# FINAL PRACTICUM REPORT: CHILD AND YOUTH MENTAL HEALTH

by

**Anastasia Russell**

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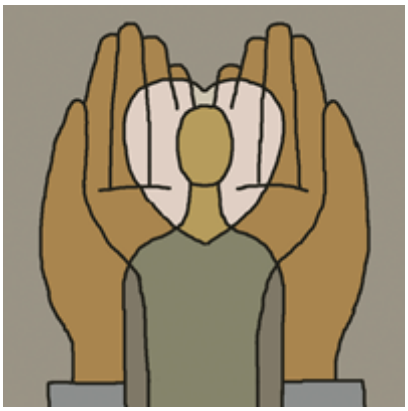

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**Abstract**

Through my practicum, I explored the role of a child and youth mental health clinician (CYMH) while also expanding and adapting my clinical skills and therapeutic modalities. Early childhood development and trauma have shown to have tremendous influence over the onset of future mental health concerns, while epigenetics and biology also play a key role in the development of potential neurological disorders. Cognitive Behavioral Therapy (CBT), Mindfulness and Expressive Arts Therapy were investigated within the realm of mental health. These modalities are actively used as therapeutic tools within CYMH. This practicum report expands on the role of trauma within mental health, exploring holistic approaches such as Expressive Arts Therapy and meditation in concurrence with CBT and MBSR to facilitate deeper understanding of a person's narrative through their own creative and subjective experience. While pharmacology helps keep symptomology at a baseline, it is the coping and regulation tools that are needed to help a person navigate their own internal processes and stress modulation in order to achieve post-traumatic growth.

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I want express my deepest gratitude for my wonderful committee. Thank you for inspiring me, cheering me on, and unconditionally supporting me through this pivotal time in my Social Work career. I would like to thank my CYMH Practicum Supervisor Jeanne Harrison and CYMH/MCFD colleagues, for their unconditional support. Our time together has given me the opportunity to learn from you and broaden my scope of clinical practice within both Child and Youth Mental Health as well as the Ministry of Children and Family Development. The guidance and hands-on experience that I have received is irreplaceable, and the bonds that we have developed within such a short time of being together will never be forgotten. I will carry forward this experience as I continue down the path of Social Work Practice. Furthermore, I would like to make two special acknowledgements to Dr. Indrani Margolin and my partner Mike. To Dr. Margolin, thank you from the bottom of my heart for sharing your wisdom with me and providing years of mentorship and friendship. I have you to thank for igniting my passion for the expressive arts and meditation both professionally and on a deep personal level, and I look forward to our future work together. And to my partner Mike, you are my pillar of strength, thank you for reminding me of how loved and brilliant I am, when I felt defeated or physically and mentally exhausted. I love you dearly, always.

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## Chapter One: Introduction

Nearly every person has experienced a mental health challenge at one point in their lifetime (Reed, 2009). Whether anxious or overwhelmed from a situation, person, one's environment or dealing with chronic challenges such as negative self-talk, anxiety or depression, mental health is imperative to address. Mental health is not limited or confined to gender, age, location, cultures, or biology. Thus, it should be central when addressing wellness across the lifespan (Hayes, Edbrooke-Child, Town, Wolpert & Midgley, 2018). From early life experiences, mental health is significant across cellular, biological, emotional, cognitive, and physiological levels (Van der Kolk, 2014). The experiences that we have can either promote or hinder development among various levels. Trauma exposure alters human development, and changes the way our brain operates, as well as the way we view and react to the world around us. There are a number of factors that can lead to traumatization and impact one's mental health. Some factors can include exposure to violence, abuse, poverty, and a lack of positive support systems. The supports that we have, the connections that we make, and what we experience all influence our identity or consciousness. From the formation of cells and neural pathways, to the perspectives that we hold and our responses to external stimuli, all experiences – good and bad, are equally important for our individual growth. Without proper supports in place, trauma exposure may jeopardize a person's capacity to cope in healthy ways. As social workers, we can equip those we work with, as well as ourselves, with tools to foster resiliency, executive functioning, and empowerment to cope with adversity. In doing so, people can expand their capacities to move forward and utilize their experiences for post-traumatic growth.

### *Atom Analogy: Understanding the Interplay between Experience, Trauma, and Development*

Imagine if an atom represented a person's developmental baseline. In order for the developmental baseline to evolve, a balance is required between genetic predispositions, social supports and connections, as well as both positive and negative experiences. At the core of this developmental atom is a nucleus. This nucleus or core is comprised of both neutrons and protons. The combination of neutrons and protons determine the overall core's structural strength (OpenStax, 2015). In this analogy, neutrons represent physical, biological and genetic markers, while protons represent a person's connections to their support networks. Too much of either can impact the overall structure of the developmental atom as a whole, and cause development to become strengthened, weakened, stalled, or altered. Moving outward, the space between the nucleus and the most outer shell of the atom are filled with ions and electrons. Ions in this analogy represent day-to-day experiences; these include neutral and healthy experiences. Electrons on the other hand represent stressors or trauma. Ions and electrons are equally important regarding developmental formation. The interplay between all components within the developmental atom is crucial for maintaining equilibrium and promoting strong and healthy development.

When a developmental atom has a weak nucleus, (i.e. lack of family or positive support, history of chronic family stress) in combination with an overload of electrons (negative experiences), the overall structure is weakened. Likewise, if there are too many neutrons and protons within the nucleus, (i.e. overzealous family influence, overly sheltered environment, or lack of opportunity to make own decisions and mistakes) in combination with a limited amount of electrons (negative experiences) that bind to the ions (person's overall experience), the developmental structure is also hindered and development is delayed due to a lack of experiential learning, resiliency, building opportunities and acquired post-traumatic growth (OpenStax,

2015). Balance is the key for this developmental atom to thrive and progress in a healthy and positive manner. “Trauma is an integral part of life for growth” **(**Margolin and Sen 2019, p. 1) and, like an atom, needs a good balance between positive and negative charges to be strong. People need a balance of positive supports and genetic blueprints, as well as positive and negative experiences to flourish and grow within their own capacities.

Adequate support and guidance to understand the processes that arise with each experience are necessary in order for a person to learn how to cope in ways that support their wellbeing. Over-controlling parents, for example, can cause a reverse affect and potentially enable a person to act out and make impulsive or irrational decisions as a result of a need for self-autonomy (Bulter & Pang, 2014). Moreover, not enough support can leave a person stranded to make poor decisions because they do not know how to distinguish between healthy versus unhealthy coping and stress responses (Bulter & Pang, 2014). There are various intricacies embedded within the symbiotic relationship between trauma, development, and overall wellbeing. As the interconnected relationship between Epigenetics and trauma becomes further understood, we can more concretely understand the threads and details that weave together the big picture of human growth and development (Pert, 1997). Literature regarding epigenetics, Polyvagal Theory, and trauma gives clarity to better understanding the threads that weave together the critical components of human growth and development (Pert, 1997).

### *Epigenetics as a Building Block of Nervous System Resiliency*

Epigenetics emphasizes the serve-and-return interaction between our environment and genetic blueprint (Pert, 1997). Through an epigenetic lens, each encountered experience influences our brain, physiology, and hormones. This is critical when examining the central role that trauma plays in developing nervous system resiliency. Nervous system resiliency increases

as a person builds upon their understanding of the mind-body-spirit response to trauma, and thus, increases their capacity and knowledge to modulate their stress responses in healthy ways (Pert, 1997). Recognizing how traumatic memories become stuck within our bodies can assist a person to move from a place of dissociation to a place of awareness for both internal and external processes (Van der Kolk, 2014). When trauma is experienced, a lack of personal awareness into the processes overwhelms the human system and creates a feedback-loop – of overworked primitive survival responses. "Trauma survivors often become cognitively stuck in flight, fight, and freeze response patterns and simultaneously lose their sense of identity, life-purpose" (Margolin & Sen, 2019, p.1), and decision-making capacity that support their resiliency and wellbeing.

Adopting a Polyvagal theoretical framework within clinical trauma practice can help clinicians explain the psychosomatic process to clients so that they can process the co-occurring physiological trauma. Polyvagal Theory denotes the inter-relationship between the autonomic nervous system and trauma experiences. This understanding helps people recognize their "bio-intelligent resources" through activating individual capacities for re-patterning nervous system responses to improve regulation and create a sense of safety and connection for clients (Margolin, 2019, p.6; Dana, 2018). Such approaches to trauma work encompass early intervention, psycho-education, and use of embodied preventative frameworks, which are imperative for working with individuals who struggle with the aftermath of traumatic experience (Reed, 2009). Working from these approaches support executive functioning skills, so that when individuals face adversity they can prevail.

Experiences from the formative years shape brain architecture and influence the subconscious, as it relates to instinctive decision-making and resiliency (Reed, 2009). When a

child or adolescent is exposed to trauma without adequate support and guidance to process events future mental health concerns may result (Holt et al., 2014). Chronic exposure to trauma affects various regions of the brain, such as the Prefrontal Cortex and the Hippocampus, by altering levels of hormones and molding neural pathways. Grooves in the brain are created that influence "impressions upon the mind" and contribute to habit formation (Margolin & Sen, 2019, p.8). Holt et al. (2014) showed that there is a strong correlation between traumatization and the onset of mood and behavioral disorders among children and youth across the life span. Hence, early identification, intervention and prevention of these disorders lessen the encumbrance of illness.

Numerous studies have exemplified the prevalence of mood and behavioral disorders among adolescents and youth. According to Read (2009), "anxiety is the most common mental health problem in children and youth (6.5%)", followed by depression (2.5%, p.1). Within British Columbia alone, there is about 1 in 7 – that's 140,000 children and youth who endure mental health concerns that are "serious enough to affect their relationships with family and friends" as well as their performance at school or within their community" (Reed, 2009, p.1). Mental health concerns can arise out of the persistence of certain emotions, beliefs, and behaviors, which include: moodiness, use of coping mechanisms, emotional responsiveness, and self-identity. This often impacts a young person's daily life (Bulter & Pang, 2014). Furthermore, behaviors and symptomology are typically the primary focus within assessment and diagnosis (Kutcher, 2017). Consequently, the underlying root causes of behaviors are often overlooked (Kutcher, 2017). Behaviors are often prevented immediately and viewed as a form of 'acting out'. By assessing the behavior exclusively in a negative manner, clinicians may eliminate the

opportunity for a young person to both: a. release their pent up emotional responses; and b. assess their behavioral stress responses for the positive elements of coping.

A safe environment to explore creative outlets helps children and youth learn to make their own decisions and allows them to exercise their voice. Helplessness that results from enduring a traumatic event can create a sense of lack of control. Thus, when children are exposed to early life trauma, they will often crave more control in situations or relationships. From a behavioral standpoint they may present as 'combative' or 'manipulative'; however, this serves to feel a sense of control over their experiences (Bulter & Pang, 2014). Facilitating safe exploration of these internalized suppressed emotions and experiences are key to trauma-informed preventative practice. A gap exists in service provision, especially around the need, availability, and applicability of trauma-informed mental health services (Reed, 2009). Nonetheless, federal funding towards child and youth mental health research has increased (Bulter & Pang, 2014). Services and programming offered through the provincial government have also increased with the establishment of Child and Youth Mental Health (CYMH) clinics throughout the province of British Columbia.

## Chapter Two: Practicum Overview

Under the umbrella of the Ministry of Children and Family Development (MCFD), CYMH clinics offer support to infants, children, youth under the age of 19, and their families with services to help navigate mental health challenges. (Ministry of Children and Family Development, n.d., p.1). Service provision is approached from Trauma-Informed, Cognitive Behavioral, Person centered, Structural, and Anti-Oppressive lenses while helping children and youth "gain access to psychological and psychiatric services. CYMH clinics offer an array of services, which include free counseling and drop-in times for children, youth and their families

to meet with clinicians for a 90-minute intake interview. This intake process allows clinicians to immediately identify client needs and provide clear information and treatment options when formulating treatment and care plans (Ministry of Children and Family Development, n.d.). CYMH clinics operate in an interdisciplinary environment and collaboratively work with "clinicians, social workers, psychologists, nurses, and outreach workers" (Ministry of Children and Family Development, n.d., p.1).

Clinics also offer specialized supports for Indigenous populations. Most programming for children, youth and families is based on a CBT model. In 2005, MCFD "began training CYMH clinical staff in CBT to ensure they could use the most effective approaches for helping children and youth" with anxiety, depression, and other mood and behavioral disorders (Reed, 2009, p. 3). Training typically occurred through various workshops including a two-day foundational CBT course through *CBT Connections and Anxiety BC* (Reed, 2009, p.3). Training currently covers CBT treatment for "anxiety disorders, obsessive-compulsive behavior, phobias, separation anxiety, panic, social anxiety and post-traumatic stress" (Reed, 2009, p.3). In addition, clinicians receive training regarding depression (Reed, 2009, p.3). When working with children, youth and families, CYMH clinicians require informed consent from clients, and if the clinician determines that the child "has the capacity to understand the risks and benefits of services and what the limits of confidentiality are", they do not legally require parental consent for services (Ministry of Children and Family Development, n.d., p.2). Both children over the age of 12 and parents are able to access their files through making a request to CYMH, and files typically include: "referrals, intake information, correspondence notes, mental health assessments, session notes, reportable circumstance reports and client consents" (Ministry of Children and Family Development, n.d., p.3). Throughout the consultation, clinicians work collaboratively with

children, youth and families, and highlight the importance of parental involvement in the therapeutic process. During intake assessments, clinicians' work in partnership with clients to determine the appropriate evidence based approach that best supports their unique needs. This type of partnership creates a welcoming and inclusive environment that feels safe for the child and family to explore their options and strategies for the development of an effective treatment plan.

My practicum is located in Squamish, British Columbia. The office is located in the heart of the community and despite its current size, the demographic in Squamish is growing rapidly. This growth is causing economic hardship in addition to other factors. The community that was built on the establishment of the logging industry now offers more opportunities for employment and lifestyle. One aspect that makes Squamish appealing is its convenient location, between Vancouver and Whistler. As the population rises, existing resources are increasingly in-demand. According to my field supervisor, as the community inflates, clinicians now feel the pressure for space expansion of the CYMH office. This pressure stems from increased need for support by clients while maintaining service resources and efficiency. While the community boom produces opportunity, it simultaneously creates new challenges for families who fall beneath the poverty line. Such challenges include affordable housing, accessible health care, and appropriate social supports, particularly more specialized mental health programing for children and youth. The Squamish community was a new and exciting demographic with whom to work. My previous experience in the social work field lay primary within the Metro Vancouver area.

