Family Therapy with Youth and Their Families

A Family Therapy Internship with the Youth Community Counseling Team

Saskatoon Health Region

Practicum Report

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Abstract

This report provides an overview of the Youth Community Counselling Teams integrated therapeutic approach of structural solution-focused family therapy, the values of the agency and how values are implemented. Case examples are provided to display my implementation of family therapy in direct social work practice within the agency. The focus for social workers in the Youth Community Counselling Team is to stay on top of their case load, which appears to limit their ability to focus on the social work value of pursuit of justice. Finally, this report describes some present service barriers to potential clients and future barriers considering the changing face of Saskatoon's population with increasing Aboriginal and Immigration populations. This report will be of value for social workers that are considering a family therapy internship at Child and Youth Services, Mental Health and Addiction Services, Saskatoon Health Region.

Acknowledgement

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Introduction

For the majority of my social work career I have worked with children, youth and adults survivors who suffered traumatic life events such as sexual and physical abuse and the perpetrators of offences. Most often the children and youth were not living with their family. My clinical focus was on the individual client. I was familiar with family therapy, had worked with families, but had no formal training in family therapy. Child and Youth Services, a branch of Mental Health and Addiction Services offers a family therapy internship training program. The program orientation is toward a family-focused integrated systemic model synthesized from structural, solution focused and narrative models.

The practicum placement gave me the opportunity to work with youth and families, from a structural solution-focused family therapy perspective to enhance my clinical skills. The learning objectives were:

1) To develop the assessment skills to understand the family dynamics that lead a family member to develop mental health related issues.

2) To integrate the concepts of family therapy with my present therapeutic knowledge and approach.

This report was written with two goals in mind:

1) To provide an integrative practicum report.

2) To use the process of writing the report, to integrate the knowledge gained from the clinical supervision, direct social work practice with the client group, and the self-directed readings.

This report will describe the family therapy internship I completed as my practicum requirements for a Master of Social Work degree with the Youth Community Counselling Team

(YCCT) at Child and Youth, Mental Health and Addiction Services, Saskatoon Health Region. The report begins with a brief description of the services provided by the YCCT. The YCCT staff compliment. The referral process and the Youth Community Counselling Teams commitment to meeting the emotional needs of youth in the context of their family and working from a family system, strength based approach.

This paper then moves to discuss the key elements of family therapy and more specifically the family therapy technique of structural solution-focused family therapy and the utilization of the reflecting team and of the Outcome and Session Rating Scales as developed by Scott Miller. This section includes a discussion of the practices that the Youth Community Counselling Team uses to build relationships both with clients and amongst staff.

In the next section of the report I present a profile of the families I was assigned, and use case examples to illustrate how I applied the concepts of structural solution-focused family therapy in direct clinical practice.

I briefly address the ethical dilemmas I faced in the internship. Next, I address the value statement of the Youth Community Counselling Team in the context of the core values of social work and the activities the Team engages in to facilitate the core values. I discuss the social work value of social justice and the limitations in the Youth Community Counselling Team social workers ability to pursue the social work value of social justice. The primary focus of the Team is on maintaining their caseload and attending to the waiting list. This focus appears to leave limited support/time for social workers to be involved in the community and to address social issues that impact families in a more macro context.

In the final section of the paper I comment on barriers to clients who may require services at the agency. This section includes comments on the changing face of Saskatoon, with increased

immigration and the increased Aboriginal population. I end this section with a discussion on the implications that these two changing demographic factors may have for the Youth Community Counselling Team and service delivery in the next decade.

Internship

Child and Youth Mental Health and Addiction Services offer a family therapy internship training program for graduate level professionals both in social work and psychology. My internship/practicum was with the Youth Community Counselling Team, in the mental health counselling side of the program, located at 715 Queen Street, Saskatoon. The internship was two days per week over two semesters from September 2010 to April 30, 2011. The advantage of an eight month internship was that I was able to work with the majority of the assigned individuals and families from intake to termination. The limitation was that by working two days per week it was difficult from a time management perspective. Balancing session time to see clients for family therapy; training time; preparing for a review of tapes in clinical supervision and completing readings was difficult to do in only two days a week.

As an intern I met weekly with the assigned supervisor who is an approved supervisor with the American Association of Marriage and Family Therapy (AAMFT). I attended bi-weekly case review meetings with staff from the Youth Community Counselling Team, and was a team member of the reflecting team. The focus of these learning components was to learn how to provide family therapy to youth and their families from an integrated structured and solution-focused family therapy paradigm as well as to learn how to incorporate the Outcome Rating Scale and the Session Rating Scale. I supplemented these learning components with self-directed readings.

As an intern in the Youth Community Counselling Program (YCCP) I also attended monthly personal development training meetings that included all staff from YCCP. The training was facilitated by staff who had received therapeutic training outside of the agency or by staff who had training in a specialized area such as eating disorders. All Youth Community Counselling staff are trained to be reliable raters of the Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS is "used to assess degree of impairment in children and adolescents with emotional, behavioural, or substance use symptoms/disorders (Hodges, 2006, p. ii). I completed the training and became a reliable CAFAS rater.

