CLINICAL SOCIAL WORK WITH CHILDREN AND YOUTH AT CONNEXUS COMMUNITY RESOURCES

by

Danielle Rasmussen

B.A., University of British Columbia, 2007
B.S.W., Thompson Rivers University, 2011

PRACTICUM REPORT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

April 2025

Abstract

This report outlines my practicum experience as a Child and Youth Mental Health (CYMH) counselor at Connexus Community Resources from July 2024 to February 2025. I completed my practicum on the clinical services team at Connexus which allowed me to get a sense of the different programs and services provided by the agency while focusing on clinical counseling. The report outlines my learning goals, which include developing skills in different therapeutic modalities (specifically Cognitive Behavioural Therapy [CBT] and play therapy) and using these skills to address complex trauma, as well as to learn how to utilize different counselling skills cross culturally; these goals are all pointed towards my overall goal, which was to start developing my identity as a clinical social worker in the north. My personal positioning and theoretical orientation, specifically how my social location shapes my current practice and how I follow a social constructivist strengths-based approach, are explored. A literature review highlights five topics that formed the foundation of my learning goals and shaped my practicum: complex trauma, the therapeutic relationship and play therapy, CBT and Trauma-Focused CBT, northern practice, and cross-cultural work with Indigenous children and youth. A discussion of my learning experience highlights the progress I made in completing my learning goals as well as demonstrates some of the challenges I encountered, such as in learning how to shift my lens from a child welfare perspective to a clinical perspective.

Table of Contents

Acknowledgments

First and foremost, I would like to thank my practicum supervisor, Paula Wylie. Paula and I have crossed paths professionally over several years and I am greatly appreciative of the opportunity to work with her directly through this practicum. Paula's support and guidance throughout my practicum has made this experience that much more meaningful and enjoyable. I know that as the Executive Director of Connexus Community Resources, she has a very busy schedule, but she always made time to meet with me and to support me as needed. I have learned so much from her and for this, I am truly grateful.

I would like to thank my academic supervisor, Emmanuel Chilanga, for his continued support and patience. I feel like we have done a good job of navigating the sometimes challenging administrative tasks of completing a practicum together and I appreciate your flexibility and availability. I would also like to thank Si Transken, my academic committee member. Si, I wish I would have taken more courses from you earlier in my MSW journey. I truly enjoyed our time together in the MSW integrative seminar and always appreciate your feedback and input.

I would like to thank the clinical team at Connexus Community Resources for their openness, support, and patience with all of my questions. I genuinely felt like a member of the team and feel that I have left Connexus with friends who I know I will maintain an ongoing connection with.

Last, but certainly not least, I would like to thank Melanie Lansall, my social work consultant through my practicum. Melanie kept me grounded when I was starting to feel a bit frazzled and supported me throughout this practicum process. I have known Melanie for years

and have great respect for her and her practice. I am so grateful to have you in my corner and thank you for all the time and energy you have spent supporting me in finishing up my MSW.

Chapter 1: Introduction

This report outlines my practicum placement at Connexus Community Resources (Connexus) in the Child and Youth Mental Health (CYMH) program from July 2024 to February 2025. This report will describe Connexus and the services the agency provides. It will delve into the learning goals I developed for my practicum experience that fell under the umbrella of my overall goal which was to gain practical counseling and clinical experience utilizing a variety of therapeutic modalities in work with children and youth experiencing complex trauma. I will discuss my theoretical orientation and my personal positionality. A literature review will ground my focus on child and youth mental health, therapeutic modalities I chose to explore, social work in the north, and clinical work with Indigenous children – all topics important to my current practice and important to shaping my clinical practice going forward. Finally, the learning experiences I gained from this practicum will be described, followed by a discussion of implications these will have for my personal professional practice.

My interest in CYMH in the north, specifically working with children with complex trauma, started several years ago when I worked in an elementary school in the small northern community in which I am from and in which I now live and work. I worked as an education assistant assigned to children who were struggling in the classroom setting. Many of the behavioural challenges these children presented were a result of complex trauma, which is trauma resulting from various traumatic experiences that occur throughout different stages of development (Mahoney & Markel, 2016). These experiences occur at all levels – social, emotional, and psychological (Mahoney & Markel, 2016). As I learned more about trauma informed practice and about trauma in general, I started to understand how it was difficult for the children to function in the classroom setting when they were struggling to function on a day to

day basis. At the time, there was a significant lack of resources to help support these children and their families; any counseling services (which were few and far between) had long waitlists. This gap in service stood out to me and this, along with my work at the school, stemmed my interest in looking at ways to support children experiencing complex trauma. My subsequent Bachelor of Social Work and work in child welfare, specifically Indigenous child welfare, solidified my interest in working with children experiencing complex trauma, helped me to understand ways to address behavioural challenges the children presented as a result of this trauma, and assisted in finding ways to support their families. As I have worked through my Master of Social Work, I found myself drawn to particular counseling modalities and became more and more curious about how these are used on a daily basis to address complex trauma in children. My hope was that through my practicum, I would not only be able to learn how to use cognitive behavioural therapy (CBT) and play therapy, but I would be able to witness how clinicians use these modalities practically and cross-culturally.

My practicum took place at Connexus Community Resources in Vanderhoof, British Columbia. I requested to complete a practicum here for several reasons. I have worked with Connexus, specifically their Child and Family Services program, over the years and highly respect the work that they do, their professionalism, and their community engagement. I have sat at the table with members of the Connexus Child and Family Services team at various community engagement meetings and have witnessed them actively working to fill gaps in service whenever identified. For example, following the Covid-19 pandemic, they partnered with another community organization to provide wellness drop-in services in the local high schools to address the increase of anxiety and depression that was witnessed in local teenagers (Connexus Community Resources, 2023). Working out of the Vanderhoof Connexus office also appealed to

me as I live and work at an Indigenous Child and Family Services Agency in Fort St. James and I was very aware that any CYMH work in Fort St. James would likely have a large client cross-over with my work in Indigenous child welfare due to the small size of the community. Vanderhoof is an approximately forty-five-minute drive from Fort St. James and my hope was that the distance would create enough separation that there would be a low risk of client crossover. This indeed proved to be true; I had an opportunity to complete a plan of care (I will discuss this further in Chapter 4) for a youth from Fort St. James and this did create challenges as this youth later became a client of the agency I work for – this reaffirmed the importance of completing my practicum in another community.

Placement Agency

As noted previously, this practicum took place at Connexus Community Resources (Connexus) in Vanderhoof, BC. Connexus has served the communities of Vanderhoof, Fort St. James, and Fraser Lake since 1977 (Connexus Community Resources, 2019). It is a registered non-profit agency "that provides support, education and empowerment to individuals and families to enhance independence, confidence and wellness, respecting the diversity within [its] communities" (Connexus Community Resources, 2019, About Us sect, para 1). Connexus' mission statement is "We foster independence, confidence and wellness in individuals and families" (Connexus, 2019) and throughout my practicum, I was able to witness a team that focused on doing just this. Connexus provides a range of child and family support services that are focused on self, family and community empowerment, and are available to people throughout the lifespan (Connexus Community Resources, 2019). There are four main program areas that house the variety of services offered by Connexus, including Early Childhood Services; Child, Youth and Family Services; Adult Services; and Housing Services (Connexus Community

Resources, 2023). The Early Childhood Services program area includes the Infant Development Program, the Community Action Program for Children, and the Early Years Resource Center (Connexus Community Resource, 2023). The Child, Youth and Family Services program area includes the Child and Youth Mental Health Program, the Sexual Abuse Intervention Program (SAIP), the PEACE Program (Children and Youth Experiencing Violence), Youth Justice, Child and Youth Care, Child and Youth with Special Needs, Family Support and Education, Family Preservation, Family Connections, and Victim Services (Connexus Community Resources, 2023). The Adult Services program area provides support to adults living with developmental disabilities and includes the Community Based Support Program, Employment Program, and the Residential Program (Connexus Community Resources, 2023). Finally, the Housing Services program area includes senior and low-income family housing at several locations in Vanderhoof and Fort St. James (Connexus Community Resources, 2023).

