences in my placement setting. I then present information on mental health and the process of assessment and diagnosis within my practicum placement, followed by a review of the literature on the theories integrated into my practice and a reflection on the theories. Lastly, I discuss values and ethics in relation to my practicum learning experience, and conclude the report with a final summary reflection.
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CHAPTER 1: Introduction

After completing my Bachelor of Indigenous Social Work degree (BISW) in 2011 through First Nations University of Canada (FNUC), I began working in a casual position as an Addictions Counsellor at Calder Centre in Saskatoon. Calder Centre is a Saskatchewan Health Authority (SHA) inpatient treatment facility for youth and adults in the stages of recovery from substance use. During the five years I worked at Calder Centre, I developed a deeper understanding of mental health and addictions, and specifically the progression experienced by those seeking treatment. This position helped me learn about the importance of counselling, addiction treatment and recovery. In addition to my former position at Calder Centre, I was employed at Community Living Service Delivery (CLSD) with the Ministry of Social Services (MSS) for six years as a caseworker, and one year in the capacity of supervisor. CLSD provides residential and vocational supports, counselling, programming and advocacy for individuals with cognitive impairments. After working at Calder Centre and CLSD I knew I wanted to further my education and build my skills in the area of clinical work with people experiencing mental health issues. I returned to the University of Regina, Faculty of Social Work in 2013 and started working towards a Master of Social Work (MSW) degree.

This report is a reflection of my clinical experience during my field practicum in partial fulfillment for my MSW degree. I begin the report by presenting the rationale for my choice of the placement setting, my practicum objectives, and discuss how the objectives were achieved. This is followed by a review of the literature on the therapeutic frameworks utilized in my practice. I then provide case examples from my practicum experience, discuss challenges related to my clinical work in practicum, ethical considerations, and conclude with reflections on my learning.
1.1 Rationale for the Practicum Placement

For the final stage of completion of my Master of Social Work degree (MSW) I chose to complete a field practicum placement. I made this decision because it would allow me to gain direct clinical practice experience with individuals and families. I specifically selected a placement with the Youth Community Counselling Program (YCC) at Mental Health and Addiction Services (MHAS) with the Saskatchewan Health Authority (SHA); given that this is a setting where mental health clinical services are provided for youth and their families. In terms of my clinical interest this seemed like a good fit for me in my practicum placement. Youth Community Counselling’s main philosophy is directed to connecting youth and families to promote well-being and recovery (Mental Health and Addiction Services [MHAS], 2016). I have always had a passion to support youth with a variety of challenges in an effort to empower, educate and emotionally strengthen them through life’s struggles. This was an opportunity to fulfill one of my life goals and achieve my desire to support clients to reach their potential. My direct experience at Youth Community Counselling as a graduate-level practicum student allowed me to observe the many ways that the staff demonstrate equity of care, professionalism, and the ways in which they ethically practice with individuals who present with a wide range of challenges.

Youth Community Counselling provides services to youth and their caregivers who may be experiencing “depression, self-harming, trauma, eating disorders, obsessive compulsive disorders, early psychosis, addictions, difficult life circumstances, complex family life, complicated bereavement, LGBTQ, and suicide risk” (MHAS, 2016, p. 2). The youth team is multi-disciplinary and includes addictions counsellors, outreach workers, a psychiatric nurse, a dietician, recreational therapists, psychologists, social workers (Bachelor and Master levels),
psychiatry supports, and administrative staff. Services are provided to all people regardless of their race, class, or ethnic background.

I completed a 450 hour practicum at Youth Community Counselling under Mental Health and Addiction Services, through the Saskatchewan Health Authority, formerly known as the Saskatoon Health Region (SHR) during the time of my placement, from May 23 to August 18, 2017. Since completion of my practicum the province of Saskatchewan amalgamated 12 health regions into one provincial governance body, the Saskatchewan Health Authority, for the delivery of health care services. During this practicum, I was in direct practice, under clinical supervision, with youth ages 12-18 who experience mental health issues. I also worked with their caregivers. The purpose of this practicum was to enhance my skills in, and knowledge of, individual and family counselling within an interdisciplinary environment. In addition, I wanted to gain a deeper understanding of youth experiencing complex mental health issues. During the practicum I supported youth clients experiencing depression, anxiety, self-esteem issues, and suicidal ideation. I also worked with clients in the stages of transition from home or to university, and with clients experiencing trauma, parent teen conflict, and self-harming behaviours. I was mentored and supervised by two Professional Associates; one is a Clinical Coordinator of Youth Community Counselling and the other is a Senior Clinical Social Worker and Parent Therapist Program Coordinator. My learning occurred through the integration of theory and practice in my work with individuals and families.

During my placement, I wanted to further my knowledge of practice theory and integrate this understanding into clinical practice. I focused on learning and implementing Cognitive Behavioural Therapy (CBT) and Solution Focused Brief Therapy (SFBT) into my work from a Strengths-Based Approach. I chose to incorporate CBT and SFBT because they are both
evidence-based and focus on behavioural change. I also incorporated Trauma Informed Care (TIC) and Family Systems Theory (FST) as I observed that a number of clinicians at Youth Community Counselling incorporated these approaches in their work. TIC became an important practice approach to me, especially given that many of the presenting problems that clients were bringing forward were as a result of current or historical trauma. TIC is also relevant given the literature on the prevalence of trauma in children and adolescents. One of my Professional Associates also created an opportunity for me to build a greater understanding of working with clients who have experienced trauma by sharing her knowledge of, and experience with, The Neurosequential Model of Therapeutics (NMT) for which she was trained through the Child Trauma Academy.

1.2 Program Objectives and Activities

The development of learning objectives was a critical component to the field practicum. I chose objectives that would enhance my skills at a graduate level in a short period of time. I wanted to better understand the experiences of individuals and caregivers, and to be able to provide them with tools to assist them in coping with their struggles so that they could live a meaningful life. My learning objectives for my field practicum placement are presented below and are followed by a discussion on how I met each objective:

1) To increase my group facilitation/co-facilitation skills.
2) To provide therapeutic intervention and assessment with youth and families.
3) To gain a deeper understanding of children and youth experiencing complex mental health issues.

Entering the field practicum, I was aware that Youth Community Counselling had an interdisciplinary team; however, I was not aware of the extent or diversity of that team. I did
know that I would have the opportunity to experience a wide range of activities while completing my field practicum, and I was flexible in the activities and learning which allowed me to grow from interactions with all members of the team. As such, my learning objectives were met through a variety of activities, including: engaging in peer supervision, attending an annual staff retreat, participating in a bi-weekly Parent Therapist Group, observing other clinicians in session, observing psychologists conducting assessments, co-facilitating and planning a Summer Blast group, and managing a caseload of clients. Each learning activity is discussed in the next sections.

1.2.1 Peer Supervision. Peer supervision takes place weekly with all staff members. During this time, staff can accept new cases, present challenging cases, receive an update in terms of business presented by management, present information to one another on educational components from trainings attended, update on intake statistics, and engage in discussion on general successes or challenges with case management. Peer Supervision is intended to be interactive, educational, and inclusive. Through Peer Supervision I was able to review the services that are provided, develop an understanding of how services are delivered, and receive ideas on how to manage individual cases that I was assigned and that I found challenging.

1.2.2 Staff Retreat. While in this placement, I attended an annual staff retreat, which was a remarkable experience. This was remarkable for me as it contributed to my personal growth in allowing me to increase awareness of my own and others’ emotions. The goal of the staff retreat was to create time for staff to reflect and engage in team building activities. The therapeutic framework that was the focus of the retreat was psychodrama. Psychodrama is a form of group psychotherapy that is aimed to bring positive change to group members and is considered to be valid and effective (Dogan, 2010). Psychodrama was a great therapeutic framework to
incorporate into the staff retreat as it is group focused. The retreat challenged me to use different parts of my heart and mind, and allowed me to become centered, and reflect on my personal and professional experiences. Additionally, the retreat allowed me to gain a better understanding of some of the complex health issues that teens experience by listening to my colleagues’ stories of resiliency from their own teenage years. We were all asked to share a story of something we had to overcome as a child/youth. As I listened to the stories of colleagues, I was amazed by their ability to cope with life struggles. I also had the opportunity to share my story which was difficult given that I was new to the team. This allowed me to reflect on how youth may feel when meeting with a counsellor for the first time to share their stories and seek support.