Mental Health and Addiction Services employs a Provincial Child and Youth Training Coordinator. The training coordinator facilitates training sessions for Mental Health and Addiction Services staff. I attended a training session that introduced the work of Dr. Bruce Perry, a senior fellow with the Child Trauma Academy. Dr. Perry's work explains what happens to the brain when children are exposed to extreme stress such as witnessing or being victim of a traumatic incident/s (Perry & Szalavitz, 2006). The goal of ongoing training, case review meetings, personal development meetings and that all staff be trained in the Child and Adolescent Functional Assessment Scale was to ensure consistency in clinical approaches across program areas. It is a means to guarantee that programs met Child and Youth's commitment of adhering to best practices and practice-based evidence therapeutic approaches.

Child and Youth Services

The goal of the Child and Youth Program is to improve the quality of life for children, youth and their families by providing counselling for mental health and addiction related issues. The services include assessment, consultation, and providing therapy for individuals and their families. The Child and Youth Program is committed to collaborating with community partners,

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and respecting cultural diversity. The program adheres to best practices and practice-based evidence (Mental Health and Addiction Services, 2010).

The Child and Youth Program consist of four distinct program areas:

1. Youth Community Counselling Team

2. Day Program for Youth

3. Young Offender Team

4. Children's Services.

These are distinct and separate program areas. This paper focuses on the Youth Community Counselling Team where I did my practicum. I had little contact with the Day Program for Youth, the Young Offender Team, and Children Services.

The Youth Community Counselling Team

The Youth Community Counselling Team provides multidisciplinary services facilitated by social workers, psychologists, nurses, addiction workers, case managers, outreach workers and a dietician. Staff are located in four sites: Outreach Centre (Avenue P and 20th St.), Youth Resources Centre (311-20th St.), Dube Centre (Royal University Hospital) and 715 Queen Street. Youth 13 to 19 years of age and their families are eligible to receive services. The services include family and group therapy; substance abuse counseling; and parent support groups (Mental Health and Addiction Services, 2010). Family therapy is not a distinct program within the Youth Community Counselling Team, rather family therapy is provided by a group of master's level social workers and psychologists who prefer to work with families based on a family systems model.

Youth and Family Support Program.

The Youth and Family Support Program comes under the umbrella of the Youth Community Counselling Team. This program is a new initiative of Mental Health and Addiction Services. Services are directed for hard to reach children and youth. Based on the Child and Youth pamphlet the Youth and Family Support Program is described as follows. The purpose of the program is to work with community partners to enhance the well being of youth and their families. The goal of the program is to build bridges between people and services, to create individual empowerment and healthier life choices. The program is available to youth between the ages of 8 and 18 with behavioural, emotional and/or addiction concerns. The program was developed for children and youth that have not responded to traditional services but might respond to alternate measure such as intense case management and/or outreach support for stabilization (Mental Health and Addiction services, n.d.).

The role of the Case Management and Outreach Workers is to engage with hard to reach youth. The workers assess and develop case plans that integrate the four pillars of health: physical, social, psychological and spiritual and refer youth to community and residential services. In addition, their role is to consult with those involved with the youth, and to coordinate services and service providers to ensure consistency in planning. The Outreach and Case Management Workers provide support to children and youth that may have multiple needs such as: a lack of response to traditional services, multiple issues, hard to engage, substance use/addiction, trauma, involvement in street gangs, sexual exploitation, lower social-economic status, mental illness, not in school, and little family/community support (Mental Health and Addiction Services, n.d.). Outreach and Case Management workers attended the Youth Community Counselling Team, team meetings and presented case situations that they were

involved with. Some of the therapists and Case Managers and Outreach workers worked with the same individual and/or family. In some situations the Case Manager or Outreach worker might transport the individual/family to the appointment with the therapist.

Staffing

The Youth Community Counselling Team consists of 31 staff or the equivalent of 28.6 full time positions.

Addictions

1-Senior addictions counselor/supervisor located at the Youth Resource Centre

5- Outreach workers located at Ave P

1- Addiction prevention workers located at Ave P

3- Addiction counsellors located at the Youth Resource Centre

1- Addiction counsellor located at Queen St.

2- Urban case managers located at Queen St.

1- Rural case manager located at the Youth Resource Centre

Mental Health

1-PhD Psychologist located at Youth Resource Centre

1.6-M.Ed Psychologist located at Queen St

1-Dietician located at Youth Resource Centre

1-Community Mental Health Nurse located at Royal University Hospital

2-Community Mental Health Nurses located at Youth Resource Centre

1-Senior Marriage and Family Therapist located at Queen St.

2.4-MSW Therapist located at Queen St.

1.6-MSW Therapist located at Youth Resource Centre

1-MSW Sr. located at the Dube Centre

1-MSW Sr. located at the Youth Resource Centre

Referrals

Referrals for the Youth Community Counselling Team come from a variety of sources such as: Public and Catholic schools, Ministry of Social Services, family physicians, child and youth psychiatrists, and from other programs within Child and Youth and self-referrals. The referrals are directed to a centralized intake and assessed for level of risk. The referral then flows to the program manager for assignment and can be assigned in any of the previously mentioned service areas. For non-urgent situations the Family Information Form is mailed to the family. Once the individual and or family have been accepted for service, they are referred to the different program areas depending on the presenting issue and the service request. Urgent situations such as a suicide attempt are immediately assigned to a mental health therapist.