My practicum took place in the Clinical Services Program area on the CYMH team. The Clinical Services Program area includes the CYMH program, the SAIP program, and the Mental Health Support (MHS) program (Connexus Community Resources, 2023). The Clinical Services Program provides clinical and therapeutic support to children, youth and families through one on one as well as group work to help children have positive mental health outcomes and to empower them to meet their full potential (Connexus, 2023). The clinical team meets with the British Columbia Children's Hospital (BCCH) monthly for psychiatric support and guidance as well as to refer children and youth requiring more specialized services (Connexus Community Resources, 2023). I also had the opportunity to work in the PEACE (Prevention, Education, Advocacy, Counselling, and Empowerment) program. This program is specifically for children and youth who have experienced violence and/or abuse and it provides "assessment, treatment

planning, and intervention" (Connexus Community Resources, 2019, PEACE Program sect, para 1).

My practicum was specifically focused on CYMH; however, I did have the opportunity to work with one client in the Mental Health Support Program as well as to shadow two of the PEACE counselors. While I did not work with clients currently in the SAIP program, I did work with one who was previously involved in this program and I did receive clinical supervision and guidance about this work from a senior clinician.

Learning Goals

Most of my social work career thus far has been in child welfare and my hope was that through this practicum, I would be able to shift my lens and learn how to practice from a clinical perspective. As I set out to on my practicum at Connexus, my overall learning goals included developing clinical counseling skills; learning strategies to therapeutically address complex trauma in children and youth; learning how to use different therapeutic modalities in work with children and youth, particularly CBT and play therapy; and learning how to work with children of different cultures in a culturally safe and appropriate manner. These goals were all under the umbrella of developing my identity as a clinical social worker in the rural north.

My learning goals to develop clinical counselling skills and to learn strategies to therapeutically address complex trauma in children and youth were really the reason why I chose to do a practicum rather than a thesis in my Master of Social Work. While I was exposed to several counseling modalities and theoretical frameworks throughout the MSW program, there was not much of an opportunity to practice these skills to the degree that I felt I needed in order to feel competent in practicing them in the real world. My background in child welfare felt like a

different realm as I focused on child and youth mental health counselling. My hope was that through my practicum, I would be able to shift my lens from a child welfare perspective to a clinical perspective and practice different therapeutic techniques to gain confidence in using them and to find my own counselling style. This turned out to be one of the more challenging aspects of my practicum. As described in chapter 4 of this paper, I had to make a conscious effort to shift from a child welfare to a clinical lens and I have realized that this will be an ongoing learning goal for me and something that I will have to be continuously mindful of in any clinical work I do going forward.

My learning goals to develop skills in CBT and play therapy were rooted in the goal of developing clinical counselling skills. Connexus houses a wealth of resources that I had access to throughout my practicum. With the support of my clinical supervisor, the clinical program manager, as well as of senior CYMH clinicians, I was able to find resources using these different modalities and put them into practice in my work with children and youth (I will speak to this more in chapter 4). I had the opportunity to shadow clinicians using CBT with clients which helped to guide my use of it in my own practice. Prior to starting my practicum, my practicum supervisor (who provided my clinical supervision) advised that there were no counselors at Connexus at the time who were specifically trained play therapists; however, some of the clinicians, including herself, have taken play therapy training and utilize it in their practice. In my clinical supervision sessions, she gave me strategies to try that were based in play therapy and these guided my work with one client in particular throughout the duration of my practicum.

My experience working with children and youth in very high risk situations throughout my career was helpful in working towards my goal of developing clinical skills. The previous experience I had in connecting with and developing relationships with children and youth

enhanced and supported this opportunity to practice different skills using different therapeutic modalities. While my role in child welfare felt separate from the clinical work I was learning to do, I could see the benefit in building therapeutic relationships with youth in challenging or high-risk situations, something that I have had a lot of practice doing. Once these relationships were established, I was able to practice using different therapeutic modalities, such as CBT, to explore different ways to address the mental health reasons that had resulted in the children/youth being referred to counseling, including anxiety.

My goal to learn how to practice in a culturally safe and appropriate manner with children and youth of different cultural backgrounds proved to be somewhat challenging due to the part-time nature of my practicum and the make-up of my caseload. Connexus provides services to children, youth and families from a variety of cultural backgrounds. The part-time nature of my practicum only allowed me to have a caseload of approximately nine clients at one time, and I had the same clients throughout the duration of my practicum. These clients were of a similar cultural background; however, I was able to complete some Plans of Care (the intake questionnaire/process used by the clinical team to assess which program area new clients fit best into) which provided the opportunity to connect with children, and in some cases their parents, of different cultural backgrounds. Throughout this process, I had conversations with senior counsellors about how they approach work with children and youth of different cultural backgrounds and how they make sure they practice in a culturally appropriate manner. One of the things that stood out to me in doing this was the importance of understanding that different cultural nuances may lead children and their parents to be hesitant and unsure of the clinical process and that their own experiences in health and child welfare systems may lead them to feel unsafe/insecure in this process. The importance of being non-judgemental and flexible in the

treatment path planned for a particular child was emphasized and I felt that the clinical team really embodied this in their work as well as their interactions in the office.

These goals all fell under the umbrella of my overall goal which was to start to develop my identity as a clinical social worker in the rural north. I truly appreciated the supportive learning environment the clinical team at Connexus provided as this allowed me the space to freely ask questions and have meaningful conversations about clinical practice and work in the north. Throughout my practicum, I was very aware of some of the challenges that come with working in the north, such as dual relationships and conflicts of interest. I learned how different clinicians navigate these in their practice and personal lives and used my reflective journal to check in with myself on a regular basis about how I was navigating this on a personal level. An example is when I did a plan of care and suicide risk assessment for a youth from the community that I work in that I did not know, but who later became a client of the agency that I work at. This was a pointed example of how easily and unintentionally dual relationships can form in smaller communities. This also made me set firm boundaries in ensuring that I did not complete any plans of care for children or youth from my home community whether I knew them or not as I found the experience of client crossover to be challenging. I also used my reflective journal to explore self-care in the clinical setting. My conversations with my social work consultant brought me back to social work guidelines and ethics and also helped to ground me as I navigated the fine balance of completing a practicum while working and managing home life.

It is important to note that when I was developing my learning goals and actions to help meet my goals (Appendix A), I was quite ambitious in the number of individual and group sessions I hoped to shadow. I had stated that I planned to observe a minimum of ten sessions (one-on-one and group); however, I learned very quickly that this would be challenging for a

number of reasons. I was only at my practicum for two days per week. While the clinical team made great efforts to provide shadowing opportunities, it was simply not possible to shadow that number of sessions (although I did manage to shadow seven sessions). Several clients were not interested in having a student attend their sessions and due to scheduling, there were days where it just was not possible. Also, due to this schedule, I was not able to actually attend a group session as there were no groups offered on the days of my practicum. In recognizing this, the clinical program manager had me review the group curriculum and assisted me in modifying the content of one of the groups offered by Connexus to use on an individual basis. As noted previously, the entire clinical team was very supportive of my journey and if I was not able to shadow with a client, they would often have conversations with me about techniques they were using and why they were using them.

My practicum at Connexus helped me achieve my learning goals and while I know there is great learning ahead of me, I feel confident that I am developing a strong foundation as I start my journey as a clinical social worker.