1.2.3 Parent Therapist Group. The third activity that I participated in was the Parent Therapist Group which occurred bi-weekly and was facilitated by a senior clinician on the youth team. The goal of this group is to educate and support therapeutic foster parents in empowering troubled youth who are connected to the Ministry of Social Services and Child and Youth Mental Health Services. During the group sessions, foster parents would share both successes and struggles with the youth in their home. The clinician facilitated psychoeducational sessions to the group and would coach the foster parents through any struggles they were facing with the youth in their care. This is also an opportunity for the group facilitator to share suggestions, thoughts, and provide information on best practice and development for the youth. My participation in this group was as an observer. In attending the groups, I was able to provide individuals and families with recommendations that I learnt while observing. I was able to gain a deeper understanding of the role therapeutic foster parents have, as well as more information around policies and practices associated with the Ministry of Social Services.
1.2.4 Assessment and Observation. Having the opportunity to observe one of the psychologists on site and participate with them while testing for anxiety and depression was an additional learning objective. Through this objective I was able to gain insight on the complex mental health issues that adolescents face and how these issues are diagnosed. I was able to observe the psychologist in several assessment processes including the Multidimensional Anxiety Rating Scale. The Multidimensional Anxiety Rating Scale is an assessment tool used to measure symptoms in children and adolescents who experience anxiety issues that impact their daily life (March, Parker, Sullivan, Stallings, & Conners, 1997). It is typically used by clinicians in supporting the development of a treatment plan. As a practicum student, I was asked to simply observe the assessment being conducted and not interrupt in any way until complete. Additionally, I observed administration of the Delis-Kaplan Executive Function System (D-KEFS). The D-KEFS includes nine individual standardized tests aimed to assess higher-level cognitive functions, referred to as executive functions, in both children and adults (Delis, Kaplan, & Kramer, 2001). The subtests I observed included the Trail Making Test, Verbal Fluency Test and Color-Word Interference Test with clients.

These observational activities provided me with an opportunity to learn how testing was done, how clients responded to the results, and what service plans should be made in moving forward with the client based on their responses to the tests. Although my role in the completion of the assessments was mainly to observe the psychologist conduct the testing, I was able to complete the Multidimensional Anxiety Rating Scale and the Depression Inventory Scale with one of the clients on my caseload, under supervision. I asked the client the questions and the psychologist provided the scoring. Based on the outcome of the testing results it was determined that the client was depressed and suicidal. The results of the assessment were helpful in
determining the client’s emotional state. My role in supporting this client was limited after the assessment and testing was completed due to my placement ending. Because of this, the client’s file was transferred to the psychologist who had been providing clinical supervision to me as I worked with the client.

**1.2.5 Applied Suicide Intervention Skills Training.** Through my placement at the SHA, I was able to renew my Applied Suicide Intervention Skills Training (ASIST), which is a two-day interactive workshop in suicide first aid. At Youth Community Counselling, the Columbia-Suicide Severity Scale is the primary tool used to evaluate suicidal ideation and risk in youth (The Columbia Lighthouse Project, 2016). I received an educational training component on this scale provided through an online video.

**1.2.6 The Partners for Change Outcome Management System (PCOMS).** I also attended a two day workshop for The Partners for Change Outcome Management System (PCOMS). PCOMS is a tool that the Saskatchewan Health Authority introduced in 2014 due to the growing need in exploring evidence-based practice in mental health and substance abuse services (Mental Health & Addiction Services, 2014). Developed in 2000 by Scott Miller and Barry Duncan, evidence-based scales are used to assess behavioural healthcare services. This outcome tool provides quantifiable data on the quality and outcomes of counselling sessions by having the client rate their progress as well as the clinician’s training (Partners for Change Management System, 2018). As a student, the use of PCOM’s allowed me to gain a better insight of the client’s progress. Additionally, when I found it difficult to measure clients’ progress PCOMS provided insight as to how clients were doing. This tool helped guide me in ensuring I was working in a way that best served the youth.
1.2.7 Case Management. Lastly, I managed a caseload of 13 clients while in my practicum placement. These clients presented with a wide array of challenges including: anxiety, depression, suicidal ideation, self-harming behaviours, trauma, intergenerational trauma, parent teen conflict, relationship building issues, and abusive relationships. My role was to provide support to individuals and families dealing with mental health disorders that at times were diagnosed and other times undiagnosed, as well as supporting clients with emotional issues. In addition, I provided recommendations and completed community referrals. Some clients received services for a short period of time, for example one session, and others were supported during my entire placement and then were transferred to one of my Professional Associates for continued service at the end of my practicum.

The next section presents an overview of mental health including the populations impacted, the determinants of mental health, and how mental health disorders are diagnosed.

1.3 Mental Health

Mental health is defined as a “state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (World Health Organization [WHO], 2014, n.p. para. 1). This definition highlights how mental or psychological well-being is influenced by personal characteristics as well as socioeconomic circumstances. Mental health can be influenced by many factors such as the social and economic conditions in which one lives, which are known as social determinants. Social determinants of health are “defined as those conditions in which people are born, grow, live, work, and age that impact health and well-being” (Shim et al., 2014, p. 23). Social determinants, such as poverty, limited education and disability, and the rapid changes in society can result in a disruption of overall health (Canadian
Mental Health Association [CMHA], 2018; Shim et al., 2014; WHO, 2014). Environmental factors such as geopolitical and sociocultural environments can influence the mental health and well-being of individuals (WHO, 2014). The mental health status within one’s household or community is also an important consideration that includes levels of access to basic life necessities and services (water, essential health services, the rule of law), exposure to predominant cultural beliefs, attitudes or practices, as well as social and economic policies formed at the national level (WHO, 2014). In fact, “low income Canadians are 3 to 4 times more likely than those in the highest income group to report mental health issues” (CAMH, 2018, para. 10). The national statistics suggest that 1 in 5 Canadians presently experience mental health related problems and these numbers continue to increase (CMHA, 2018; Mental Health Commission of Canada, 2009).

An individual’s mental health can be impacted by mental illnesses. Mental illness is a common struggle faced by many people and can affect people of all backgrounds. Furthermore, people of all races, classes, or ethnic groups can acquire a mental illness over their lifetime. “Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time” (WHO, 2014, para.1). Mental health illnesses can range from common mental health issues such as depression and anxiety to more severe mental illnesses such as schizophrenia and bi-polar disorder (Fenton, White, Gallant, Hutchinson, & Hamilton-Hinch, 2016). Mental health illnesses such as anxiety, depression, and post-traumatic stress disorder are often diagnosed with the use of The Diagnostic and Statistical Manual of Mental Disorders (DSM 5) used by health care professionals e.g., psychiatrists, psychologists, some physicians, and some social workers in specific provinces. The DSM Manual, now in its 5th version, contains descriptions, symptoms, and other criteria for diagnosing mental disorders
which can be a helpful guide in diagnosing and prescribing appropriate treatment and supports (American Psychiatric Association, 2017). In my experience I found the DSM to follow a medical model used to support the diagnosis of mental illness, and guide the subsequent goal and treatment planning.

Historically, social workers were unable to assess and diagnose mental illnesses through the use of the DSM as it was only measured and diagnosed by a psychologist, psychiatrist, and some physicians. However, in 2013 policy within the Social Work profession changed due to the lengthy wait times of patients requiring mental health treatment and diagnoses (Austin, 2017).

“The reform was introduced following extensive lobbying by the Saskatchewan Association of Social Workers (SASW) and during a time of increased recognition of mental health issues both provincially and nationally” (Austin, 2017, p. 1). As such, because of the increased recognition and lengthy wait times, there were not enough mental health clinicians available to support, diagnose, and respond to people with mental health diagnoses. This had placed significant barriers for people who needed to access services.