*Learning Goals and Timeline*

My learning goals focused on developing my therapeutic skills within a clinical setting and working toward a more grounded understanding of the role of culture within the bio-psycho-

social and medical model. As part of developing myself within the role of a CYMH clinician, I strived to gather knowledge around community resources within Squamish that could benefit children, youth and families who experience mental health challenges. Within my therapeutic role, I strived to learn more about CBT principles by creating a clinical resource book with various exercises, activities and psycho-educational resources for clients and families. Within this resource book, I developed a psycho-diagnostic section to help navigate the diagnostic criteria within the DSM-5. This section provides readily available information that is regarding specific characteristics and how they relate to various disorders. Please see Appendix 2 for my learning goals and Appendix 3 for my practicum timeline.

## Chapter Three: Theoretical Orientation

The theoretical orientations underpinning CYMH clinics revolve around a CBT framework as well as trauma-informed, anti-oppressive, strengths based, and structural social work practice. In February 2003 the provincial government developed a proposal as part of the child and youth mental health plan for British Columbia (Reed, 2009). The provincial government set out a five year CYMH plan (2003-2008) with new approaches in place that focused on prevention and early intervention so that risks of later mental health onset could be minimized (Reed, 2009). The primary framework that guides the practice of CYMH clinicians is the Cognitive-Behavioral Therapy (CBT) model due to its high recognition in value for treating "depression, anxiety, behavioral problems, and eating disorders" (Reed, 2009, p. 1). In addition to CBT, clinicians were also trained in third wave CBT such as "interpersonal therapy, dialectical behavioral therapy" and "suicide and dual-diagnosis" (Friedberg, Tabbarah & Pogessi, 2013, p.3). CYMH incorporates a collaborative approach, which contributes to operational transparency on the part of the clinician throughout the therapeutic process.

(Friedberg, Tabbarah & Pogessi, 2013). During this process, the clinician assesses the client's readiness to proceed with the treatment plan. Moreover, she also applies mindfulness as a framework for both clients and clinicians to be present in the sessions and focus on their goals. Self-monitoring by clients is a mindfulness practice and central tool used in CBT. Self-monitoring helps navigate "strong negative affective arousal" (Friedberg, Tabbarah & Pogessi, 2013, p.4). For the clinician, mindfulness comes from "radical genuineness" as well as through having "presence, immediacy and transparency" in practice (Friedberg, Tabbarah & Pogessi, 2013, p.4). Applying these skills increases connection and informality without overstepping or blurring therapeutic boundaries, "pave(ing) the way for good practice" (Friedberg, Tabbarah & Pogessi, 2013, p.2). Furthermore, service provision within CYMH is based upon a strengths-based, person-centered approach, which means that clinicians walk alongside clients in their capacity for change and acknowledge their efforts and engagement once their readiness has been assessed.

Clinicians' work from trauma-informed, anti-oppressive, and structural frameworks and understand that lived experiences, including navigating oppressive systems and structures, can tremendously impact a person's wellbeing, decision-making, coping, and readiness for change. The collaborative processes within CBT principles are similar to utilizing a shared-decision making (SDM) framework. Using an SDM framework assists in developing collaborative treatment plans specifically tailored to the individual and their family (Hayes, Edbrooke-Childs, Town, Wolpert, & Midgley, 2018). The SDM model includes the following topics for discussion: "tests for screening, undergoing procedures, participating in self-help or psychological interventions, whether to take medication or make lifestyle changes" (Hayes et al. 2018, p. 655). Despite the efficacy of using the SDM model in practice, stressors as well as

challenging emotions, such as anger or sadness, depict the level of effectiveness of the SDM process (Hayes et. al. 2018).

## Chapter Four: Literature Review

Early life experiences can influence the secretion of hormones and our capacity to properly modulate stressors. Research illustrates the strong "link between experience and biology", and highlights the correlational relationship between behavioral disorders and early life trauma (Pert, 1997, p.269). This understanding highlights the significance of the body in relation to trauma, as it is seen as a "gateway to the mind" (Pert, 1997, p. 274). Recognizing how trauma exposure impacts the body is foundational when utilizing a holistic trauma-informed lens as it focuses on emotional release and having awareness of the mind-body processes that are occurring as a response. Working with trauma through a holistic lens has the potential to "supplement or even sometimes replace talk cures and prescription pills" (Pert, 1997, p.274). Other research has shown that applying modalities that share holistic principles (i.e. CBT or REBT) in combination with pharmacotherapy (i.e. SSRIs or anti-depressants) can produce greater stabilizing long-term outcomes for clients who experience certain mood disorders such as anxiety or depression (Iftene, Predescu, Stefen, & David, 2015). However, at least one third to one half of youth who are being treated for depression through a combined treatment plan "do not respond" well to treatment, and "almost half of treated youth" continue to experience symptomatic reoccurrence "within 4 years" (Iftene, Predescu, Stefen & David, 2015, p. 687). This may be due to too much emphasis on symptom reduction and not enough skill building around stress modulation through the use of person-centered strengths-based practice. Blending these approaches with holistic tools and frameworks such as Polyvagal theory and mindfulness can assist young clients to release suppressed emotions, thoughts and sensations. Moreover,

using medications such as anti-depressants for depression among at-risk children and youth can expedite the onset of mania (Cotton, Luberto, Sears, Strawn, Stahl, Wasson, Blom, & Delbello, 2016), which can intensify the complexities of their mental health states.

There are mixed findings on research that compare the effectiveness of using modalities such as CBT with Pharmacotherapy. Whether used in congruence or separately, long-term outcomes are still jeopardized by symptomatic reoccurrence. Most clinical studies that examined how ineffective these approaches are used adult sample sizes to support their claims. Thus, the findings are irrelevant for children and youth. More research is needed in the area of early life trauma as it relates to child and youth mental health. Given the role of epigenetics in relation to human development, children and youth are vulnerable for developing mood and behavioral disorders especially if their parents have a history of mental health concerns and chronic stress exposure. Since 50% of all mental illness onset occurs "before age 14" (Dunning, Griffiths, Kuyken, Crane, Parker & Dalgeish, 2019, p.245), identifying these markers is essential for preventative trauma informed practice. Anxiety and depression are the most commonly reported mood struggles that children and youth face, with an average of 6.9% of Canadian youth and young adults being diagnosed (Bulter & Pang, 2014). Young women and Indigenous peoples are at greater risk for developing such diagnoses' when compared to young men and individuals who identify with other ethnic backgrounds (Butler & Pang, 2014). A reason for this may be tied to epigenetics and historical trauma that has been experienced through decades of oppression and assimilation.

The area of child and youth mental health is shared by federal and provincial jurisdiction. Federal responsibility lies mainly in research and funding, while provincial responsibility revolves around service delivery (Bulter & Pang, 2014). Within British Columbia, the Ministry

of Children and Families (MCFD) has recognized CBT as the "most effective approach" for working with clients who experience anxiety and depression (Reed, 2009, p.1). Using this modality is associated with overlapping findings around significant improvements among samples of youth who experience "depression, anxiety", and challenges in "social and occupational functioning" (Hides, Carrol, Catania, Cotton, Baker, Scaffidi, & Lubman, 2009, p.169). This includes considerably lower rates of substance use, psychological harm and suicidal ideation among symptomatic children and youth (Hides et al. 2009; Ai, Foster, Pecora, Delaney, Rodriguez, 2013).

The collaborative and person-centered framework that is embedded within CBT helps build a therapeutic alliance based on trust and communication, which allows adolescents the opportunity to be active throughout the entire treatment process. This is an integral part of a child's human right to be "involved in healthcare decisions" as emphasized under Articles 12 and 13 of the United Nations Convention of the Rights of the Child (Hayes, et al. 2018, p.655). Other third wave CBT modalities which include: Trauma-focused CBT (TF-CBT), Mindfulness-Based Stress Reduction (MBSR), Dialectical Behavioral Therapy (DBT), and Rational Emotive Behavioral therapy (REBT), have proven to strengthen preventative work. Preventative work helps adolescents and youth build upon their own self-acceptance, and bodily and cognitive awareness as they respond to various stimuli by allowing them to explore those variables in a safe and welcoming manner. Furthermore, the collaborative process extends to parents and guardians as their value in being active agents of support for their child(ren) are recognized in CBT principles. The impacts of CBT along with other modalities such as MBSR and TF-CBT will be further explained in this literature review.

### *Early Life Trauma and Stress*

There are several influences that can have lasting effects on wellbeing across the life span. Some of these influences include: early life trauma, chronic stress exposure, coping mechanisms, and having strong support networks. While recognizing these influences, it is also important to distinguish the two different paradigms that exist within the notion of wellbeing. Firstly, the *Hedonic* paradigm focuses on "human motives and needs" such as "life satisfaction, symptom reduction and absence of negative mood" (Ai et al. 2013, p.652). Secondly, the *Eudaimonic* paradigm focuses on meaning-making and overall potential for "achieving self-realization" such as need for autonomy, "self-acceptance, and positive relatedness" (Ai et al. 2013, p.652). Adopting one or both of these two paradigms at the outset of clinical practice can help clients move to deeper revelations, moving from a place of Post-Traumatic Stress (PTS) to Post-Traumatic Growth (PTG). By focusing on these ideologies alongside the understanding of the many facets involved in development, clinicians can structure treatment plans that provide more depth, understanding, and long-term positive outcomes around stabilization for adolescents as they mature.

Epigenetics strengthens the longstanding nature versus nurture debate as it emphasizes the reciprocal nature between development and environment, which includes relationships with caregivers and peers. Chronic stress exposure with a lack of positive caregiver and peer support leads to emotional dysregulation among infants, children and youth, and can impact a fetus in the womb. Expecting mother's that experience high levels of stress impact hormone secretion to the fetus, which cause an active state of stress as an infant enters the world. This can continue into adolescence and symptomatically shows up as difficult behaviors like an attention deficit issue or combative and impulsive behaviors. Genes are not fixed, they are in constant flux between activated and de-activated states, and therefore life events can act as triggers that transmute

biochemical messages to cells. These biochemical messages influence the way cells need to work and respond. “While life events can change the behavior of a gene, they do not alter the fundamental structure” (Van der Kolk, 2014, p.154). However, genetic structural changes that are incurred over time by parents can be passed on to their offspring. Clinical Epigenetic research studies have confirmed “the seminal importance of early psychological insults contributing to the neurobiological processes to underlie the pathophysiology of certain mood disorders such as depression” (Evans, Beardslee, Brent, Charney, Coyle, Craighead, Crits-Christoph, Findling, Garber, Johnson, Keller, Nemeroff, Rynn, Wagner, Weissman, & Weller, 2005, p. 24). These findings correlate to early psychoanalytic models that explain how the role of caregiver and positive relationships early in life can be related to Social Learning theories (Ai et al. 2013). Infants, children and adolescents mirror primary behaviors based on the role models that they have in their early lives. This partly explains some psycho-behavioral actions later in life, such as the example of abused children showing similarities in their behaviors to those of their peers (Ai et al. 2013; Evans et al. 2005).

The influence of early life trauma moves beyond cognitive and emotional distress and can transcend into physiological changes such as “negative changes in sleep patterns, heart rate, temperature, monoamine systems, immune function and endocrine function” (Evans et al. 2005, p. 13). Many of these markers are overlooked throughout childhood until the adolescent is already experiencing the onset of co-occurring mental health symptoms (Dunning et al. 2019). Co-occurring symptoms can include: “depression, attention-deficit hyperactivity disorder (ADHD), behavioral disorders, mood disorders, sleeping and eating disorders, separation and attachment disorders, substance use, and somatic complaints” (Ai et al. 2013, p. 652). Integrative assessment and treatment approaches are pinnacles for early prevention strategies so that

psychosocial and biological outcomes are addressed in congruence with one another (Iftene, Predescu, Stefen & David, 2015).

### *Neurobiology of Stress and Future Impacts*

Stress influences neurobiology through biochemical signals that tell internal systems of the mind and body how they need to work to keep us healthy. These include our monoamine and endocrine systems. Whether stress is real or perceived, the way our bodies react is the same because the brain cannot differentiate between various experiences. “Our brain works like a machine, not merely filtering and storing sensory input” but simultaneously correlating those inputs with “other events or stimuli” that are concurrent to “any synapse or receptor along the way” (Pert, 1997, p.142). In early life, caregivers help infants/children manage their arousal states by teaching them how to self-regulate, which influences the development of their “inhibitory and excitatory brain systems” (Van Der Kolk, 2014, p.163). In fetal neurophysiological development, caregiver stress can increase infant sensitivity of the intrauterine hormonal system and heighten vulnerability for infants to experience heightened levels of stress steroids. This predisposes infants to increased probabilities for developing depression or anxiety later in life (Evans et al. 2005). If children are not taught effective tools for modulating stress, then unresolved emotional content could re-surface later in life causing secondary traumatization and keep a child in a primitive response feedback loop. “Bio-chemicals in physiological substrates of emotions” underpin various levels of our experience including our feelings, thoughts, sensations, and motivations (Pert, 1997, p.141). This is due to changes that are made to our core limbic brain structures and the overall plasticity of our Central Nervous System (CNS). Regions such as the Amygdala, Hippocampus, and Limbic Cortex are responsible for stress modulation (Ai et al. 2013).

Stress and trauma exposure can lead to a chronic inability to process arousal states, which causes an altered emotional processing response. Oversensitive stress responsiveness impairs the ability to make sound decisions and judgments about situations and can ultimately affect overall wellbeing. Thus, trauma exposure can delay and impair the volume of certain brain regions. For example, an underdeveloped Hippocampus can translate into a gap or delay in emotional and cognitive processing that includes executive functioning ability. Other biological factors that involve hormone secretion of serotonin and norepinephrine are linked to the onset of depressive symptoms that often need to be brought back to a baseline through the use of medication such as Selective Serotonin Reuptake Inhibitors (SSRI's) (Iftene, Predescu, Stefen & David, 2015). SSRI's support the nervous system in the brain by enabling neurotransmitters, such as serotonin, to communicate better with cells that regulate emotion (Pert, 1997). The core limbic system is made up of 85-95% of various neuropeptide receptors that are responsible for emotion regulation (Pert, 1997). When the core limbic system is underdeveloped it further contributes to a "disruptive feedback loop" on a cellular level, which leaves the body in a dysregulated biochemical state (Pert, 1997, p. 270). This means that balancing stress hormone levels become more challenging since the limbic system shuts down and is unable to flush other peptides that inhibit behavioral responses to arousal states through the organism (Pert, 1997). Mindfulness and meditation support emotion regulation by harmonizing dysregulated communication in the core limbic system. Working with children and youth from early on helps reduce the vulnerability for children to become stuck in a cycle of dysregulation and dissociation. Overlooking internal processes that occur in correspondence to early life trauma places young people at risk for the development of mental health disorders later in life and further increasing negative consequences for various neurological areas of development.