Chapter 2: Personal Positioning and Theoretical Framework

Personal Positioning

Berger (2015) states that "the worldview and background of the researcher affects the way in which he or she constructs the world, uses language, poses questions, and chooses the lens for filtering the information gathered" (p. 220); my learning journey and my practicum have been shaped by my life experience and social location. I am a non-Indigenous settler female (she/her) working for an Indigenous organization that serves three local Indigenous communities. I was born and raised in the small community in which I now work and was raised in a middle-class family that values respect and kindness, hard work, and the connection of family and community. I left this small community immediately after graduating high school and moved to the city to complete a Bachelor of Arts with a major in cultural geography and a minor in cultural anthropology. It was here that I started to learn about the impacts of globalization and colonization on cultures around the world and I started to learn about the structural racism that impacts Indigenous peoples in Canada. In turn, this led to learning about how colonial oppression continues to be embedded in our social welfare, justice, health, and education systems, which creates a platform for trauma to be passed through generations. Completing a Bachelor of Social Work degree further impressed on me the need to understand systemic colonialism and to shape my practice through a strengths-based, anti-oppressive lens. Working in Indigenous child welfare has increased my understanding of systemic racism and I am always learning ways in which I can walk alongside and learn from Indigenous children, families and communities to decolonize child welfare practice and break systemic barriers.

As a settler working in Indigenous child welfare, I am always reflecting on how my presence impacts the children and families that I am working with. I am aware of how my presence as a Caucasian female of European descent in this role can be triggering to people who

have been negatively impacted by the Eurocentric child welfare system, the Indian Act, residential schools, the Sixties Scoop, and the ongoing residual effects of colonization. This awareness shapes my practice and sets me on an ongoing journey of learning new ways to overcome my own inherent bias and to try to create change in the systems in which I work.

My work for the past decade has largely included working with children and youth with complex trauma. Through this work, I have referred several children and youth to CYMH services to address symptoms of complex trauma. I have had informal conversations with CYMH practitioners about their experiences in working with children with complex trauma and through this, believe that play therapy and CBT are effective therapeutic models in these circumstances. I am interested in how practitioners use play-therapy and CBT across different cultures, particularly in how non-Indigenous practitioners utilize them with Indigenous children. I believe that these modalities can be used with children of varying cultural backgrounds and I sought to learn how this can be done in a culturally safe and appropriate manner. Due to my practicum schedule and the nature of the makeup of my caseload, the cultural backgrounds of my clients were similar and only one client had Indigenous ancestry; therefore, I focused my learning in this area to having formalized conversations throughout my practicum to explore how other clinicians approached this.

I have a passion for northern and remote social work practice. O'Neill (2010) outlines some of the challenges that are characteristic of northern practice, including high visibility/loss of privacy or autonomy for practitioners, dual relationships with challenges to confidentiality, practitioners working outside of their limits of practice, a lack of clinical supervision, and intergenerational issues. While these issues can be daunting to some, I enjoy the challenge of navigating them and in guiding my team through navigating them as well. The practicum setting

allowed me the time and space to start exploring the shift from working through these challenges from a child welfare perspective to learning how to navigate them in a clinical setting. The shift from perspective from child welfare to clinical was challenging for me and presented me with much opportunity for learning and growth; I will speak to this more in Chapter 4.

Theoretical Framework

My practice is shaped by a social constructivist framework built on a strengths based perspective and for me, these aligned well with my practicum in child and youth mental health. Social constructivism allows for a focus on the context of historical and cultural settings throughout social work practice (Creswell & Poth, 2018) in a way that gives visibility and voice to those accessing service (Saleeby, 1996; Salmon, 2008). Subjective meanings are "formed through interaction with others (hence social construction) and through historical and cultural norms that operate in individual's lives" (Creswell & Poth, 2018, p. 24); in drawing from a social constructivist framework in my practicum, the varying experiences and realities of children and youth experiencing complex trauma and their unique perspectives worked to guide the treatment process.

Creswell and Poth (2018) define social constructivism as a paradigm in which "individuals seek understanding of the world in which they live and work" (p. 24) by "develop[ing] subjective meanings of their experiences" (p. 24). These meanings are varied and are shaped by the individual's social, cultural and historical context (Creswell & Poth, 2018). Practitioners working within a social constructivist framework seek this understanding of the world by relying on clients' views and opinions (Creswell & Poth, 2018). Clients construct meaning through their stories and practitioners focus on the therapeutic relationship to find meaning within the stories that are unique to each individual. Many of the clients I currently

work with in my place of employment and some I worked with in my practicum are Indigenous. Stewart (2009) argues that a social-constructivist approach is a fit to working with Indigenous people because it allows for an inclusion of an Indigenous worldview in the therapeutic relationship. "[I]n a social constructivist understanding, the proof of truth of a client's story is not if the story corresponds to actual events, but that the meaning and depth the client assigns to the experience is the reality" (Stewart, 2009, p. 65). Furthermore, she explains that "constructivism works to restore continuity of self that is disrupted by inauthentic living through an attempt to promote holism that will motivate change" (Stewart, 2009, p. 66). This works for children and youth of all cultures and allows counselors to meet children where they are at as they work to address mental health concerns.

A strengths based perspective forms the foundation of my current practice and was fitting for a practicum in CYMH. Pulla (2017) describes a strengths based approach in social work as one that "allows us to identify and build on our strengths so that we can reach our goals and retain or regain independence in our daily lives" (p. 100). In the child and youth mental health setting, a strengths based approach "is founded on the premise that even the most troubled youth have unique talents, skills, and other resources that can be marshaled in the service of recovery and development" (Cox, 2006, p. 287). It allows for a collaboration between clinician and client to focus on the client's "wisdom, knowledge, and experience" (Pulla, 2017, p. 102) and allows for clients to construct and story their own experiences. The mental health field often focuses on diagnosing disorders with treatment models focused on deficits (Cox, 2006) and a strengths based approach allows for a shift to focusing on client "capacities and assets" (Cox, 2006, p. 278) while working towards treatment goals. Children's confidence and motivation to change increase with a focus on strengths and abilities (Cox, 2006) and this can empower children to

work through challenging situations, trauma, and complex trauma successfully. A strengths based approach came naturally to me in the clinical setting and I anticipate it being at the foundation of my clinical practice going forward.

Chapter 3: Literature Review

The overall goal of this practicum was to develop my clinical identity by learning about and gaining experience in using different therapeutic modalities, specifically CBT and play therapy, with children and youth experiencing complex trauma. The following literature review defines complex trauma, CBT and play therapy. I am passionate about northern social work practice and valued the opportunity to explore it from a clinical perspective; a brief overview of some of the challenges and complexities of northern practice will be outlined. Most importantly, any work or potential work with Indigenous children and families needs to acknowledge the history of colonization in Canada. Although this project is not focused on work with Indigenous children, many of the children seen by the CYMH team at Connexus are Indigenous; therefore, an understanding of the colonial structures that have led to ongoing intergenerational trauma is vital. This literature review will give a brief and comprehensive overview of the negative history of Canada's "helping" systems and how these have resulted in ongoing systemic racism, oppression, and intergenerational trauma today.

Complex Trauma

Complex trauma is trauma that results from traumatic experiences that occur at all levels – social, emotional and psychological – throughout different stages of development in childhood (Mahoney & Markel, 2016). The trauma occurrences may not be extreme events, such as the death of a family member, but are a compilation of interpersonal trauma, such as "psychological maltreatment, neglect, separation from parents, etc." (Mahoney & Markel, 2016, p. 1). In order to work through any trauma, children require a safe space and a safe adult who they trust to support them (Kress et al., 2018); for some children, this adult may be their therapist. Building relationships with children and youth who have experienced trauma requires trauma informed

practice and knowledge of how trauma impacts development and function as well as how it can be manifested through a child's behaviour, reactions/responses, and ability (or inability) to verbally express emotions and feelings (Steel & Malchiodi, 2012; Wekerle et al., 2007). For Indigenous children, the ongoing impacts of intergenerational trauma result in lived experiences of complex trauma.