Treatment for mental illness such as psychotherapy can be effective in increasing a person’s overall mental health and wellbeing. Mental illnesses can generally be addressed through supports such as individual therapy, family therapy, support groups, or medication. Many people experience fear at the thought of accessing services or admitting to having a mental illness due to the stigma and discrimination associated with it. Essentially, all people need the capacity to adapt to their social surroundings. This can include engaging positively with family members, friends or colleagues, and earning a living for themselves and their families (WHO, 2012).
The next chapter explores the literature on the therapeutic approaches that I incorporated into my practice while conducting individual and family sessions under clinical supervision. The chapter will also include discussion on challenges, successes, critiques of therapeutic approaches, and a critical analysis of my learning experiences.
CHAPTER 2: Literature Review

During my field placement, I observed clinicians incorporate a variety of therapeutic approaches into their work. As discussed in the previous chapter, I chose to incorporate Cognitive Behavioral Therapy (CBT), Solution Focused Brief Therapy (SFBT), Family Systems Theory (FST), and Trauma Informed Care (TIC) as the basis for my learning and skill development during the practicum. In addition, I worked to frame these therapeutic approaches within a Strengths-Based Perspective (SBP). Initially, when I started my placement, I chose CBT and a Humanistic Approach (HA) as my therapeutic focus but chose to incorporate SFBT instead as it was a better fit than CBT and HA with my personal style, values and beliefs. During the clinically supervised sessions that were part of my practicum experience, I would integrate the therapeutic framework that best fit the client’s needs and their therapeutic goals. This chapter will include a literature review with an overview of Strengths-Based Perspective, Cognitive Behavioural Therapy, Solution Focused Brief Therapy, Family Systems Theory, and Trauma Informed Care in working with adolescents to provide mental health support to them and their caregivers. I conclude the chapter with a critical reflection on the therapeutic frameworks discussed.

2.1 Strengths-Based Approach (Overarching Framework)

I chose to incorporate a Strengths-Based Approach (SBA) to frame my practicum work because it is an empowerment perspective that is evidence based and holistic (Saleebey, 1992, 2009; McCamey, 2015). This model continues to gain popularity as a one of the preferred therapeutic methods of treatment (McCamey, 2015). Saleebey (2009) identifies SBA as an approach that draws away from individual weaknesses and limitations and focuses on the strengths and coping mechanisms of an individual. SBA is about empowerment and helping
individuals, communities, and families identify their capabilities and options that will support them in increasing their quality of life (Saleebey, 2009). I would describe my personal approach as strengths based and I naturally incorporated it into my work currently and throughout my previous social work career. A personal belief I have as a student counsellor is that it’s important to explore my own strengths to be able to understand the process that clients go through when exploring their strengths. I believe SBA to be a model of resilience. De Jong and Berg (2002) suggest that if practitioners focus on problems or pathology, clients may become discouraged and feel that they are victims of some disease or dysfunction.

Accordingly, SBA in social work practice moves toward envisioning the survival and growth capacity that clients already possess (McCamey, 2015; Saleebey, 2009). The process is achieved through the information shared between the client and the therapist (Saleebey, 2009). SBA can be understood as a collaborative process between the client and service provider allowing them to work together to determine an outcome that draws on the person's strengths and resources available (Min, 2011; Saleebey, 2009). Ensuring that practitioners create the environment for clients to take the lead in identifying their strengths to reach personal goals can contribute to clients feeling empowered and lead to a solid therapeutic relationship. SBA was congruent with the multidisciplinary nature of my practicum setting in which multiple opportunities arose to work collaboratively with both the clients and the counselling team. By incorporating SBA into practice, I learned that it was important to implement the therapeutic framework, and that within this framework, principles have been developed.
Researchers and practitioners collaborated in the development of principles to help guide the foundation of implementing SBA into therapeutic sessions. Guiding principles are not just theoretical. They are about the values that people embrace, that influence the way they care for themselves, for others, and the deepest level of their true meaning (Saleebey, 2009). Hammond (2010) identifies nine principles that are discussed below.

First, every individual possesses several unique strengths that support them to define who they are when sharing and reflecting on personal stories. The second principle focuses on individual strengths which allow personal empowerment. This can create a reality to focus on strength, not weaknesses, problems or labels (Saleebey, 2009). The third principle focuses on the importance of being mindful of appropriate and supportive language. Positive communication can support in the creation of an authentic relationship which is a primary foundation in therapy. Within the fourth principle, the importance in believing that change is inevitable can create the internal strength individuals need to move forward. Fifth, the creation of an authentic relationship can facilitate the process of change by allowing a client to feel cared for, respected and safe. Sixth, ensuring the client’s perception of their story is taken seriously as they are the expert in their lives. The seventh principle, is where client’s will begin to develop comfort in their journey ahead and aim to envision personal growth. Eighth, the foundation of growth has been developed allowing clients to work towards achieving their goal. The final principle is one that emphasizes the importance of collaboration. Collaboration between the clinician, client, family and community is essential to support the individual to move forward. Through the use of the principles, Saleebey (2009) suggests incorporating some of the following questions in supporting to direct the helpers’ conversations during the interview. “How have you managed to survive this far given all the challenges you have had to contend with? Who are the special
people on whom you can depend on when things were going well in life? What was different and what has worked in the past to bring a better life for yourself?” (Saleebey, 2009, p. 87).

While working with youth and families in my placement, it became clear to me that the strengths-based approach is an empowering approach. Some clients experienced difficulty acknowledging their strengths and required some support, however others stated they had experienced difficulty recognizing them and were able to see them once discussed. I believe SBA to be empowering for individuals and families because it is a collaborative approach and focuses on externalizing problems.

2.2 Cognitive Behavioural Therapy

As discussed in the introductory chapter of this report, I chose to incorporate Cognitive Behavioural Therapy (CBT) into my practicum. Aaron Beck developed this approach based on his experience in treating individuals experiencing anxiety and depression (A.T. Beck, 2005; J. Beck, 2011). CBT is recognized as one of the most effective therapeutic approaches used by social workers and is seen as being particularly effective in mental health settings (González-Prendes & Brisebois, 2012; McCamey, 2015). Throughout my practicum placement, I learned that CBT was a desirable therapeutic approach utilized by several clinicians working with youth and their families at Youth Community Counselling (YCC). It was also brought to my attention at YCC that many of the groups facilitated at the agency utilized CBT as the main therapeutic approach. Throughout my graduate program, CBT was often discussed as being effective, adaptable, and easy for clients to comprehend. Entering my practicum placement, I knew I wanted to support clients who were struggling with anxiety and depression. In fact, while completing my practicum the number one presenting issue expressed by clients while at Youth
Community Counselling (YCC) was anxiety and depression related concerns. I also came into my placement with the knowledge that CBT could be an effective approach for some clients.

CBT is a short term psychotherapy that is widely used by many clinicians to support clients in developing skills, goals, and staying healthy (A.T. Beck, 2005; Herman, Shireen, Bromley, Yiu, & Granholm, 2016; Tolin, 2010). This therapeutic approach suggests that dysfunctional thinking can lead to altered behaviours and moods, which can be the root of individuals’ psychological distress (J. Beck, 2011). The aim of CBT is to replace negative dysfunctional thinking and overcome negative beliefs and behaviours by replacing them with positive and realistic thoughts (J. Beck, 2011; Knaus, 2008). J. Beck (2011) shares that in the beginning of childhood people develop certain ideas about themselves, other people, and the world. The role of the clinician is to guide the client through a process of cognitive restructuring (A.T. Beck, 2005; Herman et al., 2016). This process is done by examining the client’s inaccurate, automatic thoughts and supporting the client in replacing them with positive emotions and outcomes (A.T. Beck, 2005; J. Beck, 2011). CBT can also be utilized in a variety of settings such as schools, medical offices, vocational programs, prisons, and other therapeutic settings (J. Beck, 2011).

CBT sessions generally last 45-50 minutes, but the first session generally spans over one hour (A.T. Beck, 2005; J. Beck, 2011). Sessions do not have to follow a strict set of guidelines, however, Beck believes that it is important to establish a therapeutic alliance at the beginning of a session (A.T. Beck, 2005). The goals of the first session should include: building an alliance, educating the client on their disorder, collecting data, developing goals, and starting problem solving with the client (J. Beck, 2011). In the process of utilizing CBT many tasks need to be accomplished in a session. These include, “conceptualizing the case, building rapport, socializing
and educating the patient, identifying problems, collecting data, testing hypotheses, and summarizing” (J. Beck, 2011, p. 12). This role was difficult for me as a beginning therapist as I was always worried about missing specific information. I developed a template I would generally use during the first session to ensure I was capturing all the information required to allow me to build a treatment plan. This information included, for example, demographic information, medical information, history of trauma, family members, social interests, medications, diagnoses, and previous counselling. Developing expertise in delivering CBT takes time, experience, and training. According to J. Beck (2011) expertise in CBT can generally be viewed in three stages. Stage one: the therapist learns basic skills to examine a case during the initial intake of data collection (J. Beck, 2011). Stage two: the therapist become more proficient at integrating their conceptualization with their knowledge of techniques, and stage three: the therapist develops the ability to automatically integrate new data and has the ability to conduct sessions accordingly (J. Beck, 2011).