The Family Information Form is a brief two page form that requests the parents' description of the families and/or youth's problem, and past or present circumstances that may be related to the presenting problem. Other information requested includes any other problems the family may be experiencing, the family composition, medical and school history of the youth.

The assigned therapist receives a package of information that includes:

- documentation from the intake unit as to the presenting problem

- the service request

- the completed Family Information Form.

If the situation is rated as urgent the therapist receives the intake information and any collateral information such as clinical notes from the referring agency. After receiving the referral the clinician contacts the family and sets an appointment time.

Additional Services

The Youth Community Counselling Program also provides a number of groups on an as needed basis. Group programs are as follows:

1. **Never Mind**- A support group for teens that have a family member that suffers from a mental illness. The group provides support, information and an opportunity to connect with other youth in a similar situation.

2. **Stomping on Stress** – This is a group for youth that experience anxiety and/or fears. The group provides information, teaches coping skills and the opportunity to share information with other youth.

3. **Battling the Blues**-This is a group for youth coping with depression. Youth learn skills to feel better and have more fun. The group also offers sessions for parents to learn about depression, methods of treatment and ways to assist their youth.

4. **Skills for Anger Management-** This group is for youth that have difficulty understanding and managing their anger. By learning and practicing new skills, group members can make better choices and have fewer hassles with family and friends.

5. **Living with Mental Illness-A Half-Day Workshop for Teens**- This workshop is held in the month of May. It is an opportunity for young people that have a family member or friend with mental illness to meet other youth in a similar situation.

Additional services provided by the Youth Community Counselling Program include treatment for disordered eating. The treatment protocol involves a counsellor and/or a family

therapist, dietician, family doctor and sometimes a psychiatrist. A support group is also available.

In addition, the Youth Community Counselling Program provides a safe and supportive environment for youth who would like to discuss their sexual orientation. Youth can choose individual and/or family counselling.

From April 1, 2010 to March 31, 2011 Youth Community Counselling Program received 437 referrals for youth and their families. They were divided between family therapy, individual and group therapy, community mental health nursing and psychological assessment. These statistics do not include the referrals for addiction related issues as those statistics are maintained by another program area. Statistics are not recorded by referral source, family composition, income or race. The referrals were primarily focused on issues of depression, anxiety, anger management, autism spectrum disorder, eating issues, self-harm, suicide attempts and ideation and trauma.

Family Centered Practice

The family is a long surviving social structure that carriers significant responsibility for emotional economic and physical survival and growth of its members. The Vanier Institute of the Family (2010) defines the family as:

…any combination of two or more persons who are bound together over time by ties of mutual consent birth and/or adoption or placement and who, together, assume responsibilities for variant combinations of some of the following:

- Physical maintenance and care of group members

- Addition of new members through procreation or adoption

- Socialization of children

- Social control of members

- Production, consumption, distribution of goods and services, and

  affective nurturance – love. (p.xii)

Family composition in the last two decades has evolved. The type and size of Canadian families has been changing. The 1981 Census, 55% of the families that completed the census, were married-couple families with children. In 2006 this number dropped to 38.7%. A family grouping that has been increasing in size is the married couple families with no children at home, in part, due to the aging population. The fastest growth is common-law families, increasing from 5.6% in 1981 to 15.5% in 2006. Single parent families, primarily headed by women (80.1%), have increased from 11% in 1981 to 15.9% in 2006. Same-sex couples make up 0.6% of all couple families (Vanier Institute of the Family, 2010).

As stated in the Family Therapy Intern Manual, Child and Youth Services are committed to meeting the emotional needs of children and youth in the context of their family (Child and Youth Services, n.d.). Nicholas (2011) points out the basic premise of family therapy is that the "family is the context of the human problem" (p. 27). The counselling services provided by the Youth Community Counselling Program are based on the family systems strength based approach. Family systems theorists believe that individuals can be best understood by understanding their experience as a member of their family (Murdoch, 2009) and that highlighting family strengths assists the family in having hope that they can solve their own problems (Hanna, 2007).

The basic assertion of a strength based approach in social work is "individuals will do better in the long run when they are helped to identify, recognize, and use the strengths and resources available to themselves and their environment" (Graybeal, 2001, p. 234). To work

from a strength-based approach the therapist and client engage in a mutual discovery of client's strengths and resource. This approach shifts the therapist from a temptation to blame the client, to discovering how the client has coped with the circumstance of their situation. The therapist is not the expert. A final assumption of strength perspective is that all clients, regardless of how desperate their situation may seem, have some resources available to them (De Jong & Miller, 1995).

Family Therapy

Youth and families that are referred for family therapy or family therapy is requested by the family. Families are seen by family therapy mental health therapists, all of whom are educated at a master's level in social work or psychology. The family therapy model integrates structural and solution-focused family therapy. Families are also provided the opportunity to be involved with the reflection team as part of their therapy. The Outcome Rating Scale and the Session Rating Scale are incorporated in the sessions.