The Therapeutic Relationship and Play Therapy

Relationships are key when working with children and youth. The therapeutic relationship drives the success of therapy across varying ages and stages as well as cultural backgrounds (Muir & Bohr, 2014). In order to work through trauma, children require a safe space and a safe adult who they trust to support them (Kress et al., 2018); for some children, this adult may be their therapist. Building relationships with children and youth who have experienced trauma requires knowledge of how trauma impacts development and function as well as how it can be manifested through a child's behaviour, reactions/responses, and ability (or inability) to verbally express emotions and feelings (Steel & Malchiodi, 2012; Wekerle et al., 2007). Through play, a trusting and effective therapeutic relationship can be developed without the child having to verbalize thoughts, feelings or experiences (Landreth, 2012). For children who have experienced complex trauma, play allows them to process and move through their experiences safely, which is particularly important for children who may not have the cognitive, verbal, or emotional capacities to process and express their feelings through talk (Brady, 2015). For Indigenous children, culture-infused play therapy provides a culturally safe play environment to guide the therapeutic relationship and work through complex trauma that may be a result of intergenerational trauma (Brady, 2015). By allowing children the space to feel valued, to feel important, to be respected, to have space if needed, and by ensuring that basic needs are met,

therapists can meet children where they are at and learn to see what they see to start to understand and work through their experience of trauma (McKiernan, 2021; Schwartzenberger, 2005).

Existing literature shows that play therapy is an effective therapeutic approach to working with children and youth who have experienced trauma. Landreth (2012) defines play therapy as "a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication for optional growth and development" (p. 11). Understanding how trauma impacts children and how this may present differently through the ages and stages is required to connect, build trust, and build a genuine therapeutic relationship with a child who has experienced trauma. Through play therapy, therapists can "get to a child's level and communicate with children through the medium with which they are comfortable" (Landreth, 2012, p. 8) which allows for the child to develop trust even when lacking the developmental cognitive and verbal ability to express their emotions or the intensity of the trauma they have experienced (Landreth, 2012). Trauma resides in its effect on the nervous system, not in the event (Steel & Malchiodi, 2012) and allowing children to 'play out' their experiences in a safe environment "is the most natural dynamic and self-healing process in which they can engage" (Landreth, 2012, p. 9). Children may not have the cognitive, verbal, or emotional capacities to process and express their feelings through talk and play allows for them to do this in a way that they are free from everyday expectations while enabling safe ways to understand and resolve traumatic experience(s) without "real-life consequences" (Brady, 2015, p. 99).

Intergenerational trauma and a history of colonial oppression may lead Indigenous children and youth to experience trauma differently than non-Indigenous children and youth (Brady, 2015; Wekerle et al., 2007). Brady (2015) recommends culture-infused play therapy, which includes using "traditional arts, culturally relevant materials and symbols, the involvement and participation of family and community members, and spirituality in treatment planning" (p. 95) for working with Indigenous children and youth. Practicing from an Indigenous lens, using culturally appropriate therapeutic tools, and engaging family, community, and Elders in the healing process can transform the therapeutic relationship in work with Indigenous children and youth. I believe that the tools and techniques used for culture-infused play therapy will effectively meet children where they are at, whether they identify as Indigenous or come from another cultural background. My curiosity lies with how non-Indigenous practitioners implement Indigenous culture into their work in a safe and appropriate way and how they use these tools and techniques cross culturally. While I was not able to practice this myself throughout my practicum, I did have conversations with senior clinicians about if and how they utilize culture-infused play therapy and I will continue to explore this in my future clinical practice.

Cognitive Behavioural Therapy (CBT) and Trauma-Focused CBT

Cognitive behavioural therapy (CBT) is an approach to therapy that examines the ways in which people think about themselves and the environment and aims to change negative thought patterns that influence perception and behavior (BECK: Cognitive Behavior Therapy [BECK], 2019; Simons & Griffiths, 2014). Pioneered by Dr. Aaron Beck in the 1960s (BECK, 2019), the cognitive model illustrated how negative thinking drives emotional problems and it projected that a change in thought process could alleviate the emotional problems (Simons & Griffiths, 2014). The model has since been expanded and redefined to consider the roles of environment,

behaviour, physiology, motivation and process in the therapeutic process (Simons & Griffiths, 2014); the basic CBT model now considers the relationships between thoughts, feelings, physical sensations and behaviour as the four key elements of psychological distress (Simons & Griffiths, 2014). “The CBT model hypothesizes that situations in themselves do not cause psychological distress but, rather, what is important is the way that people interpret, make sense of and react to situations” (Simons & Griffiths, 2014, p. 23); clients learn to identify and evaluate negative thoughts to be able to think more realistically and as such, change underlying beliefs about themselves to create long lasting change (BECK, 2019; Simons & Griffiths, 2014). CBT requires the development of a collaborative relationship between the clinician and client; the clinician actively works with and engages the client to identify goals for change, to understand the “cognitive structures that perpetuate maladaptive behaviors and emotional responses, and develop a joint strategy for altering both cognitions and behaviour” (Regehr & Glancy, 2014, p. 188). The process is time-limited and includes ‘homework’ that clients engage in outside of therapy sessions which provides continuity between sessions and empowers clients with a sense of control over the process (Simons & Griffiths, 2014). A range of techniques and aids are used to examine and question unhelpful thoughts and thought processes (Simons & Griffiths, 2014). CBT effectively treats several psychological issues, including but not limited to depression, anxiety, obsessive compulsive disorder and post-traumatic stress disorder (BECK, 2019).

Trauma-focused (TF-CBT) “is designed to reduce negative emotional and behavioral responses following child sexual abuse, domestic violence, traumatic loss, and other traumatic events” (Child Welfare Information Gateway, 2012, p. 1). TF-CBT effectively treats many problematic issues that result from a traumatic experience, including but not limited to, depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder, acting out

behaviours, and maladaptive beliefs related to traumatic events (BECK, 2019; Child Welfare Information Gateway, 2012). Although it is a Western mainstream therapeutic approach, TF-CBT provides an opportunity for counsellors to work through an Indigenous lens by developing collaborative relationships with children, youth, and caregivers, and providing a foundation to assist Indigenous children in understanding their trauma experience through a historical and cultural context. TF-CBT requires a collaborative therapeutic relationship be built not only between the counsellor and child, but with the child's caregivers as well (Child Information Gateway, 2012) and this is a start to exploring and addressing mental health challenges through relationships. TF-CBT allows for counsellors to work with children within the family unit to examine interactions and identify problems and areas of strength (Child Information Gateway, 2012). TF-CBT recognizes that the child's "sense of self-worth, self-identity, and happiness is connected to, and influenced by one's relationship with others" (Rathod & Kingdon, 2009, p. 370). The involvement of the family is key to engaging and effectively treating the child (Rathod & Kingdon, 2009). The child is considered in the context of the family and relationships within the family and not treated as an individual entity that is healed outside of the family environment. I did not get an opportunity to utilize TF-CBT in my practicum, however, I have identified different training opportunities specific to TF-CBT that I am looking forward to participating in.

Northern Practice

This practicum took place in a small northern community in British Columbia and the complexities of social work practice in the rural north must be noted to understand how northern practice is shaped. The notions of 'north,' 'remoteness,' and 'rurality' have been conceived differently throughout social work literature and research as being based on population size,

service availability, and/or distance to major centers. Schmidt (2000) states that the complex concept of what is considered to be 'north' is a "place or sense of place which is defined economically, culturally and geographically," (p. 339) and Daley (2010) describes rurality as being perceived through structural domains of occupation, ecology, and sociocultural elements. The historical context of north has been related to patterns of economic activity and European settlement; the north has been defined by areas unsettled by Europeans and "associated with wilderness, the fur trade and isolation" (Schmidt, 2000, p. 338). While Europeans have historically viewed the north as "something wild that should be tamed and harnessed to generate economic activity" (Schmidt, 2000, p. 338), for Indigenous people, the north is home, is welcoming, and is a place that must be respected and environmentally protected (Schmidt, 2000). Western concepts of north have shifted through time and have been defined and re-defined, but a recurring theme throughout is the "idea of marginalization that is cast within a framework of relative isolation and remoteness" (Schmidt, 2000, p. 339). Characteristics of northern communities, such as geographic isolation, low population density, economic down turns and intergenerational trauma, shape social work practice in the north and can lead to personal and professional isolation for practitioners (O'Neill, 2010); high staff turnover and "a poor fit between urban educated social workers and northern communities and clients" (Schmidt, 2000, p. 342) define social work in the north; however, workers who are able to integrate into the community often build long-lasting connections and relationships that shape practice on an individual, community and structural level.