*Theory of Mind and Mental Disorders*

Theory of Mind (ToM) highlights that children begin to develop concepts of people's differing beliefs and desires that "account for their behavior" after the age of three (Ontai & Thompson, 2008, p. 48). Sahin, Bozkurt, Usta, Adydin, Cobanoglu, & Karabekiroglu (2019) explain, "children of 3 years old cannot understand or differentiate their own beliefs from those of others, whereas at the age of 4 years, children have developed the skill of understanding the beliefs of others" (p.38). Secure attachments and relationships play key roles in helping children learn to coherently compartmentalize mental representations of their relationships with others (Ontai & Thompson, 2008). Attachment theorists have long discussed this concept as it stems from Bowlby's concept of "goal-corrected partnerships", which highlights that children use their insights to better align themselves with essential attachment relationships and the goals of their attachment figure(s) (Ontai & Thompson, 2008, p.48). Consequently, children begin to develop an understanding that there are different belief systems and values among others. This helps expand their own psychological identifications of the world around them through relaying interpreted behavior from others back to their own internal states as a cross analysis (Ontai & Thompson, 2008). Findings (Ontai & Thompson, 2008; Meins, Fernyhough, Wainwright, Gupta, Fradely, & Tuckey. 2002) identify maternal discourse, family interactions and attachment security as strong precursors to the strength of a child's ToM. Children are more likely to score higher on ToM task performances when their family interactions are open, and expressive towards discussing emotions using causal language (Meins et al.2002). Meins et al. (2002) emphasized the importance of caregiver capacities to practice "Mind-Mindedness," which refers to parental abilities to reference "mentalistic qualities" by viewing an infant as a "person with their own mind" (p.1716). When working in congruence with one another, ToM and Mind-mindedness provide contiguity between an infant's behavior and their caregiver's mind-related

interactions thereby allowing for the connection "between behavior and its attendant mental states more transparent" (Meins et al. 2002, p.1717). Therefore when looking at these notions as predictors to future child mental state, ToM development can depict levels of intelligence around social cognition. This includes the development of pre-frontal brain regions that encompass "shared attention, pretend play, language development and executive functioning" (Sahin et. al. 2019. p.38).

Mirror neurons are associated with the ability to identify the behaviours and interactions of others (Sahin, et al. 2019). When a person observes a behavior they have engaged in previously by another person, mirror neurons are activated (Sahin, et al. 2019). Neurobiological interest in ToM development has led researchers to measure mirror neurons, and look at how neural networks are formed within a child who has a developed ToM (Sahin et al., 2019). Due to the volume of neurodevelopmental disorders such as Autsim, Schizophrenia, Borderline Disorder, Attention Deficit Disorder, Major Reactive Disorder, and various learning disorders, ToM has become an area of clinical study within Psychopathology (Sahin, et al. 2019, p.38). Sahin, et al. (2019) exemplify that individuals with impairments in ToM experience challenges related to " false assumptions of other people's intentions, lack of self awareness of own mental state, lack of empathy, non-response to social stimuli and independent living skills" (p.33). This can create challenges when trying to establish healthy relationships. Children who experience difficulties in these areas around social emotions can present as having poor communication skills, difficulties understanding non-verbal cues, and being intolerant of constructive feedback (Sahin et al. 2019). "These problems have a negative effect on self-confidence, and the skills of establishing and maintaining social relationships and these can accompany a secondary co-morbid psychiatric table" (Sahin et al. 2019. p.37). Understanding ToM as it relates to the onset

of mental health disorders is important to determine causality of certain neurological and behavioral disorders.

### *Polyvagal Theory: Back on the Regulatory Tracks*

Trauma deeply impacts the Autonomic Nervous System (ANS) and vice-versa. When faced with stress, individuals struggle to modulate their stress back to a baseline that is anchored in systems of safety without proper knowledge to navigate neural circuits of activation and inhibition. When individuals do not cognitively and emotionally make meaning, accept, and resolve traumatic material they remain stuck in primitive stress responses and inhibit the modulation process that helps them "engage, disengage, and reengage efficiently (Dana, 2018. p.17).

Polyvagal theory was developed to explain the causal relationship between 'ventral' vagal complex dysfunctioning and psychiatric disorders that include overlapping symptomology such as a "depressed social engagement system, auditory hypersensitivities, auditory processing difficulties, flat facial affect, poor gaze and lack of prosody" (Porges, 2018. p.xi). The vagal nerve runs a circuitry through the body, traveling "downward from the brain stem to the heart and stomach and upward to the face through it's connection with other cranial nerves" (Dana, 2018. p.20); the vagal system therefore acts as a channel of connection and communication within the body. The theory helps clinicians understand these neurophysiological explanations through the experiences outlined by individuals who have experienced various forms of trauma. Polyvagal theory explains how after experiencing a threat or stressor, neural reactions can become "retuned towards a defensive bias" and "lose the resiliency to return to a state of safety" (Porges, 2018. p.xi). Polyvagal theory has become a prominent component of trauma work as it helps clients learn to map their nervous system by identifying patterns of response to stressors.

The capacity to track and recognize triggers is key to navigate through stressors and responses that would be most appropriate for self-regulation in order to "regain a sense of safety and connection" (Dana, 2018. p.xvii). Dana (2018) highlighted the "4 R's in the Polyvagal approach" within therapy (p.7). These 4 R's include the capacity to "recognize automatic states, respecting the adaptive survival response, regulating or co-regulating into a ventral vagal state, and re-story" (p.7). Employing these principles into clinical applications when working with trauma helps provide a therapeutic framework for clinicians when considering reasons why certain behaviors and symptoms present themselves the way they do. Understanding that our actions are generated by the ANS and are automatic and adaptive promotes conscious awareness of patterns relating to safety. It is important that clinicians recognize that a client's comprehension and perception of an environment is more important than the reality itself (Dana, 2018). Subsequently, when working with clients to process their subconscious emotions and somatic responses, providing psycho-education can help clients understand that before they can cognitively process an event, their ANS has already assessed the environment and initiated an appropriate response.

Polyvagal Theory is best depicted though the visual of an Automatic Ladder comprised of the ventral vagal at the top of the ladder, the sympathetic nervous system (SNS) in the middle, and dorsal vagal at the bottom (Dana, 2018). Typically, individuals tend to sit on the upper middle part of the ladder as they experience daily stresses. They are not entirely in a relaxed or rested state, rather more alert of when their primitive survival instincts need to kick into gear (fight, flight or freeze). This is a healthy place to sit on the automatic ladder. As reoccurring triggers and traumas are experienced a person begins to regress from newest to oldest regulatory responses. They move from feeling safe and socially connected to having their older limbic brain

take over as a result of feeling unsafe. Consequently, the SNS becomes activated which mobilizes a fight or flight response (Porges, 2018). This can then lead to a place of immobilization (freeze response) that can cultivate a sense of dissociation between what is being experienced in their external environments in comparison to their internal environments (Porges, 2018). Dana (2018) explained, "within the framework of interpersonal neurobiology, mental health diagnosis can be viewed as related to either a hyper-aroused or hypo-aroused state" (p.18). Without the ability to impede defensive responses, the nervous system results in a continual state of activated mobilization or immobilization survival strategies. This dysregulation can result in "physical illnesses, distressed relationships, altered cognitive capacities, and an ongoing search for safety and relief" (Dana, 2018. p.18). When incorporating pharmacology to alleviate dysregulated symptomology, medication helps calm the ANS back towards regulation. Psychotherapy can help a person move back into a regulated state by naturally engaging the nervous system in its own capacities to help cope. However, therapy creates opportunities for clients to explore their ability to co-regulate in a safe environment and adds skills that engage the "neural circuits of social engagement" (Dana, 2018. p.18). By learning tools to assist with co-regulation, a person is strengthening their nervous system resiliency as a result of ongoing practice around coping.

### *Importance of Caregiver and Positive Peer Support*

Support networks are crucial in order to feel empowered. A sense of empowerment assists in decision-making that promotes resiliency and choices that move a person from a state of post-traumatic stress to post-traumatic growth. While resiliency is the ability to bounce back after experiencing adversity, post-traumatic growth incorporates mindfulness and reflexivity when choosing which path to take to overcome hardship. Resiliency and post-traumatic growth

go hand in hand, with emphasis on both self-reliance and peer support to be able to move forward. Caregiver roles in helping children deal with mental health challenges involve, "supporting their children to try new behaviors, gently questioning unhelpful beliefs, supervising and charting tasks and modeling positive behavior" (Reed, 2009, p. 2). Caregivers also influence children and youth around accessing services, and whether they will start treatment, be engaged through the process, and feel comfortable to rely on services in the future (Self-Brown, Tiwari, Lai, & Roby 2016). Hayes et al (2018) suggest that the degree of influence that caregivers have on children depends on the both the caregiver's views of therapy and the young person's decision to seek out support. Influences can stem from previous service experiences and other family characteristics including "caregiver psychopathology, family stress, health problems, trauma or maltreatment history" as well as quality of life (Self-Brown, Tiwari, Lai & Roby, 2016, p. 1877). Despite the caregiver's significant influence on mental health support access, concrete and perceptual barriers should dually be noted when looking at a young person's decision to seek help (Self-Brown, Tiwari, Lai & Roby, 2016). Concrete barriers encompass logistical challenges, transportation and scheduling issues, while Perceptual barriers involve attitudes and experiences, beliefs, and the therapeutic alliance between the clinician and active client participants (Self-Brown, Tiwari, Lai & Roby, 2016). Using integrative treatment and practice frameworks helps minimize and re-shape notions around service expectation as caregivers actively engage in the assessment, treatment, and follow up process. Caregiver engagement also helps to build upon existing parenting skills. By offering Psycho-educational workshops for parents, they can continue to provide positive supports at home. That is another reason why using modalities such as CBT are effective for enhancing caregiver support, but

caregivers must take initiative for this to work. Children can reduce negative emotions and thoughts when they have more secure attachments and relationships in their lives.

### *Effects of CBT for Children and Youth*

Cognitive behavioral therapy (CBT) assists participants in conceptualizing their internal experiences as a "function of negative thought and behavioral patterns" (Evans et al. 2005, p. 34). Emotions and behaviors are learned therefore they can also be unlearned through reinforced direct and indirect experiences (Read, 2009). Traditional CBT focuses on "cognitive restructuring, behavioral activation, pleasant activity scheduling and goal-setting" through the use of various exposure and self-monitoring exercises to help increase coping skills while making meaning of participant interpretations around their experiences (Evans et al. 2005, p. 35; Friedberg, Tabbarah & Pogessi, 2013). Since development, other second and third-wave CBT modalities have entered Social Work practice to better work with different age groups, targeting different aspects of mental health disorders, such as anxiety, depression, mood and behaviors. Investigating new CBT approaches that better fit the young populations can help elicit a higher success rate for the prevention of future mental health concerns. Modalities that stem from a CBT foundation include: Trauma-focused cognitive behavioral therapy (TF-CBT), Dialectical behavioral therapy (DBT), Rational emotive behavior therapy (REBT), and, Mindfulness-based stress reduction (MBSR). All of these modalities are collaborative in nature. Clinical transparency and immediacy are central philosophical tenants within these modalities and these tenants are viewed as imperative. Being transparent and attentive to client needs has positive influences over a participant's readiness for change. This allows participants to feel safe and welcomed to explore sensitive sensations, thoughts, and physiological markers without feeling stigmatized or judged. CBT is an excellent therapeutic choice for establishing an effective

working relationship and has been used for children and youth over the ages of 8 (Holt et al. 2014). There are programs that work with younger age groups that use creative means while incorporating fundamental principles of CBT, which makes this modality very versatile, flexible, and accessible when working with trauma and stress related mental health disorders (Holt et al. 2014). Through this therapeutic process participants learn skills to regain a sense of autonomy and build on tools to help them self-regulate. They learn how to express their emotions, sensations and thoughts through more clearly articulated dialogue, and are able to feel more confident in their own resiliency as they are exposed to challenging or stressful situations. Psycho-education is also provided around fear-based cognitive processing and learning to map out plans of action to help minimize feelings of overwhelm and re-victimization.

*Incorporating Trauma-informed practice and Mindfulness*

Trauma-informed CBT (TF-CBT) is a modified version of CBT and has been the most familiar modality for clinicians working with traumatized children and youth. Developed by Cohen and Sherman. (2014), it is a "highly structured and conjoint parent/child intervention" that focuses on "cognitive coping, affective expression and regulation, trauma narrative development and processing, in vivo gradual exposure, psycho-education, and enhancing safety and future development" (Cary & McMillen, 2012, p.748). TF-CBT is highly adaptable in that it is relatively short-term and can be incorporated anywhere. Parents are asked to complete sessions in congruence with their children, including a mix of 1:1 and joint sessions, allowing them to move down the treatment continuum together, leading to better long-term outcomes (Holt et al. 2014). Completing TF-CBT has shown to alleviate symptoms of PTSD as well as internalizing/externalizing behaviors once treatment is finished (Self-Brown, Tiwari, Lai & Roby, 2016).

Mindfulness-Based Stress Reduction (MBSR) is another variant of CBT that is gaining recognition in the clinical world. Incorporating mindfulness within the therapeutic process helps increase bodily awareness and assists in compartmentalizing emotions and memories so it becomes easier to identify and physiologically release them. Mindfulness is rooted in Buddhist philosophy and can date back to two and a half thousand years (Dunning, et al, 2019). Mindfulness means using and intentionally "directing attention to present moment experiences with an attitude of curiosity and acceptance" (Dunning et al. 2019, p.244). Using mindfulness as a tool for healing contributes to an increase in amygdala grey matter in the brain as well as neuroplasticity that is connected to "cognitive flexibility, affective plasticity, attention deployment and emotion-regulation" (Shapiro, de Sousa & Jazaieri, 2016 p. 115). As a modality, MBSR is particularly valuable for preventative work with clients as it gives them the opportunity to practice and hone their skills around self-regulation and executive functioning that moves from a place of reactivity to reflexivity. Utilizing mindfulness produces greater benefits for older adolescents, as this is a period of heightened brain plasticity and levels of comprehension around awareness of the present moment (Dunning et al. 2019, p. 244). Adolescent years between ages 14-18 provide a "window of opportunity" to engage in deep self-work. During this period, adolescents have an increased sense of self-reflection and desire to understand themselves and their environments (Dunning et al. 2019, p.253). Unlike traditional CBT, MBSR focuses on "altering the relationship" with one's own processes instead of trying to change the content of the experience (Cotton et al. 2016, 2016, p.427). MBSR seeks to relay these processes as important messages that the body and mind are trying to communicate. The use of mindfulness as a support to TF-CBT provides a better-rounded understanding of co-occurring external and internal bodily processes, which helps prolong the impact of therapy for future

participants. The flexible nature of mindfulness allows for it to smoothly integrate into continued self-monitoring and regulation as it can be applied to virtually any setting, at any given time. In relation to post-traumatic growth, MBSR helps participants accept their feelings and thought patterns while enabling them to make a conscious decision about how to act. This self-acceptance leads to "enhanced emotional regulation and interrupts ruminations, worries, and depression" (Cotton et al. 2016, p.427).