In this section I will describe some of the key elements of family therapy used by the Youth Community Counselling Team. Then I will focus on structural family therapy, solution-focused therapy including reflection team, followed by discussion of the Outcome and Session Rating Scales.

Within the family systems approach there are a number of models of family therapy. However, there are some key elements that exist across all models. Systems theorists use the term circular causality to describe their perception of family interaction. Who started the interaction, is immaterial (Murdock, 2009). Families typically come to therapy blaming a family member for the family problem. Circular causality suggests the family problems exist over time due to an unending series of actions and reactions by family members, not just the actions of one

of the family members (Nicholas, 2011). This concept is frequently observed when one observes a family interaction that repeats itself without resolution.

Another concept that is common to family system therapies is triangulation. Triangulation is a grouping of any three family members whereby a third family member is brought in to cope with the tension and conflict between the two of them. In Murdoch's time the most common triangle was the mother-father-child. As family structure has changed, considering same-sex parents and single-parent families, the triad could consist of a number of combinations; mother- step-mother-child, father-step-father-child, mother-significant-relative-child, father-significant relative-child. The triad is the main learning arena for the child. Within this triangle, the child learns how to cope with the outside world, how relationships work, and about communication (Murdoch, 2009).

> The fact that the family members engage in repetitive interactions that bring about the same unsatisfactory result is an indication of the intense anxiety that motivates their behavior. In addition, this anxiety leads to a process of *triangulation,* in which one person enlists the support of another person against a third party in the family. (Hanna, 2007, p. 15)

The third party is the family member who is viewed by the family as causing the problem. This is also known as scapegoating. A spousal couple may comment that if their child changed their behavior their relationship would improve, blaming the child for their marital difficulties.

Another common concept is that of family boundaries. Family structure is concerned with the interactions of the individuals within the family and these interactions determine how the family is organized. All families are hierarchically arranged in various systems and subsystems. Boundaries separate the various systems. Boundaries describe which family

members interact and how often, and symbolize the intimacy of family "relationships on a continuum (i.e., too close, balanced, or too disengaged)" (Hanna, 2007, pp. 10-11). Rigid family boundaries limit contact outside of the family system resulting in disengagement. Disengagement facilitates independence but limits nurturance (Nicholas, 2011). Enmeshed subsystems have diffuse boundaries that offer support but at the cost of limiting independence (Nichols, 2011).

The family life cycle is based on the concept that families progress through transitions over the course of time. The following is a summary of Hanna's (2007) discussion of family life transitions stages.

1) The first task is for couples to solidify their relationship by prioritizing their relationship over extended family and friends. If this task is not negotiated successfully, conflict with extended family can be chronic.

2) The second stage task for families that choose to have children is that parental roles are established and relationships with extended families members are renegotiated to accommodate grandparents, aunts and uncles.

3) The third stage is when one of the children reaches adolescence. The parent's task of negotiating with the adolescent may also be at a time when they may be facing midlife decisions. Ideally the parents and adolescents negotiate to gain independence from one another.

4) The fourth stage is the stage at which marital relationship needs to be renegotiated as the parents are now alone as a couple. The parents must also develop adult relationships with their children.

5) The fifth stage, the later-life stage, is the point when adults are dealing with aging, related health issues and loss of a spouse or parent from death (p. 68).

Although family life transitions are presented as progressive stages, Nicholas (2011) makes the point that there is no established course of the life cycle in that families are not all the same. For example there are blended families, same sex families, traditional families consisting of two parents and children and various other forms. The significance of the life cycle concept is that families often struggle during transition stages and problems develop at these unresolved transition points (p. 67).

Youth Community Counselling Program Therapeutic Strategies

The Youth Community Counselling Program is family focused utilizing an integrated systemic model that incorporates structural and solution-focused family therapy. Other models are used depending on the family, the presenting issue and the skills of the therapist. With the key concepts of family therapy in mind, the family therapy models of Structural Family Therapy and Solution-focused Family Therapy will be examined in more detail.

Structural Family Therapy

Structural family therapy was developed by Salvador Minuchin when he worked with families in a slum area of Chicago. A primary contribution of structural family therapy to family therapy is the focus on family structure (Nicholas, 2009).According to Hanna (2007) Minuchin believed that a family's structure needed to be modified at the different stages of the family life cycle to help the family adapt to change. Minuchin used the concepts of hierarchy, boundaries, subsystems and coalitions to describe the family structure. The subsystems of the couple, parents and siblings are key elements to understanding the functioning of families. If the parental subsystem deteriorates, the family is unable to meet the developmental needs of the other family members.

Family members form into subsystems and the various subsystems assist in the completion of family tasks, such as the parental subsystem to parent their children. Subsystems can also be formed based on gender, age, common goals and common interests. Based on structural family therapy the concept of boundaries determines who participates in the various subsystems. The purpose of the boundary is to defend and define the integrity of the subsystem. The boundary of the subsystem should be clear to family members, but also flexible. A rigid boundary creates isolation and limits the family member's access to the protection and guidance of other family members. Diffuse boundaries can lead to the subsystem becoming overwhelmed (Murdock, 2009).