CBT has been one of the most researched and effective treatments for depression and anxiety (J. Beck, 2011). Hofmann, Imke, Vonk, Sawyer, and Fang (2013) examined the efficacy of CBT and found it to be a very strong theoretical approach for many mental health issues, most cost effective, and found to be the most widely studied approach. Additionally, a meta-analysis by James, James, Cowdrey, Soler, and Choke (2013) examined anxiety disorder with children and adolescents who experienced anxiety and depression related illnesses. The study concluded those who received CBT experienced a significant reduction in anxiety symptoms (James et al., 2013).

As with most approaches, CBT has been proven to be effective in supporting clients’ success in therapy, however some limitations have been demonstrated. A challenge I experienced
while utilizing CBT was that CBT was not new to me as I had studied the approach. However, I had not used it in my practice. I found at the beginning of my placement I often had to complete preparation work prior to the session with the client. This would include gathering educational materials for the youth, collecting worksheets, and ensuring I was able to respond appropriately to my client’s emotional response if their thoughts were being challenged. I particularly found that having visuals, such as utilizing my whiteboard to demonstrate a client’s thoughts, feelings, and behaviours as part of sessions was helpful in supporting youth in understanding cognitive distortions. Additionally, worksheets would be provided and reviewed at the next session if a client wanted extra exercises to work through. I have learned that the use of worksheets and homework for the client can be beneficial in that they have the ability to implement strategies independently. However, I have had situations where clients did not want the homework but perhaps take it only to please me, as the therapist. An additional challenge I encountered when incorporating CBT was that I was often working harder than some clients. I quickly identified that some clients, especially those mandated to attend sessions by their parents, often were not invested in change. A struggle I personally faced while incorporating CBT was that I expected clients to act quicker on their goals. I think this was primarily due to the fact that I was not overly familiar with the process of therapy, was eager to solve the presenting issue, and eager to help a youth feel better immediately. I learned that therapy can be a slow process for some individuals, that patience is required, and not one style or method fits all clients.

2.3 Solution Focused Brief Therapy

Solution Focused Brief Therapy (SFBT) was one of the therapeutic models that I favoured over all the frameworks that I incorporated into this practicum. SFBT was originally developed as brief family therapy in the late 1980’s by a husband and wife team, Steve De
Shazer and Insoo Kim Berg, along with their colleagues (Lipchik, 2002; Smith, 2014). In their work they realized that people made quicker progress in therapy when they spoke about solutions rather than their problems (Smith, 2014). This type of counselling is aimed to support clients in focusing on solutions rather than struggles. The acceptance of the use of SFBT was highly desirable at Youth Community Counselling as it is adaptable, and evidence based. The reason this was a desirable approach for me is because it is evidence based, strengths-based, supports individuals in solving their own problems, and identifies client strengths. The approach is collaborative, supports empowerment, and focuses on the here and now (Lipchik, 2002). The use of incorporating SFBT into therapeutic sessions has been known to be easily adaptable. Stages have been developed to use when practicing SFBT.

De Jong and Berg (2002) identify the following stages to be utilized when conducting sessions with clients. Describing the problem is the first step with the goal of allowing clients to describe the issue(s) as they see them. The therapist will ask few details and limit the focus during this stage, listen to the problem, and think and talk about ways to turn the conversation into a pathway to transition into the next step (De Jong & Berg, 2002; Smith, 2014). The second stage consists of developing well-formulated goals. Throughout this step the therapist will work with the client to envision what will be different in the client’s life if the problem is solved (De Jong & Berg, 2002). The third step is described as exploring for exceptions stage, which requires the therapist to ask the client about times in their life in which their presenting problems were not as severe and what was happening that made it different. End of session feedback, the fourth stage, involves the therapist providing the client with positive feedback based on the information they have presented during the session around well formulated goals. The fifth and final step is evaluating client progress. This is a way for therapists to evaluate a client’s progress on a scale
from zero to ten (De Jong & Berg, 2002). This can be a great method for the client and the therapist to ensure that problems are being adequately solved, especially if the scale is on the higher level. The sliding scale was something I incorporated in conversations in combination with The Partners for Change Outcome Management System (PCOMS) which was developed by Barry Duncan (Duncan et al., 2003; Partners for Change Management System, 2018). The use of these scales supported the development of a client’s goals and captured areas where changes could be made.

Searching for goals can allow clients to become increasingly creative and take the lead in their healing process. It can create opportunities for the therapist to work in a client-centered way. It is believed that clients have the ability to know what problems need to be solved and that therapists need to strictly assist clients in constructing new ideas and goals (Cheung, 2009; Smith 2014). Well-formulated goals need to be developed by the client, at times with assistance from the therapist. Within the use of SFBT well-formulated goals have the following characteristics:

1. goal is important to the client, the goal can be stated in interactional terms,
2. goal has situational features, the goal should not be too global,
3. goal should specify some desirable behaviors rather than the absence of problems,
4. goal will state a beginning step rather than the final result,
5. goal is to be concrete, behavioral and measurable,
6. goal is realistic and achievable, and the goal will be a challenge to the client (Cheung, 2009, p. 214).

A miracle question is a tool that is useful in assisting clients in SFBT. It allows clients to move away from some of the current difficulties and view satisfaction in their life (De Jong & Berg, 2002). Miracle questions ask a client to describe what would be different in their life if a
A miracle happened overnight or what would happen if they went to bed one night and when they woke up all their problems were solved. Additional suggested questions can be asked like, what if you were not aware of a miracle happened because you were sleeping, and what would be different when you woke up in the morning? When you wake up in the morning, what would allow you to know a miracle occurred (De Jong & Berg, 2002). This is not an easy change for clients and consists of using their perception as well as support from the clinician, therefore resulting in a shifting and broadening of the client’s thoughts.

In some situations, scaling questionnaires are another component to SFBT. Scaling questions can be used to assist clients with assessing their own situations or tracking progress and generating possibilities. Scaling questions can be helpful in evaluating a client’s perception of many things including “self-esteem, precession change, self-confidence, prioritization of problems solved, perception of hopelessness and to evaluate progress” (Cheung, 2009, p. 217). A question is generally asked to invite the client to observe their perception on things, such as change or progress. Scaling questions are measured on a Likert scale from one to ten with one identifying a lack of change and ten denoting that progress has been made. Scaling questions challenged me in terms of my own learning experience and supported me in terms of where I needed improvement in the flow of the session. It allowed me to gauge progress, focus on the client’s goals and supported me in guiding sessions specific to the client’s goal.

Studies have been conducted to illustrate the effectiveness of SFBT. Gingerich and Peterson (2012) reviewed controlled outcome studies (SFBT) in an effort to evaluate its effectiveness. Gingerich and Peterson (2012) concluded that 74% of forty-three studies reported positive and effective change. Additionally, a controlled study was reviewed by Gingerich and Eisengart (2000) aimed to examine the effectiveness of SFBT. They did a meta-analysis aimed to review
15 controlled outcome studies of SFBT. It concluded SFBT to be most effective with groups and issues including “depression, parenting skills, offender recidivism, adolescent offenders, problem drinking, counseling high school students and school groups, couples therapy, mental health training, family environment, public social services, and outpatient family and mental health counseling” (Gingerich & Eisengart, 2000, p. 470).

I used SFBT with other therapeutic approaches during my placement. Similar to Strengths Based Approach, it focuses on externalizing the problem and supports the facilitating of change as opposed to solely focusing on the problem. I believe SFBT allows clients to feel empowered, it focuses on the present and the future, it holds people accountable for their own solutions to problems, it is short term, and it is effective with any mental health issue. I personally found it challenging to incorporate the miracle question into sessions due to my lack of confidence and feeling like it was an odd question. Near the end of my placement I became more confident and began utilizing this question. It became more comfortable after practicing the question in front of colleagues and exploring ways of delivering the question in a way that felt organic for me. Once I became confident, I would utilize it in individual and family sessions. For example, if I was meeting individually with a parent, I would ask them the question in an effort to try and move away from the situation or problem and move toward a more positive approach. It wasn’t until later in my practicum that I understood the importance of involving family into sessions.