*Making Sense of Internal Processes Through Creative Connection*

Creative methods such as sculpture, guided imagery, journaling, sound, meditation and self-affirmation are often used in congruence with CBT and narrative modalities. Combining creative methodology with CBT principles helps construct a holistic mind-body-spirit that may have been elusive (Rosem, 2014). Such methodology places emphasis on doing therapeutic work from an integrative and inter-modal arts-based framework and can provide introspection to complicated emotions or experiences by being able to convey them without having to construct a full verbal narrative (Rosem, 2014). When working with individuals who have a limited verbal capacity, such as children or individuals with cognitive disabilities (i.e. Autism or Dyslexia), expressive arts therapy can help mitigate limitations of verbal language when trying to "express the full range of human emotions and experience" (Rosem, 2014. p.298). Because of this, there is a surge of using such modalities within assessments and diagnosis (Rosem, 2014). According to Rosem (2014) creative expression is recognized to "often bypass the defenses of the conscious mind" therefore enabling "strong emotions and personal issues" to surface faster than they would in traditional talk therapy (p.301).

A key component to facilitating creative expression within therapy is the clinician's ability to create and maintain a safe space for art-making experiences to take place. Natalie

Rogers (1993) discusses establishing a safe holding space for clients to explore vulnerable parts of themselves through fostering a clinical awareness of the mind, body and emotions that clients may bring forth through their "intuitive and imaginative abilities as well as logical, linear thought" (Rogers, 1993. p.3). Combining clinically holistic and trauma-informed lenses into therapeutic practice helps practitioners understand the power of imagery and non-verbal modes of expression to help with self-exploration, communication and co-regulation. Emotional states are rarely logical; rather they operate on a subconscious level (Rogers, 1993). Through this process it is imperative that clinicians maintain an "empathetic, open, honest, congruent, and caring" stance. By "listening in depth" clinicians can nonverbally encourage a client's personal growth and development by focusing on the exploration sensitive memories and sensory states (Rogers, 1993. p.3). Color, line work, form, sound, and guided imagery can reveal various aspects of a person's being including "energy levels, feeling states and self-concepts" (Rogers, 1993. p.69). This is achieved through having the opportunity for the client to transform their repressed states into constructive energies that build on their own intellectual conception of any emerging symbolism that can arise through their creative process. For the client, the creative process is person-centered and strengths-based and allows them to feel in charge of guiding their own therapeutic work in a safe manner, with assistance by the facilitator.

Other forms of creative expression including sound, guided meditation, and self affirmation can help deepen emotional experience and set the motion of internal narrative restructuring. Listening to music and practicing meditation allows for movement into a deeper sensory state feeling from and tune inwards to become acquainted with source energy (Rogers, 1993. p.90-91). Attuning to a state of inner quiet can help look at internalized conflicts or emotions from an objective and constructive viewpoint thereby assisting the process of problem

solving without accompanied feelings of overwhelm or anxiety. Rogers (1993) explained, “being open and receptive has a great deal to do with the flow of creativity” and directly links to “inner source energy, self-esteem, and self-empowerment” (p.91). The use of self-affirmation within therapeutic contexts has also proven to be vital to attitude personal development by encouraging clients to reconstruct “habits of thinking” and create “inclinations for the right kinds of intellectual practices” (Weber, 2016. p.52-53). According to self-affirmation theory, people have a strong desire to “preserve a positive, moral, and adaptive self-image” as it impacts their overall sense of “self-integrity” (Morgan & Atkin, 2016. p.500). This desire to maintain self-integrity and adopt an adaptive take on self-understanding and compassion reduces the need to be on the defensive side when feeling threatened in another domain (i.e. family, job, or performance stress) (Weber, 2016).

Incorporating self-affirmation interventions within clinical counselling therefore helps rewrite an ego-based narrative that we all people fall prey to at one point or another. These interventions shine light on a person’s beliefs around their own personal core values. Having participants write out strengths-based sentences helps enhance their own capabilities for adaptive potential while also creating a “positive feedback-loop between self-esteem and the social system that propagates adaptive outcomes over time (Cohen & Sherman, 2014, p.333). Regularly stating self-affirmative statements out loud with intention has proven to be effective when trying to “improve health and relationship outcomes” by strengthening resiliency, increasing mindfulness and enhancing adaptability for coping with unforeseen stressors (Cohen & Sherman, 2014. p.333).

## Chapter Five: Summary of Learning Experiences

My learning has been rich as a practicum student with CYMH, and I feel like a more skilled and competent clinician than when I first began. Not only did my CYMH colleagues welcome me with a wealth of encouragement, I also felt supported by the entire social work team. As a student, I had difficulty diving into the everyday tasks that social workers seemed to perform effortlessly. Along this journey, I felt at ease with new ways of doing social work practice, largely because I felt valued and respected, as a key member of the interdisciplinary team. Entering into this new role, especially as a student, I was unsure of what exactly lie ahead for me. I expected to shadow and observe those around me so that I could ease into new tasks like my previous practicum placements before taking flight on my own. Instead, I was immediately immersed within the clinical world and asked to take on clinical roles that were far from my own front-line experience within social work.

On my first day my supervisor handed me a list of five files. I felt the sense of fear seep through my body as my heart began to race, knots in my stomach, my legs twitching, and silently screaming, “run away before it’s too late”. I expressed my anxiety to my practicum supervisor, as I felt like a rookie while I explained my scattered thoughts to her. She smiled and gave me advice that I carried forward through my acquired role. She shared some wisdom that she was given by her MSW practicum supervisor when she first began: “you’re only going to talk to them, you’re not going to kill them”. We both laughed and in that moment of humor, I realized how much truth that wisdom holds. It was this brief sentence that carried me through moments of internal chaos, as I sat before clients and their families, trying to map out my next steps. Knowing that my team supported me, I felt grounded amidst the chaos. I knew that help was just a door away when I needed it, as I was figuring out my own clinical style, while also becoming acquainted with the resources available within the growing community.

This area of clinical practice not only combines social work theory and practice principles but also clinical therapeutic approaches. My experiential narrative is broken down into various components to help illustrate aspects that have enriched my professional development, as I moved forward through learning this therapeutic dance. This narrative includes a reflection on working within a clinical interdisciplinary environment, the power of connection, psycho-diagnostic assessments, the art of the therapeutic dance, a reflection of learning through case examples, and maintaining self-care.

### *Working within a Clinical Interdisciplinary Environment*

I especially enjoyed that my practicum placement was within a clinical interdisciplinary environment. I could bounce ideas around and consult with colleagues from various social work disciplines outside of child and youth mental health. These included child protection, child and youth special needs (CYSN), integrated practice, probation, and resource social work. The opportunity to work within such an environment helped me navigate the various systems and policies in place to help people. Learning to access funding for a child diagnosed with a disability such as autism, or make a referral for a diagnosis was beneficial for my learning. CYMH clients are often concurrently involved with child protection or CYSN, so working together was essential for ensuring that clients received services and supports that were in their best interests. Working in an environment that valued shared-knowledge was vital for my ability to assess individuals during walk-in intake hours. I learned to conduct intakes with a broad understanding of the policies and options for clients to gain access to services. Developing a working knowledge of resources provided clients with choices and access to specialized services. Significantly, I learned that alternative services might be more appropriate for the needs of the individuals who sought support. For example, a female youth accessed intake services for

supports for anxiety and depression. In completing the intake, I assessed that trauma-informed therapeutic supports were needed when I learned she was a victim of sexual assault. . Because of my broad knowledge of community resources, I referred her to a program called SAIP (Sexual Abuse Intervention Program) based out of Sea-to-Sky Community services that offers free individual or group therapy for children under the age of 19 who experienced or are suspected to have been sexually abused/assaulted (Sea-to-Sky Community Services, n.d.). In referring her to this specialized program, she avoided a wait-time of three months to see a CYMH clinician and was immediately seen for individual SAIP counselling.

The weekly team meetings taught me to work in an interdisciplinary environment. They took place on Wednesdays and alternated each week between the full office and CYMH specific meetings. I learned the power of interdisciplinary consultations and collaborative decision-making. I also had the opportunity to take part in a team day that involved all staff, where we learned about Ethno-botany specific to the Squamish area and discussed the importance of restoring education to youth, especially those who are Indigenous, to help restore a strong cultural component into their lives. During this team day, we made personalized tea blends with native herbs, as well as a salve with various essential oils. I enjoyed taking part in this as it focused on holistic topics in which I am quite interested. This workshop emphasized self-care and encouraged building relationships among staff. We also had guest speakers from other community resources present on topics relevant to their services, such as Indigenous Mental Health Strategies as well as supporting those with disabilities. These workshops were informative and applicable to families with which I engaged. For example, the presentation by the Family Support Institute, on the peer-to-peer support platform particularly impacted me. People discussed their challenges and felt connected to the community. I learned how isolated

families caring for loved ones with disabilities can feel, and the importance of support networks during wait times as they can provide families with a sense of relief through information sharing about their specific disability strategies to better support their loved ones.

### *The Power of Connection*

Interpersonal connection was woven through each practicum experience I had. From internal and external colleagues to individuals who I have met with briefly or regularly, establishing a genuine connection was at the foundation of each interaction. For instance, I was able to take a lead liaison role connecting with a high school student to help her group with a mental health presentation that they were organizing for parents at the school. My part within this project was to create a 15-minute PowerPoint presentation for my colleagues on the services that CYMH offers, as well as some psycho-education around parent-child interaction and mental health concerns. Feeling a sense of belonging within a clinical environment alleviated the intensity of my own insecurities about my performance because I was reminded that I was in a safe and supportive place when I felt afraid to make mistakes. Through professional connections, I was encouraged to challenge myself to move past self-doubting thoughts and prompted to use any mistakes as learning opportunities. Gaining the understanding that making mistakes are part of the learning process has helped me develop into a more rounded clinician by expanding my knowledge around clinical approaches and therapeutic skill, and providing me the practice to apply theory. My practicum experience allowed me to witness the capacities that people have to create meaningful change within the contexts of their own experiences through a strong sense of therapeutic alliance. I experienced this with clients that came in for one-time intake visits to our weekly therapy sessions. On numerous occasions clients expressed their sense of comfort during their session as a result of feeling understood. I worked to provide a safe environment for them to

be vulnerable when expressing emotions or thoughts. I also noticed that clients were more inclined to return for services when the reportedly felt a strong therapeutic relationship between us.

My own accounts of therapeutic alliance with clients authenticated academic literature around clinical relationship building and positive therapy outcomes. For example, Lambert and Barley (2001) highlighted that "clients often attribute their positive therapy outcomes to the personal attributes of their therapist" (p.358). Some of these attributes include not only skill and credibility but, more importantly, empathic understanding and affirmation, along with the ability to engage, focus on client concerns, and to direct attention to the affective experience (Lambert & Barley, 2001). In reflecting on my own therapeutic skills around establishing connection, I work from a compassionate, client-centered, strengths based framework, which reminds clients that they have the strength and capacity to create meaningful change. I was transparent throughout this process, and highlighted that I was not there as an authority figure, nor to "fix" anything; I was simply there to walk alongside them, to provide perspectives, tools, and be their confidant in hopes that they would choose to act for their mental and emotional health.

### *Psycho-diagnostic Assessments: intakes, understanding the DSM-5, and treatment/discharge planning*

Psycho-diagnostic assessment skills and working in congruence with the DSM-5 was a new area of clinical practice for me. I do have a good understanding of and differentiating between mental disorder definitions, symptomology, and pharmacology from my experience as a frontline youth and adult mental health worker. However, I have never formally conducted clinical psycho-diagnostic assessments and reporting. During the first two weeks of my practicum, I took my time reading the DSM-5 and ensured I understood the differences among

disorders. There is a lot of overlap among diagnostic criteria. I had never explored the DSM-5 in that much depth before. I appreciated how easy it was to follow. Prior to working with the DSM-5 I wondered about how I would code variables pertaining to mental health issues. For example, if an individual did not meet any criteria for a specified mental health diagnosis. To my surprise, I learned that the DSM-5 has two key elements to help support assessments that do not find any significant markers for a diagnosis.

Firstly, for most disorders the DSM-5 provides a diagnostic feature to code "Other specified" disorder. For example, for ADHD on page 65 of the American Psychiatric Association (2013), one is given the option to code for "Other Specified Attention-Deficit/Hyperactivity Disorder", which applies to presentations in which characteristic symptoms of ADHD are present that cause clinically significant distress or impairment (p. 65). However, it "does not meet the full criteria for ADHD or any other disorders in the neurodevelopmental disorders diagnostic class" (American Psychiatric Association, 2013. p. 65). Knowing that this was an option provided me with a sense of comfort and safety because I was worried about coding a disorder that is not accurate of the client's presentations. I was reassured when I learned that CYMH clinicians only provide a provisional diagnosis as part of the psycho-diagnostic assessment. Thus when I transferred my file to another clinician, they were able to look at my comprehensive assessment and understand that these were the symptoms and potential diagnosis that this client was facing. Secondly, the other key feature in psycho diagnostic assessments includes the section on "Other Conditions That May Be a Focus of Clinical Attention" (American Psychiatric Association, 2013. p. 715). This section was an especially important tool for writing comprehensive assessments because it applied to all of my clients. I found that the individuals I met for an intake and a session all had specific factors that influenced their current

mental health state. This section draws clinical attention to conditions and problems that are not categorized as mental health problems (American Psychiatric Association, 2013). Instead "their inclusion in the DSM-5 is meant to draw attention to the scope of additional concerns that may be encountered in routine clinical practice and to provide a systematic listing that may be useful to clinicians in documenting these issues" (American Psychiatric Association, 2013. p.715). I learned to provisionally diagnose: "Child Affected by Parental Relationship Distress (American Psychiatric Association, 2013. p.716), Disruption of Family by Separation or Divorce" (American Psychiatric Association, 2013. p.716), "Academic or Educational Problem" (American Psychiatric Association, 2013. p.723), "Phase of Life Problem" (American Psychiatric Association, 2013. p.724), "Unspecified Problem Related to Social Environment" (American Psychiatric Association, 2013. p.725), and "Child or Adolescent Antisocial Behavior" (American Psychiatric Association, 2013. p.726).