Based on structural family therapy, the family structure needs to change as the family moves through life transitions. Transitions can be either internal such as one of the children reaching adolescence or external to the family such as a job change (Nicholas, 2011). The cultural context of the family needs to be recognized: middle class, working class, rural, urban, Aboriginal and Immigrants. For example, Immigrant families have to adapt to a new culture, learn a new language, laws, norms of behaviour and often struggle with employment. These are factors that could significantly impact a family's ability to adopt to change (Vanier Institute of the Family, 2010). Based on my professional experience of working with Aboriginal families, both in rural and urban settings, residential school and assimilation policies and practices of earlier governments have greatly damaged and weakened the traditional Aboriginal family structure. Thereby reducing Aboriginal families' ability to manage life transitions as well as the social, economic and political forces that influence their cultural context.

Healthy family boundaries help families adapt to change while families who are less adaptive "increase the rigidity of structures that are no longer functional" (Nicholas, 2011, p.

127). In disengaged families boundaries are rigid and closed. Family members are unable to reach out for support. In enmeshed families boundaries are diffuse resulting in individuals becoming dependent upon one another and limit the independence of the family members. For example, a disengaged family may not recognize their depressed youth, and in an enmeshed family members will interfere with the normal development of their youth such as making friends outside of the home (Nicholas, 2009). Structural family therapy views the symptoms (problems) of a family member as result of structural difficulties (Hanna, 2007).

The goal of structural family therapy is structural change by assisting the family in adjusting boundaries and reorganizing subsystems. Families have common needs in their structure and subsystems such as hierarchy, parents being in charge (Nicholas, 2011). The therapist actively joins with each family subsystem by acknowledging their perspective and emphatically supporting family members. In traditionally structural family therapy, the therapist acted as the expert in this approach and actively devised strategies to help the family adapt its structure. The therapist was seen as having knowledge and skills to assist the family by facilitating process that would bring about change. It is the therapist's task to help the family to see their world in a different way by changing family structure (Murdock, 2009). With families that are enmeshed the goal is to strengthen the boundaries around the subsystems and assist individual family members in differentiating from each other. With disengaged families the goal is to increase individual interactions by diffusing the boundaries separating the subsystems (Nicholas, 2011).

Minchin's model of structural family therapy was initially developed for families living in poor urban communities. The impact of social and economic influences on family functioning was acknowledged, however, the primary intervention was with the family (Frankel & Frankel,

2007). The roots of social work are imbedded in social change and social justice. The primary focus of the intervention being with the family, in part, limits social work from being advocates of social change. Social work has a dual role, to assist the family and to advocate on behalf of the family for change in the social structure.

Solution-focused Family Therapy

Insoo Kim Berg and Steve de Shazer were the primary developers of the solution-focused family therapy. A solution-focused therapists' view of an individual's problem is not that of pathology but sees problems as a result of clients' failed solutions in solving the problem, resulting in clients having a narrow view of the problem. The family gets stuck on the past and their failures in resolving the problem. The role of a solution-focused therapist is to move clients from problem talk to solution talk. "Usually, problem talk is negative, focuses on the past, and implies permanence of problems" (Nicholas, 2011, p. 249). Rather than focusing on what is wrong, strategies are developed to resolve the problem based on the client's strengths and resources. The client is the expert and the therapist assists the client in highlighting times when the problem has not been present. As Berg and Miller (1992) suggest

> If one accepts the premise that healthy patterns already exist but have simply gone
>
> unrecognized, then capitalizing on such patterns should lead to solutions without having
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> to go through the traditional process of discovering the problem and *then* developing a
>
> solution. (p. 4)

The solution-focused therapist does not view individual problems as a result of family dynamics, nor do they view the family as dysfunctional. The solution-focused therapist believes that there is no right or wrong way to live. Family problems are viewed "not seen as evidence of failure to achieve some adaptive standard but rather as normal life-cycle complications"

(Nicholas, 2011, p. 249). The concept of there is no right and wrong way to live, and not defining the family as dysfunctional appears to be an approach that is accepting of cultural diversity and the potential impact of the culture the family lives in.

Strategies for Change in Solution-focused Family Therapy

Unlike structural approaches, solution-focused therapy does not attempt to change family structure. It is an ahistorical approach therefore the history is not assessed. The entire family does not have to attend sessions, only those members that are concerned about the issue. Little intake information is required as the client's view of their problem is the initial focus of therapy (Nicholas, 2011).

The activity of moving the clients towards a solution is accomplished by helping the client elaborate on what has worked in the past. This approach moves toward solutions by focusing on times when the problem was not present and exceptions when the problem has not occurred. The purpose is to highlight the client's and therapist's awareness of the client's strengths. Therapeutic goals are stated in the client's language. The goals are small and realistic to ensure that the goals are achievable. Success is measured by concrete behavioural changes. Goals are viewed by changing behaviour rather than elimination of behavior (De Jong & Miller, 1995). In other words, focusing on past successes, measuring success in small behavioural steps and in the clients' conceptualization of what needs to change.

Exception and Coping Questions

Exploring times when the clients did not have the problem assists in recognizing possible solutions. The more recent the exception, the more likely the exception could occur again. By exploring the exceptions with clients and families it helps the family identify what was unique

about that time, how to expand on the exception and feel more hopeful for the future. If there

does not appear to be any exceptions then coping questions can be used to help the client

recognize their resourcefulness; "What keeps you from going under such difficult

circumstance?" (Nicholas, 2011, p. 254). With multi problem families it can be difficult to access

exceptions.