2.4 Family Systems Theory

Family Systems Theory (FST) was a newer approach for me to incorporate during my practicum placement. Family Systems Theory was developed by Murray Bowen, a psychiatrist, in 1978 (Kolbert, Crothers, & Field, 2012; Papero, 2014). Bowen developed a family systems theory, later called the Bowen theory, to distinguish it from other systems theories developing at
the same time. “The theory proposes that emotional, physical, relational, and social symptoms in a person or set of relationships reflect disturbances in the family relationship system itself” (Papero, 2014, p. 386). The aim of this therapeutic approach is to allow individuals the opportunity to share their stories. Through these stories, the family therapist hypothesizes about how the family is impacted and uses this information to support the family in developing a therapeutic goal (Kolbert et al., 2012). Collins, Jordan, and Coleman (2010) state that, in family systems there is a belief that if problems arise within the family unit, it cannot be attributed to individual dysfunction or pathology. Rather, understanding family dynamics will help uncover family processes that seem to foster and maintain a presenting problem (Collins et al., 2010). As such, therapists need to ensure they are looking beyond individual behaviours and focusing on, and observing, the family dynamics (Kolbert et al., 2013). If concerns within the family unit are not addressed, conflict, mental health concerns, and behavioural issues will continue to present as problems and continue to disrupt the family unit (Collins et al., 2010; Kolbert et al., 2013; Papero, 2014). Within family therapy, a therapist’s role is to ensure that they continually coach the family and praise them when something is done successfully (Carr, 2006).

According to Collins et al., (2010) family members will often agree that there is a concern within the family unit, but believe it is a problem with a specific member and not the family. Bowen developed a way of thinking that linked family members’ emotional reactions to situations. He believed that the emotionally reactive person will take little accountability for their own actions and often blame others, which can create a chain response of emotions (Papero, 2014). From my experience at Youth Community Counselling (YCC), parents would often drop off their child and put all the work into the hands of the youth and clinician, refusing family intervention. As clinicians it is important to educate and involve families within family systems
and evaluate the situations, not just the individual attending session. This is especially important due to the recognition of the stages of the family life cycle, as changes in the family structure and function do occur.

Family life cycles create unavoidable change and each stage creates stressors and demands in the need for the family unit to make change and adjust (Golijani-Moghaddama, 2014). Collins et al., (2010) confirm that teenage years are challenging and can create change and distress within the family unit. Teenagers are in a stage where they are reaching puberty, dating, making decisions and may experience little sense of responsibility and achieving independence (Collins et al., 2010). Specifically, developmental changes during adolescence can be confusing for both teens and their families. It is important for parents to develop a positive relationship with their child for the purpose of guiding their child through the developmental challenges and phases (Collins et al., 2010; Golijani-Moghaddama, 2014).

During my placement, I observed many parents who lacked an understanding of the challenges associated with adolescent development that their children were experiencing. I found I spent a lot of my time educating parents on the developmental changes that occur for youth and ways to approach or respond to certain situations. For example, these include providing parents with psychoeducation on teen development, providing information on diagnoses, behaviours and how to intervene when situations arise. I provided families with information on parenting groups in the community and academic resources available to support them. Within family therapy, Carr (2006) suggests developing a genogram as a way to identify family members, friends, teachers and others involved to help understand what roles each player has in the individual’s life.

Genograms are known to be an effective tool utilized in family therapy. In my placement I utilized a genogram for every initial assessment in an effort to capture a full picture of the
family unit (Carr, 2006; Collins et al., 2010). Using a genogram allows therapists to identify who is represented in the family unit and provide assessment and treatment. An ecomap is also a common tool utilized in family systems therapy that is useful in identifying support systems available to the family. An ecomap can be used to outline family themes for change and allows clients to problem solve for themselves (Collins et al., 2010). In my practicum work I often utilized the ecomap as a tool to determine a client’s strengths and supports.

Incorporating Family Systems Theory (FST) into clinical experience was a crucial learning component during my practicum placement. The involvement of family members allowed me to understand the family unit, dynamics, and assist in developing a treatment plan. Through my practice I also experienced resistant parents which made it difficult to support clients in meeting their treatment goals. This makes it difficult both for the client and the therapist and can result in underlying problems not being resolved; as the aim of this approach is identify the patterns within the family.

2.5 Trauma Informed Care

Going into my practicum placement I was aware that I would be working in an agency that supported individuals and families that have experienced some sort of trauma in their lifetime. I learned this through reviewing files prior to sessions, reading the literature, attending clinical meetings, and through observation of Neurosequential Model of Therapeutics (NMT) assessments being conducted. Mental Health and Addiction Services (MHAS) is an organization that supports clients who are living high risk lifestyles, come from diverse backgrounds, and have experienced an array of life challenges and experiences. A study by Ameringen, Mancini, Patterson, and Boyle (2008) identified that among all Canadians, 76 % report some sort of
trauma in their lifetime and 9.2 % of those meet the criteria for Post-Traumatic Stress Disorder (PTSD).

Early in my practicum placement I was able to see just how often experiences of trauma emerged with teenagers and how this was generally the focus of treatment. Research has demonstrated that trauma during childhood can have lifelong effects on someone’s health and wellness (Arthur, Seymour, Dartnall, Beltgens, et al. 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). For children, “early trauma can have especially negative consequences, impacting the development of the brain and normal developmental progression” (Arthur et al., 2013, p. 11). Studies have shown that an individual’s exposure to trauma early in life can increase their vulnerabilities and risk of mental illness including post-traumatic stress disorder, depression, anger issues, substance abuse, physical health problems, interpersonal struggles, eating disorders, unintended pregnancies, risk of suicide, and many others (Harris & Fallot, 2001; Levenson, 2017; SAMHSA, 2014).

The effects of trauma not only impact an individual, but can burden families, communities, systems, and public institutions (SAMHSA, 2014). Traumatic experiences take many forms and often are a result of an unexpected experience that is outside of someone’s control (Bolton et al., 2013; Levenson, 2017). Youth accessing mental health supports are often viewed as having behavioural problems, however in many cases their behaviours are a result of the ways in which they are coping with past trauma.

TIC comes from a value base of client safety and empowerment as well as an orientation to strong working alliances between clients and providers (Leitch, 2017). Levenson (2017) defines TIC as:
A way of providing services by which social workers recognize the prevalence of early adversity in the lives of clients, view presenting problems as symptoms of maladaptive coping, and understand how early trauma shapes a client’s fundamental beliefs about the world and affects his or her psychosocial functioning across the life span (p. 105).

TIC is practiced by several professions such as, social workers, counsellors, psychologists, psychiatrists, and organizations; in an effort to serve clients in an ethical way in order to help them overcome traumatic situations and support wellness and resilience. The goal of trauma-informed care is to “avoid re-traumatizating individuals and support safety, choice, and control in order to promote healing” (Bolton et al., 201, p. 15). Similarly to the other therapeutic approaches chosen for my practicum, TIC includes five principles of trauma informed care that are fundamental in creating and sustaining trauma informed settings and services: safety, establishing trust, collaboration, empowerment, and maximizing choice (Harris & Fallot, 2001).

First and foremost, establishing a safe physical environment and relationship between the clinician and the client is a core step in TIC. This could include providing a comforting office space, a quiet environment, smiling receptionist, accommodating a disability, respectful boundaries and active listening (Harris & Fallot, 2001; Levenson, 2017). In my practice I would often attempt to create a calming environment and assure I was also calm. I would at times ask the client if there was anything in my office that they may find as a trigger and remove it if needed. There was one situation when I asked the client if there was anything in the office that was triggering. I had a little ornament that was identical to one that was in a home in which they were sexually abused; I offered to remove the object and the client refused. In exploring the decline of the triggering object, the client responded by suggesting this would be a challenge as
there will always be triggers. This statement allowed me to believe that the client was in a place where they were ready to move into their healing journey.

Secondly, establishing trust is an important principle. Trust could be a difficult thing for trauma survivors to build and establish as a result of their experience. Trust needs to be developed in the early stages of the relationship to ensure success. Levenson (2017) proposes that if trust is not developed “subsequent developmental tasks of autonomy, initiative, competence, and intimacy will be compromised” (p. 4). While I conducted therapeutic sessions in practicum, I found that developing trust took a few sessions. It can be difficult for a client to share their stories and trust must be earned over time.