Throughout my practicum, I actively took part in weekly intake sessions, and I met with one or two clients each day during walk in clinic – Tuesday mornings between 9 AM and11:30 AM, and Wednesday afternoons from 1 PM to 3:30 PM. The client volume fluctuated weekly. The assessment process overall depended on the client's forthrightness. I learned to actively listen and guide the client back to the intake assessment questions in a client-centered and respectful way. The intake assessment questionnaire is called the Brief Child and Family Phone Interview (BCFPI). Although this is called a "phone interview", this screening tool can be used by phone with parents, teachers or children over 12 (there are two different questionnaires, one for adults and one for adolescents), or in person. I completed the documentation on paper rather than the computer while directly engaging with the client. This approach was more engaging for

both myself and the client The questionnaire consists of six sections, comprised of one's mood, behavior, functioning, family relationships, other concerns, and barriers/protective factors.

Typically, when I conducted intakes I brought my clients into either a warm office space or the art therapy room if there were children present. I always offered a cup of tea or water, and informed clients of the washroom locations. After introducing my role, I explained the two consent forms that they had signed. I explained the services offered by CYMH, my limits on confidentiality and informed them that it is a free and voluntary service that offers therapeutic counseling and programming on security, attachment, and parenting. I informed them that the BCFPI is not used as a diagnostic tool but rather a screening tool to help clinicians understand the nature of presenting concerns, and explained the next steps and wait times. Subsequently, while proceeding to understand what brought them in, I held space for natural conversation, as I inquired about various bio-psycho-social-spiritual factors that may be underlying and impacting their mental health. In doing so, I began to make sense of their concerns and was able to critically think about possible services that may be more appropriate.

Once the BCFPI was completed, I provided clients with some potential resources for other services or information on relevant programming. I completed safety plans with adolescents/youth if they expressed any current suicidal ideation or disclosure of self-harm. I facilitated a circle of security activity with the youth, where I highlighted safe adults they can talk to when feeling upset or in danger. During the intake process there are also opportunities to provide some psycho-education to parents and adolescents to help them comprehend various aspects of their situations or coping mechanisms. After the intake I entered the data of the screening tool into CARIS (the online data base for CYMH), which created a bar graph for a multitude of factors outlined in the BCFPI. This chart provided a clear visual for clinicians in

regards to areas of focus that needed to be prioritized. In my BCFPI document, I also constructed a thorough narrative stating the facts that were mentioned, moving through a bio-psycho-social-spiritual framework, and listed any activities or psycho-education provided for both the family and child. Once the document was completed, I faxed an intake letter to the client's doctor to inform them that the client has attended the office, advise of any referrals or safety plans that were made and the next steps for CYMH clinicians in regards to service provision. At this point, a client file was generated and the administration staff completed data entry and filing.

When writing treatment plans or discharge summaries, I have learnt that being objective and thorough is essential. Although there is much overlap between these documents and comprehensive assessments, they differ in that treatment summaries and discharge plans are more like outlines and clinical recommendations on the work that has been done with clients, rather than actual assessments of the client as a whole. Assessments include treatment plans and recommendations.

In discharge planning, I also provided a reason for closing or transferring the file, and identified whether it is on the part of the agency or client. These summaries are brief and to the point. In completing a file closure, just like the intake, we must fax the doctor a letter to inform them that the file is now being closed. There are times when we close files because the client/family are not responsive, in which case we would send a formal letter to the client/family outlining that we have made several attempts to contact them however due to no response, their file will be closed and kept for six months before being archived. If the client returns after the six-month period, they must go through the entire intake process all over. If they are within the six-month period, their file will be reopened without the need of creating a new one.

*The Art of the Therapeutic Dance*

*Finding my Groove*

Stepping foot into the world of clinical counseling was quite daunting as a novice clinician. Just like going to a dance class for the first time, when I enter the room to meet the people I must interact and dance with, my heart begins to race, my mouth becomes dry, and self-doubts trickle into the back of my mind. The sense of feeling amateur ignites power that feeds the ego, causing anxiety as a result. As I stand up and begin to move, my first steps may be awkward, however, within time I notice the movement begin to carry me effortlessly. In this moment, I come to a realization that I knew the movements all along, I just needed to let go and find the flow. The world of dance is an art form similar to that of therapy. As both processes involve a constant stop and go. I can only prepare so much. By learning and practicing the skills, however, in the moment of the performance I must learn to adapt to any unforeseen motions or missed steps. As a clinician, I can only prepare so much for my session through research and activity plans. Nonetheless, if my client is not ready to engage, I must adapt and meet them where they are. I learned that I sometimes need to repeat several steps for clients to feel confident, and other times, I need to change my approach to better foster their learning process. Dance and therapy require a mirroring of behavior and emotion so that synergy can take place between one another. In therapy, I observe the behavior and emotion of my client to help guide the therapeutic process by gauging their fears and comfort levels before inviting a discussion about vulnerable topics. I learned to move through therapy in my own style while using my theoretical knowledge to guide my practice.

As I found my own groove in this therapeutic dance, I found myself drawn to play therapy, creative expression, meditation and use of affirmations as complimentary tools to my already acquired trauma-informed CBT and narrative therapy frameworks. I found that using

creative expression helped my young clients convey thoughts, emotions, and memories that words alone would not be able to construct. In my therapeutic sessions with children and youth, using art in correspondence to narrative enabled me to empathize as they created and explained their artwork to me. For many of my clients, there were moments of insight to suppressed emotions, memories or thoughts, as they felt safe to allow them to take form through imagery, sculpture, and role-play. I will speak more in-depth on the use of creative modalities in correlation to engaging in CBT and narrative therapy to help young clients work through their emotions, anxieties and depressive states further in this chapter, within the *Case Examples* section. I found that the more I engaged with clients in this process, the more confidant I became in transitioning between CBT, narrative and creative expression to help safely uncover and explore what is circulating beneath the surface of my client's clinical presentations.

*Setting the stage: Establishing a therapeutic alliance*

I discovered that hospitality is a key attribute to establishing a good therapeutic alliance. Hospitality in a clinical context meant ensuring that the client felt welcomed and safe. In my clinician role, this was conveyed through casually checking in with the client. I asked if they wanted something to drink, reminded them that they can stop or pause the session at any time, and maintained presence in the sessions through nonverbal communication. Examples of nonverbal communication I incorporated include: having an open and relaxed body posture, attentive mirroring of what the client was expressing through facial expression, and having a soft gaze and compassionate presence and unconditional positive regard.

This practicum experience has shown me that my strengths include good interpersonal skills. In my interactions with people, I always asked for clarification when needed, and maintained a strengths-based approach. A strengths-based approach meant that I validated and

normalized clients' feelings as I provided psycho-education around emotional regulation, stress, trauma, and/or mental health. Clients reportedly felt like their voices were heard and a bridge between their own life experiences and the psycho-education I provided was built. In fostering a strong professional connection with my clients through mutual understanding, I observed strong client engagement.

Clients told me on several occasions during both sessions and intakes that they appreciated how comfortable I made them feel. One female youth during the intake process said, "if I could choose to have a counselor, I would choose you". On another occasion, the mother of my five year old client said during a phone check-in, how "happy" she was with "how comfortable" her son was in the session, and highlighted her appreciation of the chosen environment. The female youth that I saw for seven sessions resolved her internal conflicts, overcame her avoidance with school and homework, and experienced an overall decrease with her depressive mood and anxiety related symptomology. At the end of our time together, she shared that she "really enjoyed the activities" and felt "pretty bummed" that our last session was ending. This feedback bolstered my confidence that I was developing strong therapeutic skills.

*Mapping Out the Steps and Putting it all Together: Client knowledge and Skill Building*

One of the therapeutic elements I was transparent about was my role in their clinical interaction. I conveyed that I could not "fix" their concerns but rather provide another perspective and guide them to learn skills that would benefit their wellbeing and emotional-regulation. I worked to ensure that clients and their families comprehended the power of their own roles in the healing process. I highlighted the notion that genuine therapeutic intervention often occurs after clients leave therapy and apply skills and tools they learned through therapy.

I realized an important therapeutic factor: I needed to slow down and move at the pace of the client. I became so excited with thought-out solutions that in a couple of instances, I gave too much information. I realized that this could overwhelm the client. This learning curve enabled me to slow down and focus on one skill at a time. Slowing down the learning process helped the client with knowledge integration and the application of the material. The clients were given space to independently practice over the course of a couple of sessions. Everyone has a different capacity and processing system for comprehension. This was important for me to recognize from a clinical perspective because it greatly influences long-term outcomes and skill adaptability.

*The Final Curtain: Preparing for Closure*

I was not prepared for the emotional aspects of ending therapeutic work. At CYMH, I experienced this emotional transition with three clients. I became used to routinely seeing clients weekly, and I watched their development take place. During our time together, I had the privilege to get acquainted with client strengths, capabilities and resiliency through each session. As a clinician, I felt proud of the progress that each of them made, and when parting I imagined the emotions that a mother bird would feel as she watched her young take flight for the first time.

In processing my own feelings around termination and my professional role, I also understood that my clients needed their own process for closure. From the start of our professional relationship, I informed my clients of my position as a practicum student, was limited. I also revisited this conversation at our halfway point, and informed clients that we were approaching our final session. During the last session, I focused on reflection and planning their next steps. With one five-year-old male client, I tried to mitigate his feelings of shock or abandonment from my termination with him. I wanted to safeguard against causing harm by providing a positive ending for him. I regularly engaged in dialogue about me “going back to

school" and reaffirmed that a new clinician will see him weekly to play and share feelings. Sadly, we could not have the clinician sit in on our last session due to scheduling conflicts so I made sure that I listed off positive traits about her to the boy so that he felt a sense of preparation with who is next to come. I noticed his body language became more open and relaxed as opposed to appearing closed off and dismissive. I highlighted to him that this new person is "funny, kind, and excited to get to know him by playing together".

*Case Examples: A Clinical Review of Learning*

In order to exemplify the significance of my experiential learning through clinical therapeutic interventions such as CBT, Crisis Intervention, Expressive Arts therapy, Self-Affirmation and Meditation, I will share some of the case examples I had through my clinical experience within my practicum. These are case examples that I feel echo the essences of the therapeutic modalities that I have discussed thus far.

*Case Example One: Working from a CBT framework to explore emotion and psychosomatics*

While working with two separate clients on exploring their somatic sensations and internalized feelings relating to strong emotions such as anxiety and anger, I was able to modify and facilitate similar activities to fit their specific needs. For one of my youth clients whose main concerns revolved around anxiety, we spent time creating a visual body-map using larger post-it paper and different colored markers. This activity used color-coding and imagery to help illustrate emotional sensations and line formation to help represent the somatic movements of each sensation (Figure 1.1). In participating in this activity, this client was able to develop a legend highlighting each emotional sensation (Figure 1.2). Light green was used to resemble discomfort/overwhelm; indigo represented heart rate; light pink represented Jitters; red represented racing thoughts; and lastly, dark green represented a scratchy throat. As we mapped

out these emotional sensations through her bodily illustrations, the varying lining styles exemplified the somatic intensity of each sensation across various parts of physiology. Some of these somatic representations were then labeled for more clarity on the precision of sensory feeling such a “pressure” in her forehead and over her eyes, as well as “knots and nausea” in her stomach. Debriefing about each part of her body where she felt these sensations enabled this client to brainstorm a list of coping tools that could be used to help regulate and take control of these sensations. This list included: a “list of thoughts and triggers, drinking water, breath work, using binaural beats, doodling and going for a walk (to name a few) (Figure 1.3). This activity helped externalize her internal sensory and dysregulated processes and helped her create a visual that she could turn to when experiencing any of the above.

My next client, a 5-year-old boy engaged in an activity called “My Many Colored Thoughts” as we explored emotions that he felt automatically drawn to (See Figure 2). In preparation for this activity I had drawn out several empty bubbles so that he could draw faces in each one of his choice. During activity facilitation I observed a theme take shape as he drew in the many faces. Most of his emotional identification and vocabulary comprised of emotions that could be depicted as sub-emotions under the overarching emotion of anger or fear. The sub-emotions that were identified included: frightened, gross, scared, mad, and silly. This activity helped gauge this boy’s level of emotional intelligence and overall content of vocabulary. It solidified the underpinnings for his aggressive, explosive and violent behavioral representations because it was evident that those feelings were all that he knew how to verbally articulate. These behavioral representations were a product of learned behavior on part of his father who mirrored violence and aggression when feeling stressed out at home. Therefore this boy adopted the same behaviors to express himself when he felt similarly to his father. On one occasion, as his mother

was showing a video of him ripping apart a calendar, when asked why he was doing that, he said "I'm mad so I'm doing just what daddy does", then later identifying that "hitting is a feeling" for him. The use of art-based CBT activities in both of these cases were significant in helping myself as the clinician to understand what they were processing on deeper levels where verbal difficulties arose to convey them.

*Case example 2: Using Play-Doh as creative expression for uncovering repressed thoughts and emotions*

When working with a 15 year-old female client, we spent a session creating sculptures with Play-Doh to help her reflect on some of her underlying emotions. This client was invited to create whatever she wanted that could represent an uncomfortable situation or feeling. Once she felt like she was finished, I provided her with instructions to choose what she would like to do with her creations: squish them save them, hug them, etc. Providing a choice gave her the opportunity to tap into her personal power and utilize her capacities for self-determination. After she had chosen her actions towards her creations, we would debrief on her creations and what came up for her through those processes as she created and chose what to do next with them. This client ended up creating three separate creations: two-human like creatures and one macaroon-like object.

The first creation was a black human-like figure with red hair. My client explained that the creature represented herself and the red colored hair represented her anger. She said that when she is feeling sad or upset she "skips the irritated part" and goes straight into feeling angry. The action that was chosen for this creation was to give it a pat on the back. The reason behind this course of action was that she really wanted to work on "being friends" with her emotions and work on better recognizing them and working with them instead of suppressing them. My

client stated, “it’s inevitable that I may be sad or angry, however I want to control my emotions and learn how to separate my feelings to identify if its sadness or anger that I am feeling”. In this reflection, she was able to draw connection on her behaviors when feeling these specific emotions, stating that when she is feeling sad it can come out as an “attitude” that reflects anger.