Mental health practitioners in northern communities often experience unique and complex challenges that can increase their risk of secondary trauma (O'Neill, 2010). O'Neill (2010) outlines some of the challenges that are characteristic of northern practice, including high

visibility/loss of privacy or autonomy for practitioners, dual relationships with challenges to confidentiality, practitioners working outside of their limits of practice, a lack of clinical supervision, and intergenerational issues. She notes that the "combination of challenging physical and sociocultural environments results in limited health options, including mental health services for northern inhabitants" (2010, p. 1370). This leads to practitioners experiencing higher levels of responsibility and stress which increases the risk of experiencing secondary trauma, which O'Neill interprets as being a construct of burnout, compassion fatigue, and vicarious trauma and specifically defined as "the presence of post-traumatic stress disorder (PTSD) symptoms in caregivers connected to the client's trauma experience rather than the caregiver's own trauma" (2010, p. 1374). For CYMH clinicians in the north, high caseload demands and few community resources can increase the challenges to already challenging work. Often, formal supports, such as counsellors, psychologists, social workers, and nurses are unavailable and clients and clinicians need to rely on informal supports, such as lay counselors, Elders, family supports, community identified supports (O'Neill, 2010).

Cross-Cultural Work with Indigenous Children and Youth

The community in which this practicum took place has a high population of Indigenous peoples and many of the children seen by the CYMH team are Indigenous. Further, part of my learning goals were to learn how clinicians use various therapeutic modalities cross-culturally in a culturally safe and appropriate way. It is essential that the destructive history of Canada's "helping" systems be noted and understood in any therapeutic work with Indigenous children to prevent ongoing cycles of oppression and systemic racism. It is also important to understand that culture is not necessarily a binary construct and people may place themselves differently along a continuum. Many tools and techniques that incorporate pieces of Indigenous culture are effective

at different places on this continuum and for children of different cultures as well. Understanding how to incorporate these in a culturally safe and appropriate manner is essential to not perpetuate colonial oppression through cultural appropriation and the first step to doing this is to have an understanding of Canada's colonial history.

The effects of intergenerational trauma caused by colonial oppression cannot be overlooked when considering the mental health and well-being of Indigenous children and youth. The Indian Act, the residential school system, and the Sixties Scoop were tools designed to assimilate Indigenous children by stripping them of their families, community and ultimately their culture and identity which has resulted in ongoing historical trauma (Bombay et al., 2013) that continues to impact Indigenous people on an individual, family and community level. Hart (2002) states that "colonization is driven by a worldview that embraces dominion, self-righteousness and greed" (p. 24) that is in direct contrast with an Aboriginal worldview that centers around collectivism and community. This contrast and the tools used to enforce colonial oppression left longstanding and ongoing reverberations for Indigenous communities, families and individuals that continue to have adverse effects on the mental health and well-being of Indigenous children and youth.

The trauma experienced by residential school and Sixties Scoop survivors continues to effect Indigenous people through the overrepresentation of Indigenous involvement in the child welfare and justice systems, as well as the disproportionate numbers of Indigenous individuals and families experiencing negative outcomes, such as poverty, unstable housing, substance use, and mental health issues (Blackstock et al., 2004). The systematic destruction of traditional family systems and traditional models of parenting has resulted in generations of Indigenous people who have not had an opportunity to learn how to form healthy emotional bonds with or

create healthy and stable environments for their children (Mussell, et al., 2004). Indigenous families who have survived trauma by internalizing the process of colonization often repeat the patterns of unhealthy family relationships they were exposed to as children (Hart, 2002; Mussell et al., 2004). This has created ongoing cycles of abuse and trauma that impact the overall well-being of Indigenous families, children and youth.

The negative effects of intergenerational trauma on family members of survivors of the residential school system and the Sixties Scoop has been confirmed in research that demonstrates correlation between suicide ideation and attempts with exposure to parents or grandparents who attended residential school (Elias, et al., 2012; McQuaid, et al., 2017). The Cedar Project's 2008 study of the connection between historical trauma, sexual abuse, and HIV risk among Indigenous youth who struggle with substance use found evidence that at-risk Indigenous youth experience "several devastating sequelae of sexual abuse that signify continuing intergenerational transmission of trauma" (Pearce et al., 2008, p. 2193). Understanding the ongoing impacts of intergenerational trauma on Indigenous individuals, families and communities is critical for those in helping professions to work in a way that breaks the systemic barriers to self-determination for Indigenous people and works towards reconciliation and decolonization.

While often unintentional, colonial oppression continues to be prevalent through the helping professions by those using western models of assessment, diagnosis and treatment when working with Indigenous people (Hart, 2001; Stewart, 2009). Therapeutic relationships are often "dominated by Western ethics and ideas" (Stewart, 2009, p. 62). Indigenous paradigms of health and ways of knowing need to guide work with Indigenous clients (Stewart, 2009). In order to work to end oppression within the therapeutic relationship, therapists need to be informed on the history of colonization and the effects of intergenerational trauma (Stewart, 2009). They need to

understand the diversity of Indigenous cultures and work to educate themselves on learning about the specific culture and traditions of the particular Indigenous group(s) they serve, but also understand that there are some values that are shared throughout Indigenous cultures, such as the importance and interconnectedness of family and community (Stewart, 2009). Western models of therapeutic intervention that focus on healing the individual as separate from his/her family or community may not be appropriate for Indigenous people and "a lack of understanding of Indigenous culture, beliefs, values, and spirituality could result in erroneous assumptions in assessment of family or individual mental health problems and the treatment used in dealing with the problem" (Stewart, 2009, p. 64). By not acknowledging Indigenous perspectives and cultural nuances, practitioners may inadvertently undermine the therapeutic relationship and may miss important cultural nuances and family healing resources (Stewart, 2009). An Indigenous approach to health should be a part of the multitude of methods counsellors may use in work with various clients and this can not be done without collaborating and building meaningful relationships with the Indigenous community in which practitioners practice.

Chapter 4: Learning Experiences from the Practicum

My practicum experience at Connexus provided me the opportunity to start developing my identity as a clinical social worker in the north. I had access to a wealth of resources, including a library of books and online resources, as well as to a team of experienced and professional clinicians who all provided me with information and support to begin my journey in the clinical world. This chapter will outline the key learning that pertained to my goals and will explore how this learning has shaped the beginning of forming my identity as a clinical social worker. An overview of the tasks I completed will contextualize how I worked to meet the sub-goals leading to the larger goal of developing my clinical identity.

Practice Environment and Overview of Tasks

My practicum took place at Connexus Community Resources in Vanderhoof, British Columbia, from July 2024 until February 2025. For the month of July, I attended my practicum three days per week; this decreased to two days per week in August and for the duration of my time at Connexus. The part-time nature of the practicum was intentional as it allowed time for me to connect with clients, develop a therapeutic relationship, and see the work with most of them through or almost through at the end of my time there. The first month of my practicum was spent studying resources, getting to know the agency, getting to know my colleagues, and shadowing client sessions when possible. I found this first month to be extremely valuable to my learning. Not only was I able to peruse the wealth of resources held by Connexus, I was able to connect with my colleagues and start asking questions about practice and experience – I believe this was a major contributing factor to the success of my practicum. The support and patience that my colleagues provided truly guided my learning. I was able to explore the different styles

used by each clinician, from preferred therapeutic modality to style of practice, through their interactions with clients in session as well as through their style of documentation and case notes.