The third principal includes collaboration. This principle suggests that a collaborative relationship between the client and therapist must consist of them working together to achieve the client’s goals (SAMSHA, 2014). The worker must have knowledge of trauma and skills to best support the client in healing. In practice, I found collaboration to be a crucial component to healing, especially with traumatized clients. Not only would the clinician and client have to build a solid collaboration, but that collaboration should also include the family or support providers. There were times during my practicum that I had to educate the family on how to respond to situations, especially if the client was unsettled. For example, I often provided family members of traumatized children with information about Bruce Perry’s approach. Dr. Perry is a neuroscientist who supports traumatized children to learn, think, and reflect (Perry & Hambrick, 2008; Perry, 2009). His approach is not a therapeutic approach but more so a model suited to support younger individuals whose chronological age may not be consistent with their developmental stage due to a traumatic past (Perry & Hambrick, 2008; Perry, 2014).
The next principle is prioritizing empowerment and supporting clients in building on their strengths and skills. Empowerment is a key principal to TIC. It is a “strengths-based approach that reframes symptoms as adaption and highlights resilience instead of fixation on problematic behaviours, neglects the importance of acknowledging and reinforces strengths” (Levenson, 2017, p. 5). This a crucial yet difficult step when working with youth, as youth who have experienced childhood trauma often feel powerless when choice and predictability are missing in their daily life (Levenson, 2017; SAMSHA, 2014).

Lastly, choice is a principle that can allow clients to take an active role in their treatment plan. Allowing choice can permit clients to feel empowered and in control of their life. It also allows clients to take an active role in their treatment plan. One way therapists can include clients in choices is by asking clients to identify options or alternatives to support them, and then assisting clients in their decision making and allowing them to focus on their strengths and problem solve (Levenson, 2017). This is a crucial yet difficult step when working with youth, as youth who have experienced childhood trauma often feel powerless when choice and predictability are missing in their daily life (SAMSHA, 2014).

Prior to my experience at Child and Youth Mental Health, I worked for the Ministry of Social Services (MSS) as a case manager with individuals with intellectual disabilities, their families, and community based organizations. My experience with trauma victims and survivors was different in comparison to my experience at my practicum placement. In my work at MSS, I was always directed to utilize Critical Incident Stress Management (CISM) to support a colleague or client when they encountered a traumatic experience. Within the framework of CISM, support is often provided during or immediately after a traumatic event (Mitchell, 2003).
CISM is an approach different from my learning experience at my practicum placement as mental health follows a positive psychology approach and Trauma Informed Care. I quickly began to understand that as a social worker it is my ethical responsibility to gain knowledge and develop skills in TIC and positive psychology. According to the CASW (2005), “Social workers strive to maintain and increase their professional knowledge and skill” (p. 8). TIC practices from a Strength Based Approach which aligns with the approaches I chose to incorporate into my therapeutic work at Youth Community Counselling. To me TIC is a core foundation to working with youth, given the prevalence of trauma. For example, during my practicum, seven of the ten clients on my caseload experienced a history of trauma. In addition, I worked closely with my Professional Associate whose clients also experienced trauma in their lifetimes.

2.6 Reflection on Theory

Under the guidance of my Professional Associate, the Youth Community Counselling team, incorporation of research, and front-line experience, I have a stronger understanding of therapeutic approaches and how to incorporate them into sessions. I learned that the therapeutic approaches that I focused on in this practicum share several similarities but have many differences. Below I will identify my personal reflection on each approach incorporated into sessions.

In terms of the Strengths-Based Approach (SBA), I have always practiced from this approach throughout my career as a front line social worker. The Strengths-Based Approach has been demonstrated to be an empowering perspective geared towards supporting individuals towards resilience, and self-determination (Saleebey, 2009). Prior to completing my practicum, I was aware of SBA, however, I was not aware of how I had been integrating this approach into my work. I learnt that SBA is not just based on a theoretical framework, its an approach that
focuses on values and attitudes that people hold. I have always utilized SBA in my work with clients in all areas I have worked in, and will continue to practice this approach as I further my career.

Solution Focused Brief Therapy (SFBT) is similar to SBA in the focus on externalizing a client’s presenting problem (McCamey, 2015). It is my belief that both therapeutic approaches aim to support clients to have a better future. They both focus on utilizing client’s strengths, resources, and work towards finding solutions that work rather than focusing on weaknesses. Additionally, SFBT can be similar to Cognitive Behavioural Therapy (CBT). This is especially evident in having similar techniques such as homework assignments, imagining a miracle has happened, and applying forms of cognitive challenges (A.T. Beck, 2005).

Cognitive Behavioural Therapy (CBT) is considered one of the most effective forms of treatment utilized by many professionals to support clients with disordered thought patterns (A.T. Beck, 2005). I agree with the effectiveness as it was adaptable and strengths based. However, being new to using this approach I found it required much research in order to practice understanding and utilize the framework effectively with clients. It was easy to support the client in identifying the cycle of cognitive distortions but the approach limited work with clients with trauma-related experiences, especially when these experiences were connected to past issues. It can also be seen as inflexible for some clients who do not participate regularly in counselling, do not complete homework, or those who do not take treatment seriously (J. Beck, 2011). Additionally, CBT has been a reputable method of therapy for use with several mental health problems (J.S. Beck, 1995; Holmes, 2002).

The opportunity to incorporate Family Systems Theory (FST) into practice taught me how important family is to youth, their psychological development and the profound influence
family members have on one another. I learned that the relationship between family members establishes the foundation for emotional responses within the family setting. There had been times when I had observed individual family members experiencing struggles. These struggles were often difficult as some family members were not open to accepting their reactions and didn’t take personal accountability. This, for me, was difficult to address in sessions with families as I was new to therapy, and often family members were not receptive or refused to take accountability for their actions. When I took the opportunity to consult with colleagues around this challenge it seemed to be a trend and others were experiencing the same challenge in terms of parental/individual accountability.

Trauma Informed Care (TIC), being one of the areas I wanted to gain knowledge in, was an approach I implemented into my practicum placement. TIC is a strengths-based approach that fit well with my learning objectives. I quickly learned that having an understanding of TIC is crucial to engaging in clinical work. This is important as a clients can easily become re-traumatized based on a clinician’s approach. Often the root of mental health issues is directly related to trauma (Bolton et al., 2013). The lack of knowledge and understanding about the impact of trauma can get in the way of services providing the most effective care and intervention (Bolton et al., 2013). I believe that all clinicians and human service workers should have some level of training and understanding of TIC principles and practice. From my perspective, TIC education and knowledge should be incorporated as a job requirement when working in any human services sector in order to minimize the possibility of re-traumatization.

The next chapter presents two case examples to demonstrate theoretical integration. I will include strengths and limitations of the approaches, commonalities across approaches, as well as provide examples of how the approaches were incorporated into sessions.
CHAPTER 3: Integrating Theory into Practice

In this next section I provide two brief case examples focused on how I incorporated theory into practice. The examples include a youth client who struggled with anxiety and a client who experienced depression and suicidal ideation. All clinical work was guided and supervised by my Professional Associates at Youth Community Counselling.

3.1 Case Example 1

I had the opportunity to incorporate CognitiveBehavioural Therapy (CBT) into almost all of my work with clients on my caseload. I found CBT to be one of the most effective approaches utilized for clients experiencing anxiety based on literature reviewed, and clients I supported who struggled with anxiety. Based on the limited timeframe during my practicum placement and my desire to build skills and abilities, I primarily utilized CBT in my student practice. Two resources were helpful in guiding my practice with CBT. I drew on the work of Knaus (2008) in the book The Cognitive Behavioural Workbook for Anxiety, and I utilized techniques from Aureen Pinto Wagner’s (2002) book Worried No More: Help and Hope for Anxious Children. I utilized these resources as they were user friendly, supported me in my learning experience, and were recommended by clinicians on the Youth Community Counselling team.

CBT was incorporated into my work with a youth that self-referred for difficulties with anxiety and self-esteem concerns. At the time of seeing the 17 year old youth, they lived in their family home with their mother, father, and younger sibling. This youth worked part time and had expressed having a good social life, no substance use, and lived in a typical family setting. The youth had many events from which they were struggling with and seeking supports. This included anxiety related to final exams, graduation, and transition into university, as well as worry about the financial stresses of attending post-secondary education. Based on my
observation in the first meeting with this youth, they presented with perfectionist tendencies; for example wanting to have everything done perfectly.