The second sculpture that my client made depicted a pink human form. She explained that this creation represented her “frenemies”. Through this creative process, she explained some of the thoughts that came up for her. These thoughts included “understanding that you are not always around people who are real, honest friends”. The course of action that she chose for this sculpture was to simply leave it alone because she recognized that she invested a lot of time in pleasing others. She expressed feeling a sense of increased neutrality upon reflecting on this creation, stating that she felt the need to vocalize and prioritize her own personal boundaries with her peers within her social networks.

The third creation that my client had made was the macaroon shaped figurine. The macaroon was made up of black and pink colors, with the black color placed on top of the pink color. For her, the black symbolized feelings of “guilt, doing bad in school, and feeling defeated”. The pink on the other hand, represented her “desire to do well in school”, her efforts and “feeling confident” in her skills and knowledge at school, and attributes that she strives for. Her course of action with this sculpture was to separate the black from the pink. As she separated the two colors she explained, “when the black is always there, I hold myself back. When I think about school, I think of the fourth grade. I’m not in fourth grade anymore. I’m moving on and I want to get past that memory”. She expressed that this specific memory has lingered with her ever since because she associates it with feelings of incompetence and not being able to finish what she had started academically.

Through this creative process, I was able to maintain a strengths-based approach and provided my client with validation around how powerful and insightful her creations and interpretations were, while also reflecting back on her many "ah-ha" moments through this creative process. When debriefing on how the activity went for her, my client stated that she was "taken back" by the depth of her analogies, explaining that it made her realize many things including being reminded that she has the power to choose how to respond to situations and/or emotions.

*Case Example 3: Using meditation and affirmation to help reconstruct automatic thought patterns and narratives*

Incorporating the use of brief guided mediations along with intently vocalizing three self-affirming statements based on anxiety and depression at the end of my sessions with young clientele proved to be highly engaging and beneficial for them. There is an array of literature that discusses the benefits of meditation and self-affirmation as practices to help reduce psychological barriers. This occurs by helping clients buffer perceived threats and curtailing defensive adaptations, while striving to maintain a narrative that is supportive and promoting of personal adequacy (Cohen & Sherman, 2014; Schmeichel, 2009; Margolin, 2014). The use of empowering self-affirmative statements has also shown to help a person identify ego-based thinking patterns and shut them down before they spiral into a cognitive conundrum. Some of the feedback by clients around practicing meditation was that it helped them eliminate tension within their bodies and feel more relaxed and at ease. Furthermore, initial feedback around positive self-affirmation activities proved to be challenging and emotional for some clients to complete, as they were not used to saying or hearing positive things about themselves. However, with gradual exposure to these statements, my young clients reported that the statements became easier to

express, and some clients began to look forward to this part of the session as opposed to being avoidant of this exercise. In particular, by the end of our sessions together, one of my female clients began to practice meditation before bed on her own and was able to create some short but powerful affirmations of her own to recite when feeling anxious at school. Exploring the youth's core values about themselves helped to develop these self-affirmative statements; for some this was an emotional roller coaster that they did not feel prepared for. In this instance, we took a step back from taking part in this activity until they gave me the go-ahead that they were ready to try again.

*Case Example 4: Safety plans and coping mind mapping*

On one account through my practicum experience, I had a regular client came in for a post-crisis intervention session after witnessing a traumatic event that involved a friend attempting to commit suicide. During this session, we spent time debriefing how she felt about the situation while also exploring tools that she could utilize when coping with vicarious trauma. We explored coping mechanisms that could be used at home, at school, during the nighttime, and when in the moment experiencing traumatic events (See Figure 3). This was a valuable exercise to help strategize various coping avenues and identify safe places and people that could provide support and comfort. I thought that this was a simple yet effective tool to use when working with clients who were coming out of a crisis situation as this helped move them out of a self-victimizing place to a more solution-focused and constructive plan of action. Being able to visually brainstorm strategies helped ground this client and provided her with a sense of regained autonomy around her ability to self-regulate and reinforced her ability to compartmentalize what has happened without keeping her stuck within survival mode instincts.

*Case Example 5: Using Imagery to explore anxiety*

Other activities that I gravitated towards through therapeutic processes with clients included allowing them to express and give meaning to their internal experiences through the use of visual art. During one of my sessions with a female youth, I invited her to create imagery stemming from a single line that represented her anxiety (Figure 4.1). The illustrations that she produced were colorful and full of various shapes and movements. One would not be able to interpret them just by looking at them. In the middle of her page she had a saw-like wheel spinning and within the wheel were blue and pink colored rings. This wheel appeared to be enclosed within a layered box with a thick blue line diagonally cutting through the shape. The colors within this box included yellows and purples with immense masses of green and red projection from the top of it. On the far edges of the paper, she drew black waves that interchanged between being more transparent or solid. The direction of the waves appeared to be closing in towards the middle of the page. At the top of the page, in the space between the red and black solid shapes, were light green arrows pointing outward towards the black outline. This illustrated a motion of expansion, as if the red was trying to expand and push against the black. Once she was finished, I asked her to explain her artwork. My client chose to draw another drawing to explain this initial piece (Figure 4.2). As she explained these illustrations to me, I was taken back by the layering of emotion and internal responses to them. In her second image (Figure 4.2), she drew a square and in the middle wrote out the words “Shut off”. As a frame around this box she drew black lines that looked as if they were caving in on the box in the middle. On the far sides of the page in green, she drew straight, solid lines with the words “frozen” overtop and on bottom of the page she drew lines pointing towards one another in blue crayon with the words “waiting”. She explained that the black lines depict a sense of caving in on her, producing a sense of claustrophobia. My client explained that when she feels

claustrophobic she becomes shut down and frozen in her state of overwhelm, waiting for the negative emotions/sensations/events to pass. She defined this feeling of being shut down as being helpless to come out of it amidst its climax, leaving her to wait until it passes on her own. When connecting her second illustration to the first, my client was able to engage in a deeper analysis around the saw-like wheel centerpiece that she had illustrated as being enclosed within a layered box. She stated that the wheel represents her sense of overwhelm and anxiety from external forces and despite her efforts to protect herself (i.e. the box form, and blue line crossing through it), she feels a sense of entrapment within these negative states. She mentioned that the green and red coloring expanding from the wheel is her attempt to overrule these negative thoughts, emotions and sensations with love and self-compassion, adding that she feels like no matter how much she tried to emit those positive emotions, the blackness is overpowering. This activity was powerful for both my client and myself as I was reminded of Rogers (1993) explanation of how moving visual arts can be when exploring conflicting elements and making discoveries through the creative process.

In another session, the same client had asked to use this activity to explore feeling of anger specifically. Her imagery around anger involved the use of triangles and arrows to portray push and pull type movements. She explained that she feels an internal power-struggle when feeling angry, stating that as soon as she starts feeling angry about something, she escalates herself to feel a sense of increased anger towards herself for feeling this emotion to begin with. She described this as “getting mad at myself for getting mad” that enables her to react by either “shutting down” or trying to “push it to the side”. During debrief, this client spoke highly of using art to express herself, adding that it was her preferred method, as it’s “easier to communicate feelings that sometimes words can’t explain”. This moment as a clinician was

pivotal in seeing first-hand the power that the expressive arts hold in fostering deep self-exploration and reflection.

### *Maintaining self-care*

I am in constant re-evaluation of my self-care as it is not a linear process but more of an ebb and flow moving between my mental and physical needs based. Moving into this practicum, I knew that my workload would only intensify however I did not have the means to cut back on my work hours outside of my practicum. Despite this, the practices that I had in place for self-care kept my own mental and physical health in check, through meditation, stretching, many naps, food, and beauty pampering. The one component that fell on the backburner was my exercise. This was mainly because I did not have the time for it, and when I tried after working long hours, I prioritized resting over hitting the gym.

During my practicum, it was evident that my colleagues valued lunch times. More than just eating lunch, I was constantly reminded to go for a walk or have lunch in a different setting than at my desk as I worked through paperwork whilst simultaneously munching. This was an aspect of my self-care that I also felt needed lots of reinforcement maintain it. I was used to eating and working through my lunch hours, thinking it was "more efficient" however, in watching my colleagues engage in their own lunch hour self-care through going home, going for runs or simply hanging out in the lunch area with co-workers, I came to a realization that I had been doing it all wrong. Working through lunch breaks was not healthy. I noticed that there was a difference between my focus and stress levels when I actually took a break opposed to going about my usual routine. I started going out for walks more and in doing so, I felt a sense of gratitude and presence. This led me to feel calmer and more rejuvenated going back into my afternoon clinical sessions with clients. Another piece that I had to work hard on was my fluid

intake. I was so used to drinking a lot of coffee through my days I neglected water all together; this leads to escalating feelings of fatigue and dehydration. With all these areas of self-care improvement needing my attention, I came to understand that I needed to incorporate more mindfulness in my day-to-day tasks: mindfully eating, drinking water, and taking time for solitude.

One of the major self-care practices that began to infuse into my days was the use of chanting and mantra meditation. On my hour-long car-rides to and from Squamish, I would take time to chant Sanskrit mantras such as "Ohm, Tat Tavam Asi, and Shanti" (Margolin, 2014). These mantras signify connection and embodiment to a higher consciousness, as well as being in harmony with self and the environment around you (Margolin, 2014). These mantras helped bring a sense of inner peace and hope into my being, helping me get past negative ego-based thought patterns. Other times, I would play binaural beats as I drove, mainly in the mornings. I found that listening to these sound frequencies helped clear my mind and energized my cognitive capacities. I love the use of sound as a form of healing because I strongly believe in the power of vibrational frequencies that help align my mind, body and soul. Meditation provided me with a safe space to tune inwards to my internal world while objectively evaluating any emotions or thinking processes that may have been impeding on my sense of balance. Taking time for introspection allowed for deeper self-reflection and personal development to take place. The mind can is a strong influence over our being and it can easily become self-destructive if efforts are not made to strengthen our relationship with it.

## Chapter Six: Clinical Implications for Professional Practice

There are several therapeutic capacities that I will take away from my practicum experience as it relates to clinical implications for professional practice. These include the

capacity to establish a therapeutic alliance with future clients; incorporate CBT principles into clinical work; and feel comfortable to facilitate safe exploration of complex emotions and experiences through creative expression; create safety plans for coping with trauma; refer to the DSM-5 as a key diagnostic tool when writing assessments; and navigate through systems in order to meet client needs. Adopting these skills within future clinical social work roles will help strengthen my therapeutic techniques through consistent practical application and enable me to continue to develop positive therapeutic relationships and my overall professional practice.

Developing a therapeutic alliance through a strengths-based approach encompasses three important conditions including, “empathetic understanding”, having “unconditional positive regard”, and “congruence” (Lambert, Lambert & Barley, 2001, p.358). Empathetic understanding consists of a therapist’s ability to successfully communicate their understanding of a client’s experience while unconditional positive regard refers to the extent to which a therapist “communicates non-evaluative caring and respect” (Lambert, Lambert & Barley, 2001, p.358). Congruence occurs when a therapist maintains a “ non-defensive and genuine stance”, (Lambert, Lambert & Barley, 2001, p.358). Having well-established rapport with clients is at the forefront of good therapeutic practice. However, this should not distract from improving clinical techniques. According to Lambert, Lambert & Barley (2001), therapists need to remember that “the development and maintenance of the therapeutic relationship is a primary curative component of therapy” and that “the relationship provides the context in which specific techniques exert their influence” (p. 359).

Browne, Muser, Meyer-Kalos, & Gottlieb (2019) give recognition to significant improvements that can be harnessed for clients within improved psychosocial domains as well as symptomatic reduction over an extensive 24 month time period post-therapeutic engagement (p.739). One of the main changes I noticed within the process of good rapport building was the

power that providing psychologically safe environments had for portraying therapeutic authenticity and enabling clients to feel a willingness to engage in emotional risks through the use of creative expression. Rogers (1993) validated this claim by explaining that facilitators who create the psychologically safe environments provide fertile opportunities for their clients to flourish and grow.

The use of creativity, expressive arts, and holistic modalities are approaches that I feel naturally good at, and in utilizing them within clinical practice I have come to realize just how versatile and easily modifiable these modalities can be across a multitude of settings and cognitive capacities. These approaches help explore trauma in ways that can provide a person with a sense of safety and comfort while addressing rather complex and sensitive memories, states or processes. One of the areas of clinical practice that I hope to work within is the area of child and youth mental health. The other is working within primary care or hospital settings with children. Using art and play therapy as a way to connect, explore and build resiliency is highly effective within these settings as well as with people across all ages or developmental levels. Furthermore, I also believe that as I engage in these modalities professionally, I can strengthen my own clinical judgments and analytical skills, which can assist me in being able to have a deeper understanding into my clients' internal world or their perceptions of the world around them in ways that narrative alone cannot achieve. In my experience as a practicum student at CYMH, I have gained the capacity to recognize both the power and limitations of using narrative therapy in isolation to other modalities. While words can convey meaning and expression, it is important to note that verbal language can also be easily filtered. Expressive Arts on the other hand, allows a person to unlock their Pandora's box with reassurance, confidence and sense of safety and security, creating a potential restructuring of how a person views their relationship to their own experiences, thoughts, emotions and behaviors.

## Chapter Seven: Conclusion

Child and youth mental health is an area of mental health that continues to grow in clinical inquiry. Despite several studies around early life trauma and epigenetics as they relate to the onset of mental health concerns across the lifespan, more research is needed when addressing the effectiveness of modalities such as CBT and mindfulness on younger populations. Helping clients increase awareness and learn tools that can help them move from a place of dissociation to a place of mind-body connection can have long-lasting benefits for biological and physiological responses to stress and trauma. CYMH clinics that are operated through MCFD assist with propelling trauma-informed mental health services in a progressive way by offering services through collaborative, holistic, and preventative measures. The hands-on experiential learning that I have received from completing a practicum with CYMH in Squamish has greatly helped build on my own existing therapeutic skills while also providing new dexterities around clinical and creative skillsets so that clients can be supported through best practice principles that can run deeper than traditional talk therapy. Working and learning within an interdisciplinary team has enriched my experience and strengthened my overall foundation as a clinical social worker. Overall, all of the activities and approaches that I adopted and implemented through my clinical work with clients have been truly rewarding and meaningful for making sense of inner worlds and emotions. These modalities and frameworks transcend through all therapeutic work, not just within the realm of mental health. The holistic nature of these modalities align with my own clinical style and I find that they provide clients with a sense of accomplishment, realization, empowerment, and sense of safety to explore hidden vulnerable aspects of themselves. I look forward to applying my newfound skill sets in future clinical social work practice.