The team was very supportive in trying to have me shadow as many sessions as possible and I was able to sit in on sessions with almost all of the members of the clinical team. I observed one worker using CBT and grounding techniques to address anxiety in a client and one worker using exposure therapy with a client afraid of needles. I sat in with a worker conducting a Suicide Risk Assessment (SRA) with a client and another worker completing a BECKs Youth Combination assessment with a client – both of these sessions were training opportunities for me to complete SRAs and BECKs assessment with my own clients later on. I also worked with a counselor to complete a Plan of Care – the assessment process used by Connexus to gather information and determine which program would be best suited to each referred client. Eventually, I was assigned Plans of Care to complete and then present to the team at the weekly intake meetings. Connexus refers clients to the British Columbia Children's Hospital's Telehealth Outpatient Psychiatric Services (TOPS) program where clients are assessed by a psychiatrist who can make a formal diagnosis, recommend a treatment plan, and prescribe medications. The clinical team at Connexus supports clients through the assessment process and provides clinical support following the assessments. I was able to complete a referral to the TOPS program as well as sit in on an assessment with a client and another clinician. All of these opportunities significantly contributed to my learning and helped prepare me to gradually take on my own caseload. The shadowing sessions also helped me to see the importance of talk therapy and the trust that comes with an established and effective therapeutic relationship.

The clinical program manager had developed a plan to gradually transition clients to me, starting with clients who had already been opened with a previous practicum student. These

clients were deemed ‘lower risk’ meaning that they did not have any current suicidal ideation, they had developed skills/tools in previous counseling work and were currently working to enhance those skills. Once I established a connection and routine with these clients, I was tasked with opening with clients who had been on the waitlist for service, some for several months. I worked with my clinical supervisor in our clinical supervision sessions to develop treatment plans for these clients and she guided me throughout my work with them in suggesting tools and strategies to use to address the reasons they had been referred to counseling.

Every Wednesday morning, the Child, Youth and Family Services team meets for an intake meeting. At these meetings, Plans of Care for clients are presented and these clients are assigned to specific program areas and put on waitlists for upcoming groups. Once a month, the intake staff from the TOPS program joins the clinical team meeting to update on the TOPS program and to answer specific questions that might arise from the Connexus team. These weekly meetings contribute to a strong sense of team in the clinical environment and allowed me another opportunity to connect with colleagues, to see how the different program areas intersect, and to get a sense of how referrals were assigned and triaged if needed.

In August and September, I started to have more clients as well as Plans of Cares assigned to me. As my caseload increased and I started to become more and more busy, I found the need to be more intentional in my self-care strategies as well as in focusing in on my learning goals. In September, I was assigned to the community of Fraser Lake one day per week with two colleagues. Every second week in Fraser Lake, I worked with a colleague to run a wellness drop-in at the local high school. Outside of the drop-in program, I opened with new clients who I saw for the duration of my practicum. My time in Fraser Lake was invaluable as I spent those days with two senior workers; one who works in the PEACE program and one who is a senior CYMH

clinician. I used the time we travelled together to and from Fraser Lake to ask questions about self-care, northern practice, and clinical work in general; I was also able to use this time to debrief if needed and explore the challenges I had at times with separating my child welfare work from my clinical work (I will speak to this more below). My days in Fraser Lake became quite busy as I took on more clients and I was grateful for the travel time with these colleagues to decompress and reflect on the day. As I look back on my reflective journal, this became a large piece of my self-care throughout my practicum and contributed greatly to the sense of clinical identity I started to develop in my time at Connexus.

Clinical Skill Development

A main focus of my practicum was to develop clinical skills and tools with a focus on CBT and play therapy and understand how these are used to address complex trauma. The practicum at Connexus afforded me the opportunity to do this in a structured and supported way. It started with the opportunity to study the available resources and ended with me holding a caseload of clients and utilizing different therapeutic modalities to work through treatment plans with them. It became evident very quickly that the team at Connexus is well versed in utilizing CBT and trauma-focused CBT and there were many books, workbooks, and resources that I was able to study prior to getting a caseload. I was fortunate enough to be able to access these resources and utilize some of the readily available CBT workbooks, including "*Mighty Moe: An Anxiety Workbook for Children"* (Woloshyn, 2009), a workbook I used with two clients. As I noted previously, due to my practicum schedule not aligning with the schedule of the groups being offered, I was not able to participate in any group facilitation; however, with the help of another clinician as well as the clinical program manager, I was able to modify the curriculum from one of the groups to use on an individual basis. This curriculum is the *"Taming Worry*

Dragons" (Garland,1995) and uses a CBT approach to addressing anxiety in children. I used this with a six year old client who told me that she no longer wanted to live in an 'anxiety world.' Using this program, she was able to identify the root causes of her worry and to establish a connection between her thoughts, feelings and her behaviours. She was very excited to make a dragon cage out of popsicle sticks and at one point, she reported back to me that she kept her dragon cage beside her bed and had been practicing 'taming' her dragons.

Prior to starting my practicum, my practicum supervisor had advised that there were no certified play therapists at Connexus at the time, but that she and some of the other counselors had had some training and integrated play therapy into their work with children. Under her guidance, I was able to use aspects of play therapy to work with a child who was struggling with transitioning between her parents' houses following their separation. This child would use dolls to show me who was all in her family. We practiced this with both her mom and dad's side of the family and I was able to explore with her who she included in the family groups – her dad had recently entered a new relationship with a partner who had children and the child would sometimes include the partner and her children in the family grouping and sometimes would not. She would play with the dolls in the doll house which gave me the opportunity to observe the way she had the dolls interact and subsequently explore with her the similarities between the interactions that occurred within her own family dynamic.

Developing Identity as a Clinical Social Worker in the Rural North

My overarching learning goal was to start developing my identity as a clinical social worker in the north and I believe this practicum at Connexus gave me the foundation to build on to do this. By allowing me the opportunity to work directly with clients to develop and enhance my skillset while having plenty of guidance and clinical supervision, this practicum allowed me

to start to form my own style. I realize that I am only at the beginning of my journey and I am grateful for the practical experience I gained in my practicum to guide me as I embark on a clinical career.

I come from a career background in child welfare, Indigenous child welfare to be specific. I knew it would be a challenge to shift my lens from a child welfare perspective to a clinical perspective, but this proved to be more challenging that I realized. Part of this challenge stems from doing any type of social work in the rural north. As I previously noted, I live and work in Fort St. James and I requested to do my practicum out of Connexus's Vanderhoof office to avoid client-crossover. For the most part, I was able to avoid client-crossover, but there were some instances where it was inevitable and I had to use my reflective journals, debriefing conversations with colleagues and the clinical program manager, and my clinical supervision time to ensure that I maintained appropriate boundaries between my work and practicum as well as to ensure I maintained a protective level of self-care. In my work, I have come to enjoy navigating the challenges of social work in the rural north; however, from a front-line clinical perspective, with the added complexity of my work in child welfare, I found there to be a shift and I had to re-focus on ensuring that I was navigating this in a good way.

A clear example of this for me was the first Plan of Care that I was tasked to complete. A Plan of Care (POC) is the assessment or intake tool used at Connexus to gather information to determine which program would best meet the needs of referred clients. The POC process typically involves a minimum of one meeting with the client and/or the client's parents, but it often requires several meetings to gather all of the required information. The information required includes a psycho-social and medical history and a description of the current concerns or reason for the referral. Within the POC, there are opportunities to utilize assessment tools,

such as the BECKs Youth Combination assessment to assess symptoms of anxiety, anger, disruptive behaviour, and self concept (Beck, Beck & Jolly, 2005), which are used to determine which program the referral or client would best be suited to as well as to start mapping out a treatment plan for clients. Suicide Risk Assessments (SRAs) are also completed in the POC process should a child or youth disclose suicidal ideation or attempts.

The first POC I did was for a youth from Fort St. James. I recognized her name, but this was just because it is a small town, I did not know her or her family. I consulted with the clinical program manager to explore whether this was a POC I should be completing due to it being a youth from Fort St. James or whether it should be assigned to someone else. Since I did not know the youth or her family, we decided that it would not be a conflict of interest or present as a dual relationship situation if I were to complete the POC. This youth was referred to Connexus by her mom following a recent suicide attempt. My first conversation as part of the POC was with mom and following that conversation, it became evident that an SRA should be completed with this youth. I met with the youth and completed the SRA as well as the POC, which was presented at an intake meeting and the referral was assigned to the CYMH team.