A technique used to shift from problem discussion to solution discussion and potential

solutions is the use of the miracle question.

Suppose while you are sleeping tonight a miracle happens. The miracle is

that the problem that has you here talking to me is somehow solved. Only you don't

know that because you are asleep. What will you notice different tomorrow morning that

will tell you that a miracle has happened? (De Jong & Miller, 1995 p. 731)

The miracle question sets the stage for a series of questions that will assist the client in choosing

behaviours that expand on exceptions and build solutions. The questions assist the client in

developing an expectation that change can occur, and the goals in which to direct their energy.

DeJong and Miller (1995) suggest the following questions to help clients develop in detail what

would be different in their life if the miracle occurs:

What is the very first thing you might notice after the miracle happens?

What might your husband (child, friend) notice about you that would give him the idea

things are better for you?

When he notices that, what might he do differently?

When he does that, what would you do?

And when you do that what will be different around your house? (p. 732)

Individuals view and react to others in a reoccurring pattern; they get stuck. The miracle question assists the individual in shifting their perception and hence their reaction. I found the most effective use of the miracle question was with parents that were coming in on their own, and were stuck in a conflict relationship with their teen child. The introduction of the miracle question assisted the client in recognizing shifts in their behaviour they could make that would change the circular pattern of the interaction.

Scaling Questions

Scaling questions are a solution-focused technique used to assist the client and therapist to recognize change and focus on what the client did to facilitate the change regardless of how small the change is. Nicholas (2011) provides the following example.

> The therapist asks the depressed client, for example, "On a scale of one to ten, with one being how depressed you felt when you called me and ten being how you feel the day after the miracle, how do you feel right now?"
>
> The client might say two and the therapist might say, "So you feel a little better than when you first called. How did you achieve this improvement?" (Nicholas, 2011, p. 255)

I found the scaling questions particularly helpful in assessing change in conditions such as depression and suicide ideation because symptoms are often difficult for clients to express. Utilizing scaling questions over a series of appointments assists both client and therapist to recognize change or lack thereof.

Types of Clients

Assessing client motivation for change is important in solution-focused therapy. Nicholas (2011) describes three categories of clients that were originally conceptualized by Insoo Berg.

1. Visitor - Visitor clients are people who have been sent for counseling by an authority figure, but they have no interest in change (p. 251). In the Youth Community Counselling Team the visitor was typically a youth sent by a parent or the school. A helpful strategy with the visitor is to ask a question of what they need to do to satisfy the person that sent them: What is the least you have to do to not have to come back here again? This strategy might reduce their resistance to the counseling and move them from a visitor to a customer. An additional strategy I employed was to contact the referring parent and request that they attend at least one session to explain their perception of the problem. In one situation, the mom, having initially referred her son, became the customer and the child refused to attend counselling. The mom was then able to explore behariour changes in her parenting style, to reduce the conflict with her son.

2. Complainants - Complainants are individuals who have complaints about someone else they believe is the problem. In this type of situation a useful strategy is to suggest to the client that they watch for exceptions in their youth's behaviour. The therapist does not challenge the client's perception of who they believe to be the problem but attempts to shift the client's perception of what they parent might do differently in response to that person. An example is asking What do you need to do, so your son will be easier to live with (Nicholas, 2011, p. 251)? In the case of the Youth Community Counselling Team it is usually a parent complaining about their youth and the parent may not see themselves as part of the problem or solution, they want the therapist to make their child change.

Again, I would contact the parent and request a session with the parent. In dealing with a

mother-daughter conflict situation, I saw them together for a short time and then

requested that the mom attend counselling on her own, as the daughter did not appear to

be instigating the conflict. Mom quickly became a customer as we explored her issues

and her experiences in her family of origin were spilling over into her present parenting.

3. Customers - Customers are individuals that have a clear complaint and are ready for

change.

The purpose in the differentiating client types is that by engaging the visitor and complainant in a

solution-focused conversation, they may become a customer (Nicholas, 2011, p. 252). None of

the client group that I was assigned presented as customers, however by keeping these concepts

in mind, I was able to assist some of the clients in becoming customers.

Coping and Compliments

Many clients view their live as extremely difficult, see little hope for improvement and

are not able to recognize any value in their present situation (Iveson, 2002). Compliments

acknowledge what a client is doing that is working. An example is to ask a question like, "What

type of work have you done?" rather than "Have you ever worked" (Nicholas, 2011, p. 257) By

showing approval by a asking a question such as " Wow! How did you do that?" assists the client

in recognizing that they are doing some things that are working. By asking such a question the

therapist is engaging the client to self-compliment by answering the question (Dolan, n.d.). The

concept of compliments helped me to phrase questions from a position of expecting exceptions

to the client's experience.