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## Appendix 1

Figure 1.1: Body Map Overview

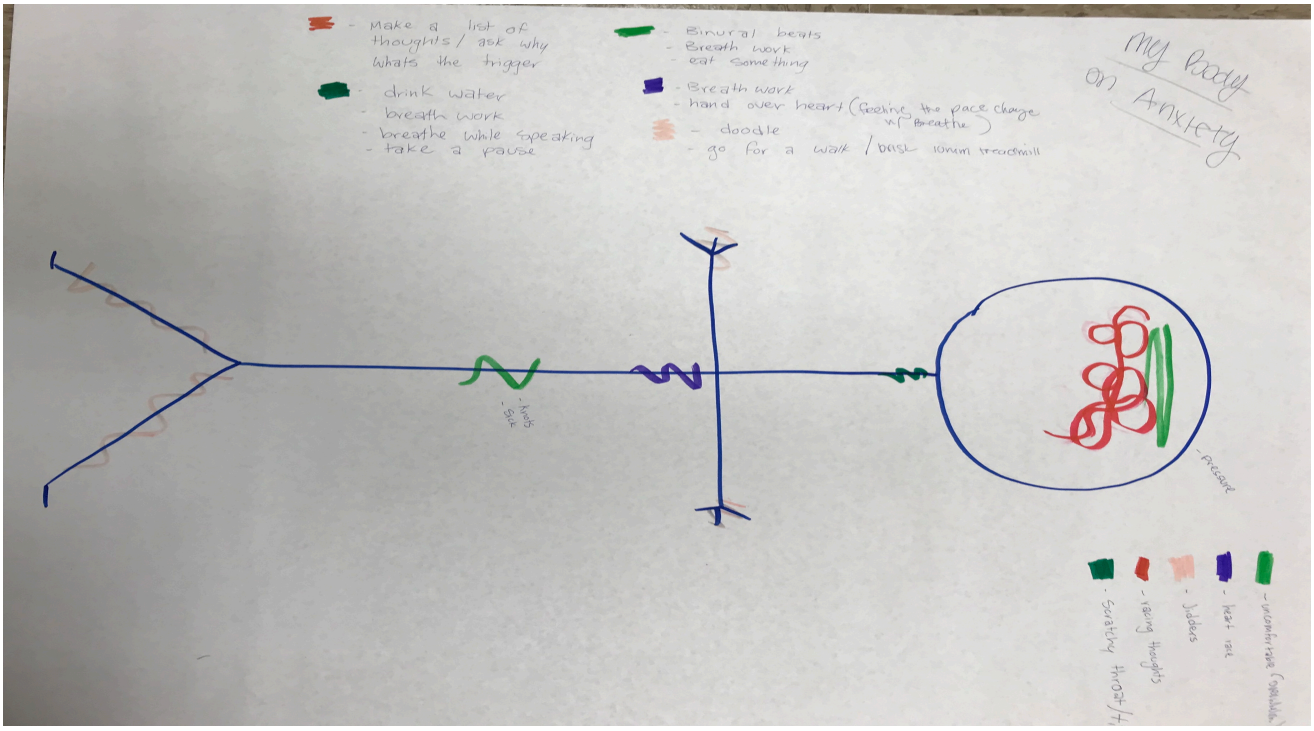



Figure 1.2: Somatic Legend

Figure 1.3: Coping Strategies for somatic symptomology

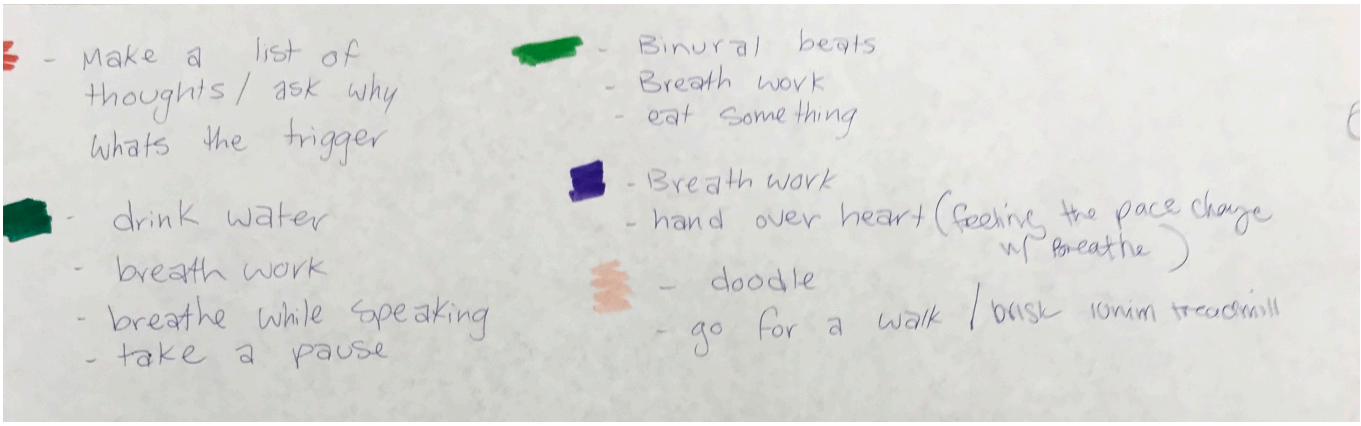



Figure 2: “My Many Colored Emotions” Activity

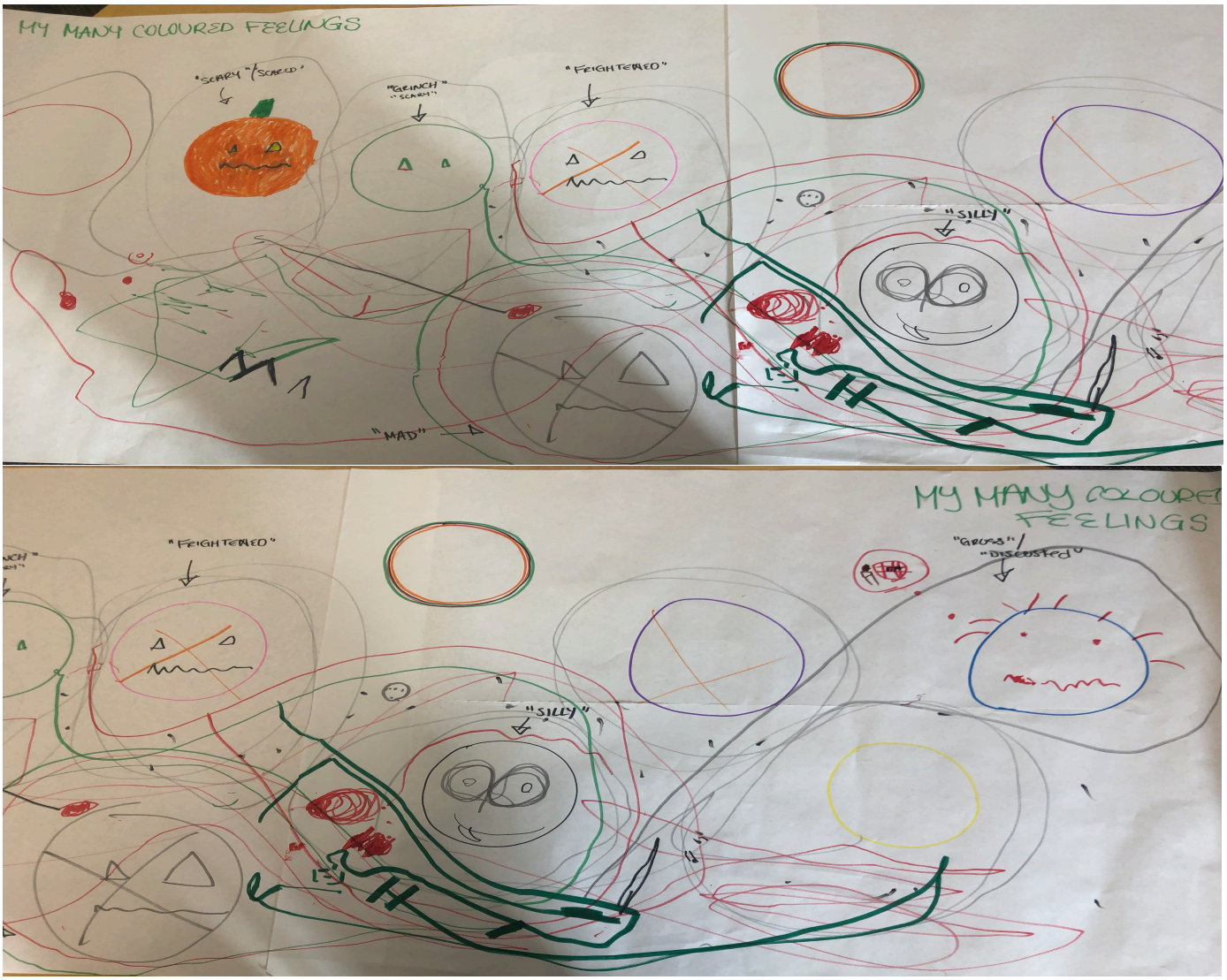


Figure 3: Vicarious Trauma Coping Mind Map

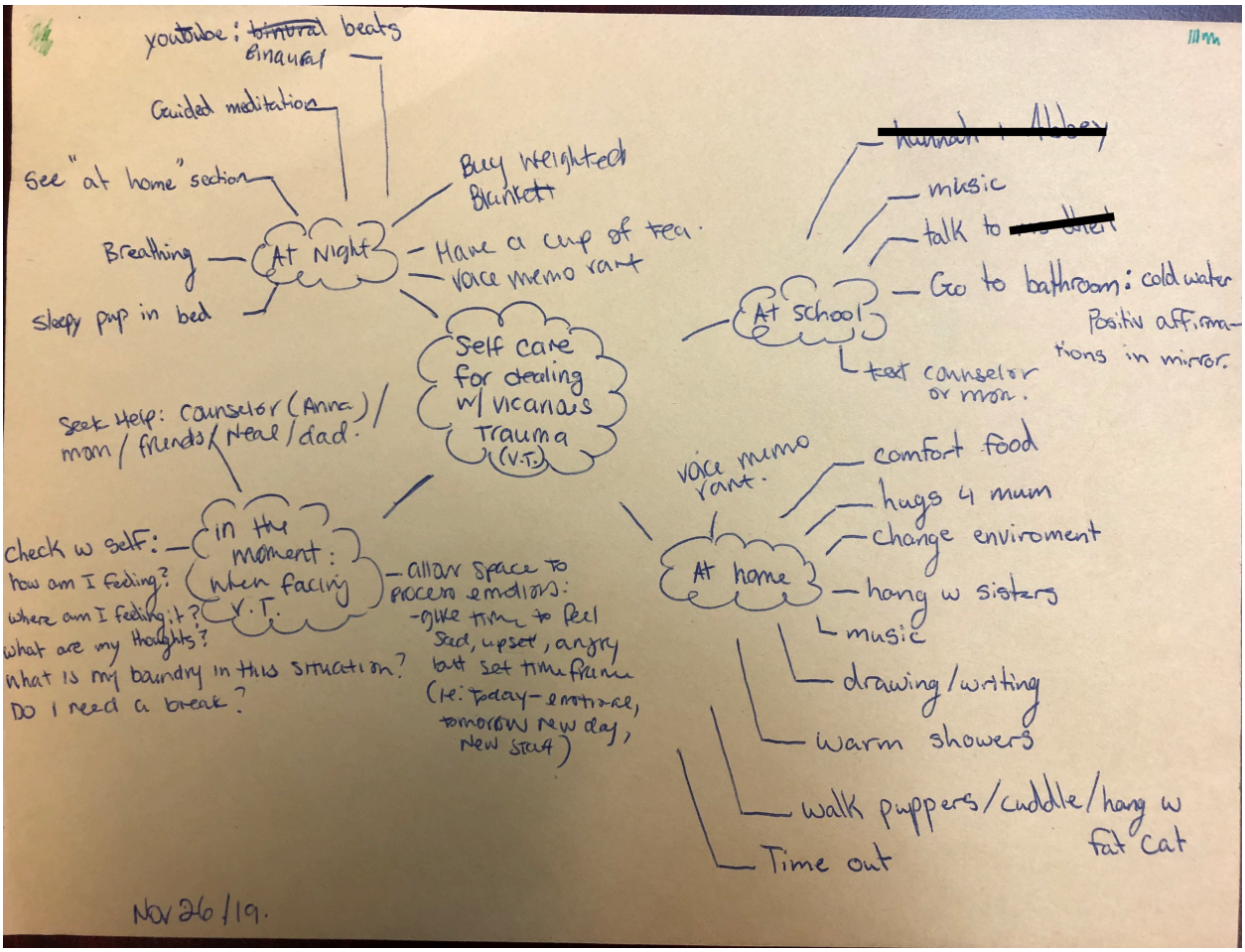


Figure 4.1: Anxiety Drawing Exercise

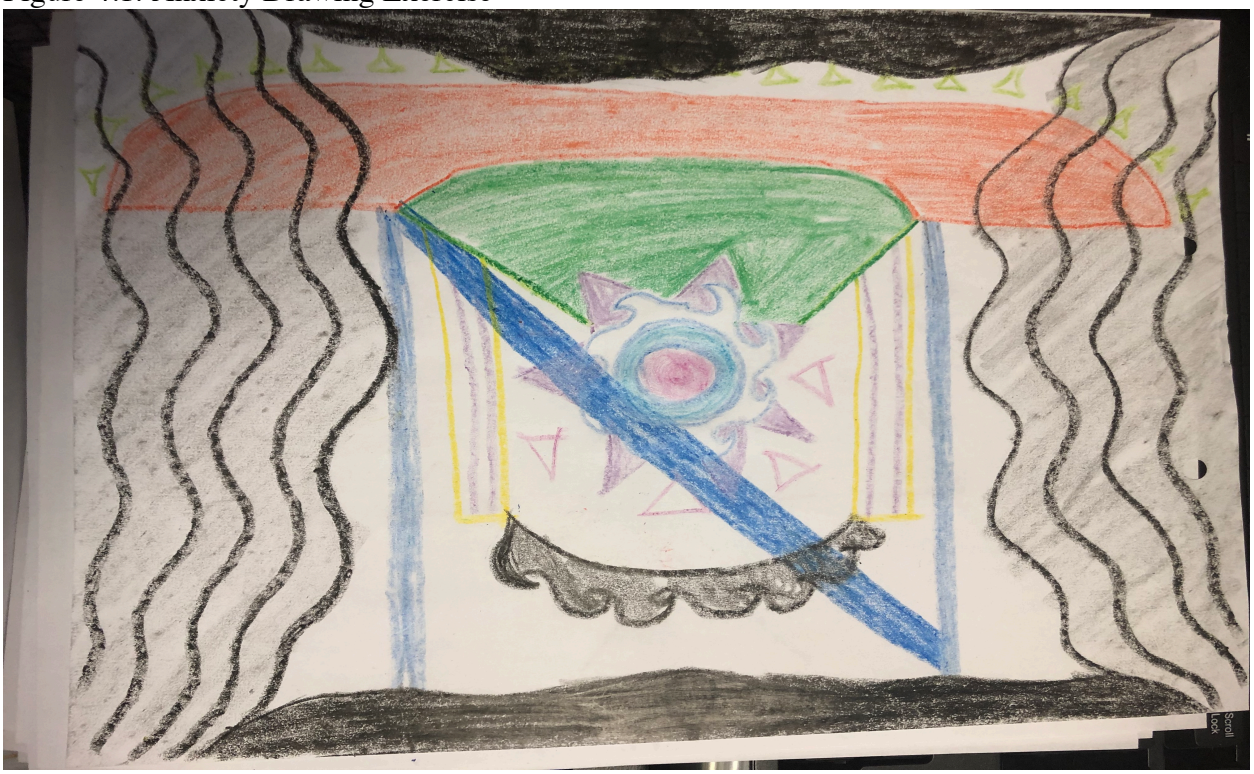


Figure 4.2 Anxiety Drawing Exercise

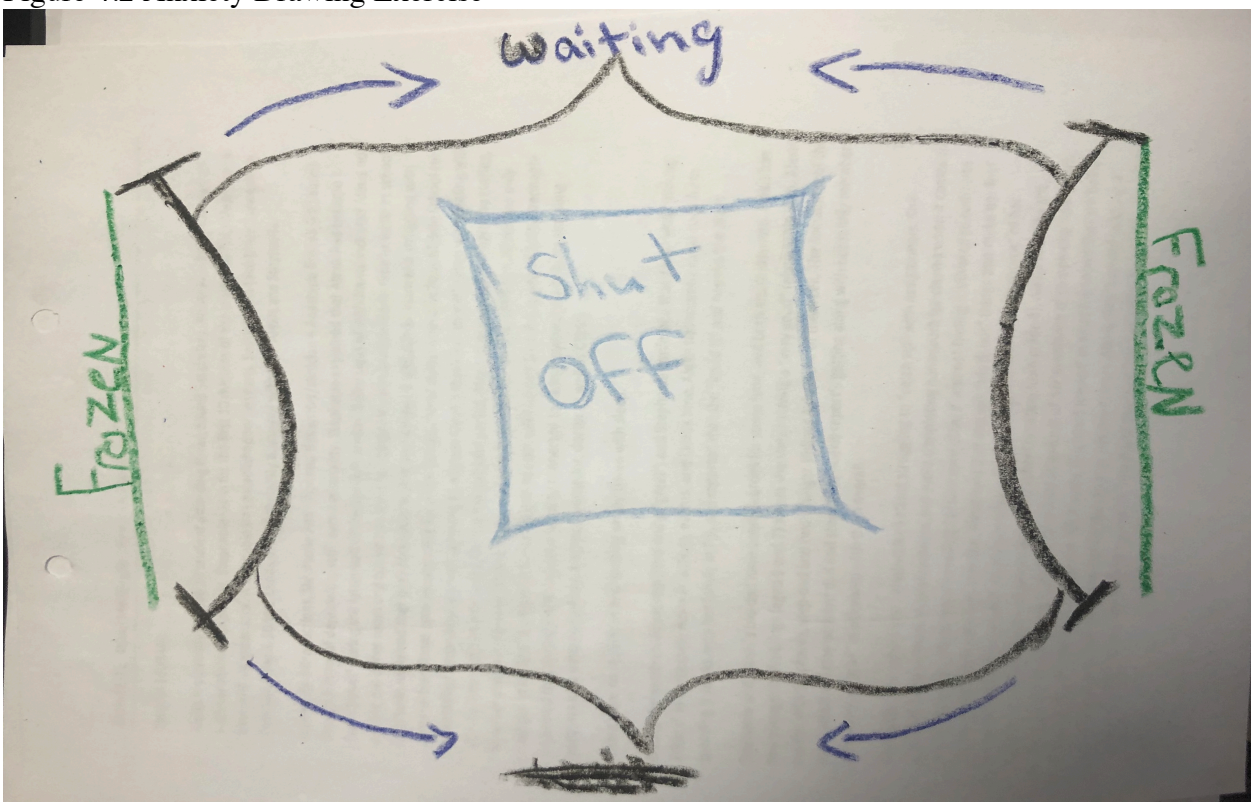
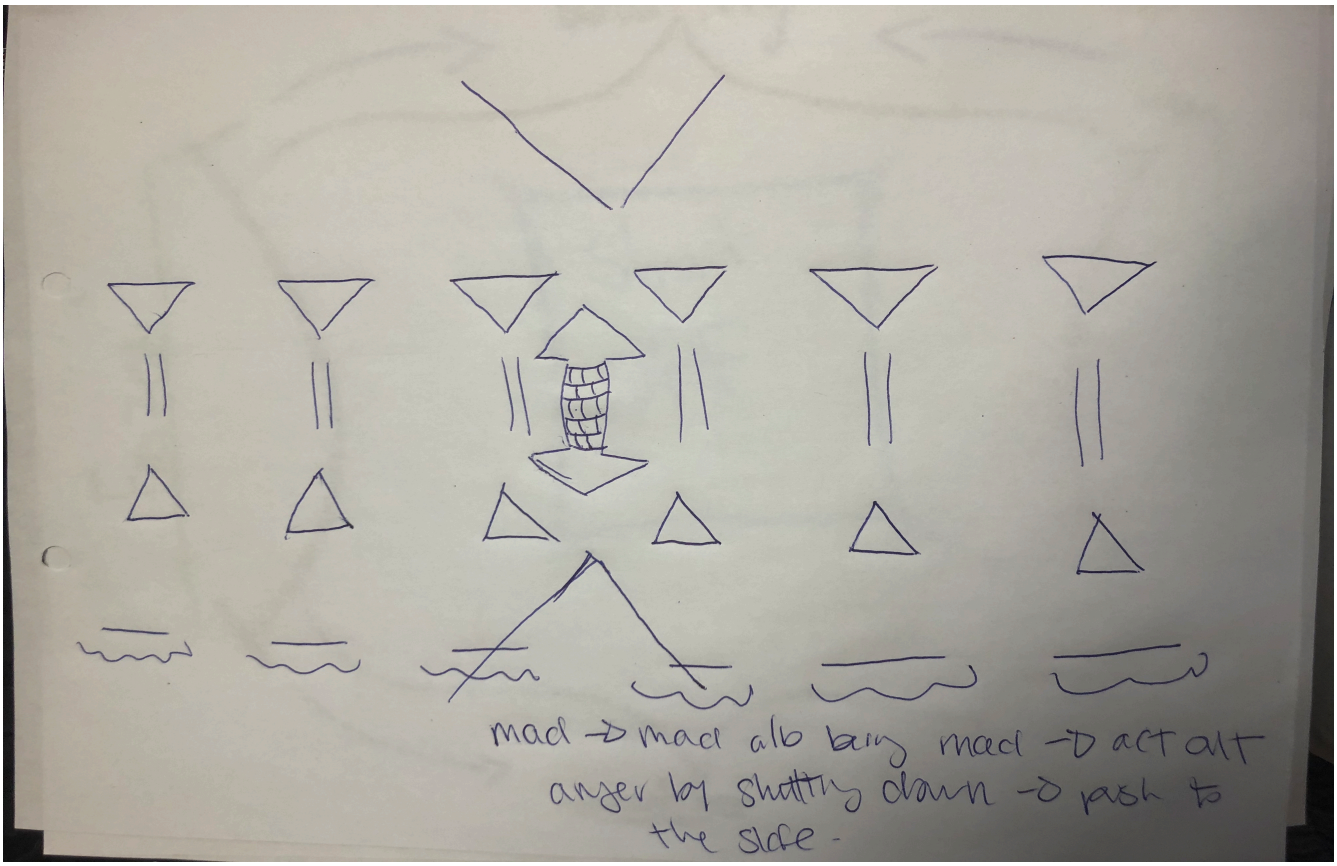


Figure 4.3: Anger Drawing Exercise



## Appendix 2

*Learning Goals*

1. Familiarize myself with the BC Mental Health Act, Infants Act, and gain concrete understanding around consent
    - Read both acts
    - Read CYMH Policy handbook
    - Read MCFD Practicum Orientation handbook
    - Take notes for reference when reading all resources
2. Know the difference between the Bio-psychosocial Model and Medical Model, and how Culture plays a role within these models (refer to DSM-5 for cultural practice and assessment guidelines).
    - Talk to CYMH clinicians about the two models, and see how each model fits into service provision within CYMH
    - Do some research on both models → compare and discuss with Practicum supervisor
    - Go through the DSM-5 and identify areas where the Bio-psychosocial model fits vs. where the medical model fits
    - Read on the DSM-5's definition of culture and the role culture can play within Mental Status Exams and Assessments (i.e. language, understanding on mental health, treatment planning)
3. Be able to complete a Mental Health Assessment (Mental Status Exam).
    - Become familiarized with the BCFPI (Brief Child and Family Phone Interview)

- Go through the two versions of the BCFPI (Parent vs. Adolescent) and critically think about the topic areas covered: what's missing, what does the language look like (i.e. is it easy to understand?)
- Observe CYMH clinicians conduct both versions of the BCFPI then have a CYMH clinician observe the first intake assessment
- Read the "Mental Status Exam: Explained" book

4. Be able to develop an effective treatment plan accordingly once an assessment is done, and become grounded in knowing which treatment plans are appropriate for specific diagnoses.
    - Brainstorm action plans for each file
    - Take out books from the office library at CYMH and read/research appropriate exercises and tools that may help clients throughout the sessions.
    - Refer to the DSM-5, become familiarized with sections of the DSM, the various axis's and codes for diagnoses.
    - Ask questions/seek support when stuck
    - Debrief and consult with Jeanne before implementing anything
5. Build upon existing knowledge of CBT and be able to create a treatment plan based on CBT principles.
    - Continue in ongoing learning of CBT through reading and online course through Udemy.net.
    - Consult with Jeanne to make sure treatment plan reflects CBT principles
6. Be able to identify the differences between CYMH and child protection policies.

- Read between the two policy manuals', take note in the differences (i.e. use of legislation, services that can be offered, protocols in place for child safety)

7. Have grounded understanding for common mental health disorders facing children and adolescents in accordance to the DSM-5.
    - Keep track of trends/patterns that come up for the clients that I work with
    - Speak to CYMH clinicians about their experiences and what they typically see during the intake assessments
    - Read Scholarly material about child and youth mental health
    - Read scholarly material about the use of Pharmacotherapy for working with children and/or youth.