During the my initial three sessions I gathered all of the required information with the youth such as reviewing the Privacy Notice/Confidentiality form that is utilized by the Saskatchewan Health Authority (SHA) and confirmed demographic information such as address, date of birth, contact information, and parental information. Additionally in the first session, I worked to create an environment whereby the client could provide me with their presenting problem. I did this by incorporating a strengths-based approach in addition to being gentle, developing a calming environment, speaking in a soft voice and at times using humour, such as making a joke about myself or something I did when I noticed the youth getting anxious. Additionally, I utilized the SHA Provincial Intake Assessment Tool to gather information about the youth’s past. I also provided the client with psychoeducational resources focused on anxiety. This included the use of images and explanations from Worried No More: Help and Hope for Anxious Children (Wagner, 2002). I then discussed the practice approach that I intended to incorporate into our sessions. With this we incorporated some situations that could increase the youth’s anxiety and began utilizing the exposure hill illustrated in the book by Wagner (2002).

In the sessions that followed, the youth and I reviewed some CBT activities in terms of anxiety and self-esteem. I utilized tools from several workbooks provided by colleagues that included worksheets on triggers, daily mood logs, disordered thinking patterns and scaling anxiety from 1-10. Due to the youth’s perfectionist thinking, we focused on some of the cognitive distortions such as the all or nothing thinking. Additionally, we used real life examples in the anxiety triad to explore the youth’s thoughts, feelings, and behaviours. While working on self-esteem, the youth presented as having a difficult time identifying strengths or things they
liked about themselves. I did not push the client during the session as I did not want them to feel pressured, but I asked them to think about this and review during follow up sessions. The client was able to self-reflect and provide me with two things at the next session, but indicated this was very hard and felt uncomfortable. As discussed previously, when using SBA, clients can often experience difficulty identifying strengths. In an effort to minimize the clients discomfort in further discussion, I began asking open-ended questions like “what was discomforting, what did you feel in your body, how have you regulated your body in the past?” By asking the client these questions, I was able to provide support to gain more control of thoughts and actions to search for approaches used to overcome these feeling in the past. Additionally, I encouraged the youth to identify positive affirmations daily while getting prepared for the day. If negative feelings arose while practicing this, it was suggested that the youth utilize some of the thinking trap activities we practiced while in session.

This youth was eager to learn while in treatment and attended six sessions. During the fifth session, the client and I discussed how they felt her treatment goals have been going. The youth stated that they felt like the treatment goals were successfully met, the anxiety had decreased and they had learnt some new tools to incorporate when anxious. However we decided to add one wrap up session to review some of the techniques the youth had learnt during treatment. Looking back to this case example, utilizing the CBT approach was a good framework for the client. If I were to change anything during the sessions with this youth, I would have provided the client with some homework as this is known to expedite change for clients who are motivated in this regard. PCOMS was a tool that supported me in identifying positive progress during the six sessions.
3.2 Case Example 2

The next case example describes the opportunity I had to incorporate several theoretical frameworks into sessions with one client. I was able to utilize a strengths-based approach (SBA) with the use of Cognitive Behavioural Therapy (CBT), Solution Focused Brief Therapy (SFBT) and other techniques. This youth was reluctant to attend counselling and indicated that they were only attending as their parents requested they attend counselling in an effort to decrease anxiety, depression, and isolation. The parents also wanted the youth to get support with excessive bullying that had been experienced in the past. The youth was very quiet, shut down, and reluctant to attend counselling. For the first session, identical to all sessions, I reviewed the SHA Privacy Notice, gathered assessment information, and attempted to develop goals with the youth and the youth’s mother.

It was challenging to engage the youth in most sessions as the youth did not want to engage in services. Often I attempted to involve the youth’s mother; however the mother would often drop off or have someone else drop off the client. This posed a challenge for me in terms of developing a treatment plan, as the willingness of both parties was limited. For the first few sessions this youth made limited eye contact, fidgeted with clothing, had closed body language and offered short responses to questions. To me, this demonstrated some anxiety. The client showed a great interest in the games, which allowed me to ask some questions and support the client in identifying strengths. I attempted to incorporate SFBT by utilizing a miracle question, but got no response from the youth. I also attempted to utilize scaling questions and the Partners for Change Management System (PCOMS), which had some success. The youth shared higher emotional wellbeing a few years ago where grade seven to grade eight seemed to be the struggle.
In further conversation, the youth was exposed to bullying at the end of grade seven, which they defined as increasing anxiety.

In the sessions that followed I was able to develop some rapport and learn more about the youth. I again began to explore the client’s thoughts around suicide. This was assessed during the first session; however the youth denied any suicidal ideation. My instinct suggested that something was seriously wrong, due to minimal family involvement, bullying at school, and anxiety concerns. I asked the youth if they were having any suicidal thoughts and they disclosed that this was the case. The youth indicated to not have a plan or intent but, admitted to, at times, engaging in self-harming behaviours. Although at low risk for suicide, I developed a safety plan with the youth and, as a requirement of my practicum, placed her on a suicide protocol and informed my Professional Associate. This information was shared with the youth’s parent and a copy of the safety plan was provided to the parents and the youth to take home. Based on my observation, the youth’s parents did not take this too seriously. In all sessions to follow, I asked the youth about suicidal ideation as part of adhering to the safety protocol.

After implementing the suicidal protocol with this youth, we decided to have sessions weekly. During the sessions the youth was primarily interested in talking about a dating relationship, and the relationship they had with the parents and sibling. During conversations about family members I attempted to assist the youth in exploring the strengths the family had and how they supported each other. The youth had a difficult time accepting their parents as being supportive as they felt their parents had turned every conversation into a “teachable moment”, which pushed the client away from their family. In reflection of this comment, I knew that family involvement in counselling was a missing piece to the counselling process. As a result, with the youth’s permission, I met with the youth’s mother independently and provided
feedback on the sessions. According to the tenets of FST “problems arise within the family, it cannot be attributed to individual dysfunction or pathology. Rather, understanding family dynamics will help uncover family processes that seem to foster and maintain a presenting problem” (Collins et al., 2010, p. 47). As such, the parent of the client was requested to attend the last 20 minutes of the subsequent four sessions when the file was transferred to a colleague due to my placement ending.

Cognitive Behavioural Therapy was utilized for this same youth’s anxiety and depression. The youth and I completed a few exercises together to work on identifying cognitive distortions. The client did not like doing these sessions, so we continued playing games and I continued making small progress from a therapeutic perspective. I believe we were making progress as the youth had increased communication, was able to make eye contact, demonstrated open body language, and had committed to the safety plan. Near the end of my practicum placement the youth and I were meeting for a closure session. The youth informed me that they still had some suicidal ideation and did not believe the feelings would ever go away. When I asked the youth again about a plan to attempt, they shut down and could not articulate one. I asked the youth again and they stated that they did not want to talk about it anymore.

In consultation with the psychologist on site, it was determined that depression and anxiety testing should be conducted at the next session to determine the severity of the depression and anxiety. After the testing was conducted it was determined that the youth was experiencing a high level of depression and was highly suicidal. Another treatment plan with the family, youth and psychologist was completed and a psychiatric referral was completed as my practicum placement was ending.
In reflection of this case example, I would have approached the therapeutic process differently from the beginning. I would have included the mother in sessions right from the beginning and would have done more family therapy as opposed to individual support with the youth. The importance of family therapy became evident to me during this case as well as the importance of case consultation. Although my work was guided by my Professional Associates, I should have asked for more direction in supporting this youth. The case consultation supported me in guiding my work and taking the appropriate clinical steps moving forward.
CHAPTER 4: Values and Ethical Considerations

As a social worker I have experienced ethical dilemmas in the past and will likely face them as I further my career. My professional and personal values have always been congruent with the Canadian Association of Social Workers (CASW) Code of Ethics. The CASW Code of Ethics (2005) sets forth values and principles to guide social workers’ professional conduct. The six values include:

- **Value 1**: Respect for Inherent Dignity and Worth of Persons,
- **Value 2**: Pursuit of Social Justice,
- **Value 3**: Service to Humanity,
- **Value 4**: Integrity of Professional Practice,
- **Value 5**: Confidentiality in Professional Practice, and
- **Value 6**: Competence in Professional Practice (CASW, 2005, p.4).

These values are the foundation for a companion document to the Code of Ethics that provides guidance on ethical practice by applying values and principles from the Code to common areas of social work practice (Canadian Association of Social Workers [CASW], 2005, p. 8). Social workers are required to work in good faith in the best interest of all individuals regardless of their situation. I was fortunate to work in an organization that had high ethical standards.