Several weeks later and as part of my other work, the youth I completed the POC for was referred to the youth team that I manage at the agency I work for; this referral was due to high risk behaviour. While I would not be working with this youth directly, I was acutely aware of how she might feel even seeing me at the office after I had completed the SRA and POC for her in which she had shared some detailed personal information. While this youth chose not to access services from that agency that I work at for reasons I do not know, this made me reflect on the challenges of dual relationships in a small community. After much contemplation, I decided that it would be best to not complete POCs for children/youth from Fort St. James whether I

knew them or not as I did not want to be in a situation where the dual relationship could impact the child/youth's comfortability with their respective service provider.

This example of a dual relationship and the self-reflection I did to navigate it seemed to be when I started to really reflect on and examine my thought processes from a child welfare perspective as compared to a clinical perspective – this was something interwoven throughout my practicum and was something that I frequently reflected on in my journal. For example, there was a situation where a child made a vague disclosure of a possible child protection concern in a counseling session. My child welfare brain mapped out a detailed response to this vague comment that stemmed from the step-wise interview training that I have received to investigate child protection concerns. This includes establishing whether the child knows how to differentiate between telling something that is true and something that is not true, establishing timelines of an alleged incident, and getting details of what had reportedly taken place. It was a conscious effort for me to take a step back from pressing this child for more information to actively listening as she processed her emotional response to a situation that had occurred several years previously. In the end, this was not a situation that required a child protection response, however, it made me reflect on how my prior training can and does impact my clinical work.

This was something that I consulted with my clinical supervisor on throughout my practicum as it was something that I was very aware of. I was appreciative of the clinical guidance I received. When I put this into the perspective of starting to establish an identity as a clinical social worker, I realize that this is always something that I will need to be reflective on and will be able to find balance with. Working as a social worker in a small northern community comes with unavoidable challenges, including dual relationships (like the one I described above) and very real conflicts of interests. I was not surprised that at my first intake meeting, I saw

names on the intake list of children who I am related to and I had to remove myself from the room whenever information about them was presented. These are situations that I was prepared for and that I was familiar with navigating through my other work, and navigating them through a clinical lens felt familiar to me.

One of my learning goals was to learn how to work in a culturally safe and appropriate way with children of different cultural backgrounds, particularly with Indigenous children. My work as a settler in Indigenous child welfare has made me acutely aware of the ongoing historical impacts of colonization, particularly in the helping fields, and I want to ensure that any time I am working alongside Indigenous children and youth, I am not contributing to cycles of oppression. I did not get an opportunity to work with Indigenous clients on my caseload, but I was able to witness how the organization as a whole provided an inclusive and culturally safe environment for practice. This started in the on boarding process where information on the local Indigenous culture was shared, which included a guide to pronunciation as well as a history of the local Indigenous groups. On an ongoing basis, land acknowledgments were a key part of starting all meetings and at one meeting with all Connexus staff, the Executive Director made a point of explaining the importance of a land acknowledgement and how it is something that needs to be done with meaning and intention.

Chapter 5: Implications for Personal Professional Practice

I entered into this practicum with the overall goal of starting to develop my identity as a clinical social worker in the north. My time at Connexus Community Resources gave me the opportunity to identify and explore implications for my future practice, stemming from understanding the importance of the therapeutic relationship, particularly as it pertains to working with children and youth who have experienced complex trauma, to implementing clinical tools to work to address this trauma or whatever reason the child had been referred to services. I have consciously had to work to shift my identity from a child welfare social worker to a clinical social worker and I believe that the skills that I have gained in doing this for the duration of my practicum have built the foundation for my clinical work in the future

The professionalism, comradery, and support the clinical team at Connexus exhibited throughout my practicum exemplified what I believe is a model of teamwork that facilitates growth for all members. I saw the weekly intake meetings as the root of this team cohesiveness and saw how the team worked together to not only support each other but also to ensure that the needs of the clients were met in the most comprehensive manner. I witnessed the team in the meetings and also on an individual basis connect with each other to bounce ideas off of each other and to ask for advice in complex cases. There was a genuine feeling of support which contributed to my self-care in feeling that I was in a safe and supportive environment; I felt this resonate throughout the space as the entire clinical wing of the office felt calm and inviting. As I think about clinical work in the future for myself, I think about the importance of teamwork and connections and how these relate to my self care as well as to my own professional and personal growth.

Shifting from a child welfare to a clinical perspective presented as one of the biggest learning opportunities for me throughout my practicum. I see this as being something that I will continuously have to navigate in future clinical practice. This, and the realities of clinical social work in the rural north (conflicts of interest and dual relationships, for example) shaped my practicum and will be ongoing aspects of practice for me going forward. Understanding this for me has been key in developing a clinical identity but I also now understand the importance of clinical supervision and support. Not only did my clinical supervisor provide practice support, she also provided overall guidance to navigating some of these challenges.

Prior to my practicum I had a well established self care plan that worked well for me in my other work. This plan included creating space for myself several times a week, which might mean walking my dogs, reading a book, or even just sitting for a peaceful cup of coffee. It included creating and sticking to firm boundaries that supported a healthy work life balance. It also included giving myself the time and space to have regular and ongoing debriefing and consultation sessions with my supervisor. All of these things worked well in creating self-care throughout my practicum as I dove into clinical work; however, I also started writing in a journal on a regular basis and I found that this contributed greatly to an overall sense of self-care. This is something that I will commit to continuing in my future practice as it carved out a space for me to be intentionally self-reflective. Through the process of journaling, I was able to process my experience as well as consciously write personal goals and ideas for future work.

Chapter 6: Conclusion

This report summarizes my learning journey during my practicum at Connexus Community Resources. As I look to completing my Master of Social Work, I look forward to the ongoing process of developing clinical skills and shaping my identity as a clinical social worker. I believe that my current work experience, my practice in the north, and my experience as a non-Indigenous worker walking alongside Indigenous children and families assisted me in my practicum and will continue to guide me in CYMH work in the rural north. I know that the experience I gained at Connexus has formed the foundation for my future clinical work. The learning I have had throughout my practicum has triggered a desire for more learning and more practice with the skills I have learned over the last several months. I am grateful to Connexus for allowing me to begin this process at their agency.

References

Baskin, C. (2016). Strong helper's teachings: *The value of Indigenous knowledges in the helping professions* (2nd ed.). Toronto: Canadian Scholars' Press.

BECK: Cognitive Behavioral Therapy. (2019). Retrieved from https://beckinstitute.org

Beck, J.S., Beck, A.T., Jolly, J.B., & Steer, R.A. (2005). *Beck Youth Inventories Second Edition for Children and Adolescents manual*. PsychCorp.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234. doi: 10.1177/146879112468475

Brady, M. (2015). Cultural considerations in play therapy with Aboriginal children in Canada. *First Peoples Child & Family Review, 10*(2), 95-109.

Blackstock, C., Trocme, N., & Bennet, M. (2004). Child maltreatment investigations among Aboriginal and non-Aboriginal families in Canada. *Violence Against Women, 10*(8), 901-916.

Bombay, A., Matheson, K., & Anisman, H. (2013). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry, 51*(3), 320-338.

Child Welfare Information Gateway. (2012, August). *Trauma-focused cognitive behavioral therapy for children affected by sexual abuse or trauma*. Retrieved from http://www.childwelfare.gov/pubs/trauma

Creswell, J.W., & Poth, C.N. (2018). *Qualitative inquiry and research design: Choosing among five approaches.* SAGE Publications, Inc.

Cohen, J.A., Mannarino, A.P., Kliethermes, M., & Murray, L.A. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse and Neglect, 36,* 528-541.

Connexus Community Resources. (2019). *About us.* https://connexus.ca/about-us/

Connexus Community Resources. (2023). *2023 Annual report.*

https://connexus.ca/wp-content/uploads/2023-Annaul-Report.pdf

Cox, K.F. (2006). Investigating the impact of strengths-based assessment on youth with emotional or behavioural disorders. *Journal of Child and Family Studies, 15*, 278-292.