Youth Community Counselling Team-Reflecting Team

Another technique of solution-focused therapy utilized by the Youth Community Counselling Team is the reflecting team. The team can be utilized at the intake interview and/or later in therapy to assist a therapist, when the therapist believes no progress is being made with an individual or family. Johnson, Waters, Webster, and Goldman (1997) describe the original reflecting team model as the consulting therapist conducting a standard solution-focused interview, with a team of therapists behind the mirror. The consulting therapist would take a break after 40 minutes, consult with the team and return to the family with a message and task to be delivered to the family at the end of the session. Johnson et al. (1997) stated that their team had followed this model for several years and found a series of issues that were limiting the impact of the process. A visiting team of therapists introduced the concept of the team switching places with the consulting therapist and the family. The consulting therapist and family then observe the team and their observations of the family (Johnson et al.).

The Youth Community Counselling Team has adapted this model in use of their reflecting team. The reflecting team meets monthly with a rotating therapist (consulting therapist). The therapist brings a family or individual to meet with the team. The team typically is made up of five other therapists from the Youth Community Counselling Team and the consulting therapist. The consulting therapist and the team meet for 30 minutes prior to the reflecting team session which gives the consulting therapist the opportunity to describe the family and the presenting problem. The consulting therapist and the team discuss and develop the possible directions for the session.

The consulting therapist then conducts the interview with the reflecting team watching from behind a one way mirror. A member of the team might interrupt the session, by knocking

on the door, to request the therapist to focus on a missed area or clarify an issue. After the session is completed the team and the consulting therapist and family switch places, with the team now in front of the mirror and the family watching. The team introduces themselves and begins to make statements that support the families' struggle. The team then engages in a solution-focused therapeutic discussion based on the information that has been brought forth in the session. When the team feels the therapeutic material has been presented, the team and the family and the therapist again switch places with the team again observing. The family now has the opportunity to reflect on what has been stated.

The rules for the reflecting team are as follows:

1. Comments by the team are restricted to what the family and therapist have stated in front of the mirror.

2. The team should limit discussion amongst themselves while the session is in progress.

3. The comments are nonjudgmental, confrontational or critical and must be based on the present and future.

4. The comments are made using tentative language, such as "I am curious about,"

5. It is important to comment on each family member.

6. Team members when presenting their feedback to the family should respond to each other and maintain eye contact with each other.

7. Gentle humor is encouraged.

8. Team members should not make comments that take away from another's team members' comments but rather constructively contrast another team members comments. (Johnson et. al, 1997, p. 54)

I was the consulting therapist on two occasions and a team member on two occasions during my internship. I utilized the team with one family for the intake interview and with another family when I felt that little progress was being made. I will expand of the reflecting team experience when I discuss the direct practice.

Integration of Structural and Solution-focused Family Therapy

On the face, the two models seem in opposition to each other. The basic premise of structural family therapy is that healthy families can accommodate change by adapting the family structure, and less adaptive families do not. Family change requires a shift in the family structures to accommodate change. Structural family therapists clearly state that the source of the problem is the wider social, economic and political context the family lives within. The therapists' role is to assist the family in managing life transitions in the midst of challenges occurring in the wider society. In solution-focused family therapy the client is assumed to be the expert of their own life and family problems are not seen as failure to adapt but as a "normal life-cycle complication" (Nicholas, 2011, p. 249). The role of the therapist in solution-focused approaches is to shift the family toward solutions. Murdock (2009) makes the point that solution-focused therapy is "more a theory of counselling than a theory of human nature" (p. 469). One would assume that solution-focused therapy would facilitate therapists working for a shorter term with families.

I attempted to integrate the two models by using the concepts of structural family therapy to assess the family structure and utilized solution-focused family therapy to inform my

interventions. Solution-focused family therapy was the best fit for me clinically as I have historically worked from the premise that we as individuals have the answers within us, and the role of the therapist is to assist individuals in accessing their solutions. I do not live their life; therefore I cannot be an expert in how their life should be lived.

Based on the case discussions in the bi-weekly team meetings it was apparent that Youth Community Counselling Team family therapists incorporated different therapeutic techniques depending both on their training and the family situation they were dealing with. Nicholas (2011) terms the utilization of different therapeutic techniques as "Selective Borrowing" (p. 284). "To borrow selectively, you need to a solid foundation in one paradigm" (p. 284). The family therapy group is well grounded in the family systems theory. What is consistent across the therapists was the use of the Outcome Rating Scale and the Session Rating Scale.

The Outcome Rating Scale

The Outcome Rating Scale is introduced at the beginning of each session and asks the client to comment on how they had been feeling on the four scales over the last week. In the first session the client is asked to reflect back on the last 2 or 3 weeks. Often just by making the appointment for counselling, the client can experience a reduction in their distress. The expansion of the time frame will provide a more accurate presentation of the client's level of distress.

If the session was with a parent and/or parents and youth, the youth would complete the Outcome Rating Scale for just themselves. The parent/s using two different colors of ink could use one color mark to represent them and another color mark to represent their perception of the youth. The Outcome Rating Scale measures three dimensions, individual well-being (symptoms of distress) personal well-being (clients relationship with intimate others), and satisfaction with

relationships outside of the home (at work and or school). Changes in these dimensions early in the counselling process are valid indicators of a successful therapeutic outcome. The scale includes these three dimensions as well as a fourth, overall sense of well-being. Most clients experience change in the first six sessions, those that do not show change in that time period, tend not to show change throughout the counselling process or terminate from counselling. Change in the first sessions, is an indication of commitment to the counselling process and a likelihood of a positive outcome (Duncan & Miller, n.d, pp.1-3). The Outcome Rating Scale is a reliable and valid tool to measure client change early in the therapy (Duncan, Miller, & Sparks, 2004). Another important component of a positive therapeutic outcome is the therapeutic alliance.