This section will focus on the importance of adhering to the Code of Ethics and Guidelines (2005) in relation to potential ethical dilemmas that social workers are likely to encounter in practice. In my practicum placement potential ethical issues arose that gave me cause to consider how I might respond to these issues in an ethical manner. For example, a client requested I meet them for coffee in the community at some point to continue with our relationship. I had to respectfully inform them that this was not a practice I could engage in due
to a requirement that I must follow a code of ethics as set out by my Professional Association. Even though the client and I had developed good rapport for the purpose of treatment, it was important for me to utilize appropriate boundaries. This situation made me reflect on how powerful therapeutic relationships can be and how important boundaries are. It also made me reflect on the importance of setting clear boundaries at the beginning of treatment.

4.1 Self-disclosure

Self-disclosure was a topic that my supervisor and I discussed during clinical supervision. I informed my supervisor that I believed self-disclosure is important in therapy, but also that there is a fine line between professional and personal disclosure and that it is important to be mindful of the limitations of self-disclosure. Our discussions included the types of self-disclosure and how it should only be carried out for the clinical benefit of the client and to ensure that this is done in an ethical manner.

On a daily basis we, as social workers, are interacting with others and building alliances. The balance between professional and personal life is a debatable topic. Self-disclosure by the therapist can be an important element in the development of the therapeutic alliance and a trusting relationship. “Self-disclosure promotes increased visibility that allows the marginalized client more power in the relationship than [he or] she would have with a less forthcoming psychotherapist” (Barnett 2011, p. 319).

I self-disclosed in a session with an adolescent informing them that my parents had separated when I was a young girl. Prior to sharing this information, I contemplated if this information would be appropriate in serving the client’s needs. It seemed that sharing this information could build a solid trusting alliance with the client by showing that I was able to relate to her feelings and support her. I had seen this client for three sessions prior to sharing this
information and believe this supported the client in developing a trusting relationship. I was careful not to provide the client with unnecessary details and kept my personal experience to a minimum. I ensured that I kept the focus on the client allowing them to be heard. Boundaries were not violated and in this situation the self-disclosure was for the sole purpose of supporting the client. Self-disclosure can be beneficial in developing a therapeutic alliance however, it’s important for clinicians to be mindful about what information to share and when to limit information sharing.

4.2 Confidentiality

All clients have the right to privacy and the trust between a social worker and client is an essential piece to developing good rapport. Social workers are obligated to respect the privacy of clients however, according to the CASW the general explanation is that: “Social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable and imminent harm to a client or others” (CASW, 2005, p. 11).

While completing my practicum, I always informed clients and their caregivers of their rights in terms of confidentiality in accordance with the SHA Privacy Notice. Working as a student for SHA allowed me to incorporate this policy into my work. When I met clients for the first time I would review the SHA MHAS Privacy Notice. I was always diligent in presenting the information in terms of the situations where I, as the clinician, would be responsible to disclose information in accordance with the law. There was one situation when I was required to disclose information due to a client wanting to commit suicide. According to the CASW (2005) “Social workers may break confidentiality and communicate client information without permission when required or permitted by relevant laws, court order or this Code” (p. 8). As a social worker I had guidelines, policies and practices to incorporate to keep the client safe.
4.3 Boundaries.

Maintaining boundaries is a practice in the client-worker relationship to ensure professional integrity and responsibility. It is important for social workers to maintain professional, respectful, and clear boundaries with clients. While attending Peer Supervision at MHAS, staff began discussing ethical dilemmas they had encountered with current clients or clients whose services had ceased. Social media was the topic of discussion and how clients are often trying to add workers to Facebook. In discussion with supervision and management, this was determined to be an ethical issue on multiple levels. It was described to be a conflict of interest, inappropriate in terms of self-disclosure, and a relationship outside of the professional environment is unethical. The CASW (2014) states,

“ethical dilemmas pertaining to social media use include how to handle friend requests from clients or former clients, deciding whether to search or follow a client on a social media platform, whether to post information related to work with clients on a blog or personal Facebook page, or whether to use client testimonials on their professional website” (p.4).

In addition to the discussion of social media, staff wondered what the guidelines were if clients approached staff in the community. Some staff discussed clients hugging them, some trying to be their friend, and others feeling unsure on how to approach them while in public. In situations such as this, “social workers must use their own professional judgment, seek information from their provincial/territorial regulatory bodies, review best practice guidelines and risk management strategies, and engage in on-going dialogue with colleagues” (CASW, 2014, p. 9).
4.4 Challenges

Overall my practicum was an important learning experience for me. It was one of the most satisfying but challenging experiences I have encountered as a professional. A challenge that I encountered was the fact that I had limited clinical social work experience and I wanted to advance my understanding of integrating theory into practice. I had worked as a social worker for seven years prior to my practicum, and have been able to build skills and knowledge in the line of counselling, but not to the extent provided at Youth Community Counselling. I learned about the importance of patience and the power of vulnerability. I modified my first objective, which was increasing my skills in group facilitation. This was due to groups discontinuing for the summer months. I did play a role in the planning and facilitation of a Summer Blast Camp, but the development of the group was limited as it was a repeat of the previous year outline. However, I was able to attend Activating the Here-and-Now, a Psychotherapy workshop which supported me with strategies to incorporate when facilitating groups of two or more clients. This included strategies on how to manage cross talking, handle group conflict, revert to the purpose of the group when it gets off topic, and bring people back to focus.

Second, my practicum at Mental Health was a total of 450 in duration. I found this to be a significant amount of time to invest as a student; however I felt as though I could have benefitted in terms of increased skills and knowledge if the duration of time was extended. Going into the placement, I had minimal experience with direct clinical practice and believe I could have increased my skills in terms of applying theory to practice if the timeframe was longer. In addition to a longer duration in placement, I would have also requested to have a larger caseload from the beginning of the placement, due to no shows and drop outs. It was shared with me that at Youth Community Counselling the no show rates and cancellations increase over the summer.
months, and that this could be a challenge for me in terms of continuity with clients. This could in fact have been as a result of the season, me being a new therapist, clients not connecting with my style, or that clients were simply not ready to make change. Overall, the placement was an excellent experience for my professional and personal development. I increased my skills and have come to learn that clinical counselling is a passion of mine and I hope to further develop my skills in clinical work during my career.

Lastly, in my experience from working with Community Living Service Delivery (CLSD) for seven years, I have noticed a limitation in this population accessing services at Youth Community Counselling. The primary population from my experience accessing Youth Community Counselling services is Caucasian families. From my experience in completing referrals to Youth Community Counselling while at CLSD, it has been suggested at the intake level that this population access private counselling supports. I was told that clients are only supported if they have the mental capacity to develop goals and achieve them.

Additionally, I would have liked to see more involvement from Youth Community Counselling (YCC) in terms of cultural awareness and involvement in supporting Aboriginal and immigrant families due to the increased mental health needs with these populations. During the practicum placement I became aware that Children’s and Adult Mental Health have designated workers that attend the Open Door Society and Global Gathering. The designated worker would attend to the organizations weekly to support those newcomer families, but no one on YCC team had this role. In terms of Aboriginal supports, staff were able to access a worker who could connect Aboriginal youth and families to elders, sweat lodges and other cultural practices through an internal referral. However, I would have liked to see a worker at YCC with the expertise in supporting Aboriginal families. I believe Youth Community Counselling should be
attempting to reach out to the community where services are limited and adopting a holistic view on mental health wellness.
Chapter 5: Conclusion

This chapter provides a final reflection on my experience at Youth Mental Health and Addiction Services in Saskatoon. The report provided an overview of my practicum placement, the activities I participated in, my learning objectives and identifies how they were met. It also includes the theoretical framework implemented into practice that was reviewed as part of a literature review, as well as some case examples. The first objective of increasing my group facilitation skills was partially fulfilled through my participation in planning Summer Blast Group and observation in the Parent Therapist group. The second learning activity was to provide therapeutic intervention and assessments with youth and families. This objective was met through direct practice with youth and families, observing other clinicians in sessions, as well as clinical supervision with my Professional Associates. The last objective was to gain a deeper understanding of children and youth experiencing complex mental health issues, which I gained through front line experience.

Generally, this practicum experience has been a valuable in terms of my professional growth. It has taught me more about self-reflection, balance, and the process of change. I believe this experience has set the foundation for me to become a strong clinician, which is my career focus at this time. I have been able to broaden my critical thinking skills, understand the foundation of theoretically guided practice in sessions, and have been able to learn and grow in many other areas of professionalism.

I believe the experience I had while in practicum has served a purpose for myself in my personal and professional growth and will serve a purpose as I learn and grown in my social work career. This opportunity has confirmed that I’m working in the right line of work and am satisfied with my career choices.
References