Daley, M.R. (2010). A conceptual model for rural social work. *Contemporary Rural Social Work, 2,* 1-7. Retrieved from https://digitalcommons.murraystate.edu/crsw

Elias, B., Mignone, J., Hall, M., Hong, S.P., Hart, L., & Sareen, J. (2012). Trauma and suicide behaviour histories among a Canadian indigenous population: An empirical exploration of the potential role of Canada's residential school system. *Social Science & Medicine, 74*(10), 1560-1569.

https://doi.org/10.1016/j.socscimed.2012.01.026

Garland, J.E. (1995). *Taming Worry Dragons: A manual for children, parents, and other coaches.* Mood and Anxiety Disorders Clinic, Department of Psychiatry, British Columbia Children's Hospital.

Hart, M.A. (2002). *Seeking mino-pimatisiwin: An Aboriginal approach to helping.* Fernwood Publishing, Ltd.

Kress, V., Haiyasoso, M., Zoldan, C.A., Headley, J.A., & Trepal, H. (2018). The use of relational-cultural theory in counseling clients who have traumatic stress disorder. *Journal of Counseling and Development. 96*(1), 106-114.

Landreth, G. (2012). *Play therapy: The art of relationship* (3rd ed.). Routledge.

Leavy, P. (2020). *Method meets art: Arts-based research practice.* Guilford Publications.

Lebowitz, E.R., Omer, H., Hermes, H., & Scahill, L. (2014). Parent-training for childhood anxiety disorders: the SPACE program. *Cognitive and Behavioral Practice, 21,* 456-469.

Mahoney, D. & Markel, B. (2016). An integrative approach to conceptualizing and treating complex trauma. *Psychoanalytic Social Work. 23*(1), 1-22.

McKiernan, J. (2021, January 24). *Module 4: Connecting with clients.* [Online class lecture notes]. Blackboard.

McQuaid, R.J., Bombay, A., McInnins, O.A., Humeny, C., Matheson, K., & Anisman, H. (2017). Suicide ideation and attempts among First Nations Peoples living on-reserve in Canada: The intergenerational and cumulative effects of Indian Residential Schools. *The Canadian Journal of Psychiatry, 62*(6), 422-430.

Muir, N., & Bohr, Y. (2014). Contemporary practice of traditional Aboriginal child rearing: A review. *First Peoples Child & Family Review, 9*(1), 66-79.

Mussel, B., Cardiff, K., White, J. (2004). *The mental health and well-being of Aboriginal children and youth: Guidance for new approaches and services.* Children's Mental Health Policy Research Program, University of British Columbia. https://childhealthpolicy.ca/wp-content/uploads/2012/12/RR-8-04-full-report.pdf

O'Neill, L. (2010). Mental health support in northern communities: reviewing issues on isolated practice and secondary trauma. *Rural and Remote Health* (10). 1369-1382.

Pearce, M.E., Christian, W.M., Patterson, K., Norris, K., Moniruzzaman, A., Craib, K.J.P., Schechter, M.T., & Spittal, P.M. (2008). The cedar project: Historical trauma, sexual abuse and HIV risk among young Aboriginal people who use injection and non-injection drugs in two Canadian cities. *Social Science & Medicine, 66* (11), 2185-2194.

doi:10.1016/j.socscimed.2008.03.034

Pulla, V. (2017). Strengths-based approach in social work: A distinct ethical advantage. *International Journal of Innovation, Creativity, and Change, 3*(2), 97-114.

Rathod, S. & Kingdon, D. (2009). Cognitive behaviour therapy across cultures. *Psychiatry, 8*(9), 370-371.

Regehr, C. & Glancy, G. (2014). *Mental health social work practice in Canada (2nd ED).* Don Mills, ON: Oxford University Press.

Salmon, J. (2008). Fetal Alcohol Spectrum Disorder: New Zealand birth mother's experiences. *Journal of Population Therapeutics and Clinical Pharmacology, 15*(2), e191-e213.

Saleeby, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work, 41*(3), 296-305.

Schwartzenberger, Ken. (2005). *Child-created metaphors in play therapy.* www.playtherapysseminars.com

Schmidt, G.G. (2000). Remote, northern communities: Implications for social work practice. *International Social Work, 43*(3), 337-349.

https.//doi-org.prxy.lib.unbc.ca/10.1177%2F002087280004300306

Simmons, J. & Griffiths, R. (2014). *CBT for beginners (3rd ED).* London, UK: Sage Publications Ltd.

Steel, W., & Malchiodi, C.A. (2012). *Trauma-informed practices with children and adolescents.* Routledge.

Stewart, S. (2009) Family counseling as decolonization: Exploring an Indigenous social-constructivist approach in clinical practice. *First Peoples Family Review, 4*(1), 62-70.

Wekerle, C., Waechter, R.L., Leung, E., & Leonard, M. (2007). Adolescence: A window of opportunity for positive change in mental health. First Peoples Child & Family Review, 3(2), 8-16.

Woloshyn, L. (2009). *Mighty Moe: an anxiety workbook for children.*

Zarb, J.M. (2013). *Cognitive-behavioral assessment and therapy with adolescents.* New York, NY: Routledge.

Appendix

Appendix A: Learning Goals and Actions to Help Meet Goals

Learning Goals	Actions to Help Meet Goals
Develop my identity as a clinical social worker in the rural north	• Work closely with at least two practicing team members to get a sense of agency culture; document observations in reflective journal • Shadow practicing clinicians to learn about various therapeutic models and understand how to use them; observe a minimum of ten therapeutic one-on-one or group sessions (this number may change with input from practicum supervisor) • Engage in a minimum of fourteen clinical supervision sessions over the six-month practicum period; this is approximately one session every two weeks and this number may change with input from practicum supervisor • Have ongoing conversations (a minimum of five) with clinicians about managing professional/personal boundaries when working in a small community; this will be documented in reflective journal • Keep a reflective journal that is updated at least once per week • Meet with social work consultant at least once per month to ensure I am adhering to social work guidelines and ethics

Develop clinical social work skills	• Engage in tasks to develop and enhance counseling skills that include:
	  ○ At least one full intake from start to finish, including an assessment and treatment plan
	• Participate in monthly collaborative meetings with CYMH team and BCCH (approximately six meetings through the six-month practicum period)
	• Conduct a minimum of three mental health assessments using assessment tools used by Connexus
	• Work directly with children and youth seeking mental health support
	  ○ Have a minimum of ten sessions shadowing clinicians in one on one and group settings

	• Engage in a minimum of fourteen clinical supervision sessions over the six month practicum period; this is approximately one session every two weeks and this number may change with input from practicum supervisor
Learn how to use various therapeutic modalities and understand how they are used to address complex trauma	• Shadow practicing CYMH clinicians; observe a minimum of ten sessions (individual and/or group); this number may change based on input from practicum supervisor • Engage in any available training and produce certificates of completion • Under the supervision of practicum supervisor, practice techniques with children and youth seeking support ○ Conduct a minimum of five sessions (individual and/or group); this number may change with input from practicum supervisor
Develop skills in using CBT and play therapy and learn how to use these to address complex trauma	• Shadow practicing CYMH clinicians ○ Observe a minimum of five sessions (individual or group) with the clinician using CBT and five sessions (individual or group) with the clinician using play therapy; this number may change with input from practicum supervisor • Engage in any available training opportunities and produce certificates of completion • Read any agency training/guides for use • Under the supervision of practicum supervisor, practice techniques with children and youth experiencing complex trauma

Learn how practicing clinicians use CBT and play therapy cross culturally	• Engage in ongoing conversations (a minimum of five) with practicing clinicians about how to work cross culturally in a safe and effective manner
	  ○ Document conversations in reflective journal
	• Engage in ongoing conversations (a minimum of five) with team members about providing culturally relevant and safe services
	  ○ Document conversations in reflective journal

	• Participate in cultural competency training if available and produce certificate of completion