8. Gain knowledge of the various psychotropic medications associated with the major mental disorders.
    - Read the Early Psychosis Guide
    - Familiarize between appropriate dosage among typical and atypical antipsychotics, read up on side effects and possible long-term neurological impacts on the developing brain
    - Speak to the Child and Youth Paediatrician
    - Develop an understanding of the impact of pharmacotherapy during the acute phase of early psychosis (i.e. Pharmacokinetics and Drug Interactions)
9. Become familiar with community resources within Squamish and North Vancouver
    - Explore the MCFD IConnect website to see what services and programs are offered
    - Speak with CYMH clinicians about programs/workshops they run out of CYMH → become acquainted with demand/need: i.e. how many times a year are these programs

facilitated, what does participant turn out look like (i.e. # of people), what does the structure of the programs look like (i.e. modules, lectures, etc.)

- Discuss community resources/programs that CYMH clinicians find beneficial to parents and children/youth.
- Explore services offered through local community centres and friendship centres.
- Do own research (Google)

10. Practice Consistent Self-Care
    - Set healthy and firm boundaries for myself: to not take work home (i.e. thinking about practicum outside of practicum time)
    - Practice mindfulness and Mantra meditation: at home and when driving do "OM" in car
    - Make sure to sleep and make time for sleeping →leave phone outside of bedroom, use binaural beats/self-hypnosis when struggling to turnoff the mind
    - Keep active → go for walks, be observant of nature; show gratitude for the earth; maintain a reasonable routine for going to the gym/kickboxing and don't feel bad if you need a day off (i.e. go 2xweek instead of 4)
    - Make time for loved ones
    - Snuggle the cats and disconnect from outside world for a few hours (i.e. turn off phone when at home)
    - Travel (going to Ireland and Las Vegas)
    - Keep a self-reflective journal of the process of self care and being in the process of learning/in practicum
    - Debrief with Jeanne and Indrani/do mental health check ins

- Don't be afraid to say "no" when feeling overwhelmed by the workload (for both in practicum and in work)
- Cut back on working Saturday evenings at Peggy's.

## Appendix 3

*Practicum Timeline*

- July 15: Submit first draft for Practicum Proposal
- July 20: Complete MCFD Privacy and Confidentiality workshop
- August 6: Submit second draft for Practicum Proposal
- August 8: Contact Lorne Milne to submit Vulnerable Sector Police Check; contact Jeanne Harrison to set up meet time for mid/end-August.
- August 23: Complete Practicum Proposal; submit to committee for approval.
- End of August: Practicum Proposal Presentation.
- Over the month of August: Complete Brain Story Certification, CBT certification course, DBT certification course, Psycho-diagnostic interviewing course and Emotionally Focused therapy course.
- September 3: Start Practicum. Complete required MCFD paperwork with Jeanne and set up work phone and laptop. Practicum will be completed Mondays, Tuesdays and Wednesdays, with some Thursdays, until the end of December, at 8 hours per day. Total hours = 460.
- November 15, 2019 – December 6, 2019 School Strike
- December 9, 2019 – January 2, 2020 practicum 4x per week (Mon-Thurs) to make up for lost hours.
- December 12, 2019 – Midterm Evaluation

- January 29th, 2020 – Last day of clinical work with clients
- February 6th, 2020 – Last day at Practicum and Final Evaluation Meeting
- February 28, 2020 – Submit Approval Page Request Form to Graduates office
- March 2, 2020 – Submit Final Draft of Practicum Report to Dr. Indrani Margolin
- March 27, 2020 – Send Final Practicum Report to committee
- April 22, 2020 – Final Practicum Defense Presentation