Therapeutic Alliance

The therapeutic alliance is defined as a reciprocal relationship between the therapist and client. It is considered an essential contributing factor of an effective outcome for the client. The therapeutic alliance is believed to influence the positive therapeutic outcome across an array of therapeutic techniques (Krupnick, Sotosky, Elkin, Simmens, Moyer, Watkinns & Pilkonis, 2006). Duncan et al. (2004) describes the therapeutic alliance as having three interacting components: the development of an attachment between client and therapist, agreement on the goals and an agreement on tasks of the therapeutic process. The Session Rating Scale facilitates conversation between client and therapist about the relationship with the goal of addressing any issues in the helping relationship.

The Session Rating Scale

The Session Rating Scale is used at the end of each session and "translates what is known about the alliance into four visual analog scales" (Duncan & Miller, n.d., p.4). The client places a mark on an analog 10 cm line from 1 to 10. The first scale is the client therapist relationship which measures whether the client felt heard and understood. The second scale measures the client's goals and whether they felt the goals were focused on or not. The third scale measures the clients thoughts about the approach and the fourth scale measures the clients overall satisfaction or not with the session. The scores of the four scales are totaled. A Session Rating Scale score that falls between 0 and 34 reflects a poor alliance, 35 to 38 reflect a fair alliance and a score in the range of 39 to 40 is a good alliance (Duncan & Miller, n. d., p. 4). The Session Rating Scale is introduced towards the end of the session, to allow for discussion time and the client is asked to comment on the four areas for the session.

Personal Observations of the Outcome and Session Rating Scales

The Youth Community Counselling Team meets bi-weekly to discuss cases. Frequently cases that are brought forward are ones situations that have gone passed the 6 sessions. These cases were quite complex often involving childhood trauma from abuse and deep seated problems. A few of the clinicians noted that youth around the age of 13, appeared to lack interest in scoring the Outcome Rating Scale or deliberately scored the scale high to indicate they are showing change, in other words, falsifying the results. The use of the Outcome Rating Scale and the Session Rating Scale is relatively new for this agency and staff are assessing the scales effectiveness with various types of client groups. The most positive aspect of the two scales is that they are short and take only minutes for clients to complete and have good reliability and validity (Duncan et al., 2004).

I found the utilization of the Outcome Rating Scale and the Session Rating Scale helpful in facilitating discussion with clients about their level of distress and in defining their goals for therapy. By utilizing the Outcome Rating Scale in the initial session it was easy to assess the client's level of distress and in what dimensions they were experiencing the most distress. By graphing the results over sessions, it visually assisted both myself and client in recognizing change and facilitated a basis for conversation about change between the therapist and family or individual client. In addition, the Session Rating Scale helped facilitate discussion about the client's goals and if these goals were reached in that session, plus provided an assessment of the therapeutic alliance.

The concept behind the Outcome Rating Scale is that if some change is not shown by session 3 and if no change by session 6, there is a high likelihood of a low therapeutic outcome for the client. If change has not occurred at these points and most specifically after 6 interviews alliance problems may be contributing to the lack of change. If there is no change at the end of the sixth session it means a change in the intervention is required. This change could mean bringing in another family member, use of reflecting team or a referral to another therapist (Duncan & Miller, n. d.).

In mental health settings

measures that are easy to integrate into treatment and have face validity encourage a partnership between the client and the therapist for monitoring the effectiveness of services. Accountability becomes a joint endeavor, integral to alliance building rather than simple more paperwork. (Miller, Duncan, Brown, Sparks & Claud, n. d, p. 16).

Mental health research by Duncan et al. (2004) has shown the resources that the client brings to the therapeutic process account for 40% of the therapeutic outcome; the therapeutic alliance

accounts for 30% of the change; the client's expectations account for 15% of change; while the therapeutic technique accounts for 15% of the change.

From this, one can see that the resources that the clients bring to therapy and the therapeutic alliance formed with the therapist are key factors to a positive therapeutic outcome. The technique or model of therapy plays a lesser role. To be precise, Duncan, Miller, Sparks, Claud, Reynolds, Brown and Johnson, (2003) propose that the amount of client change attributed to the therapeutic alliance is approximately seven times that of the model or technique. These are interesting outcomes when one considers that most clinical social workers spend much time learning techniques when the benefits are derived from a good therapeutic relationship with our clients. It is apparent that time is better spent developing a good working relationship with clients and families. The concept of therapeutic alliance takes social work back to basic principles of being non-judgmental and encouraging and supporting client self-determination.

Relationships

The practices that build the relationship between the mental health therapist and the youth and family begins with the therapist making the first phone call to the family. Reviewing the Service Agreement and the Privacy Notice with the clients in the first appointment helps build trust and the relationship between the therapist and clients. The use of the Outcome Rating Scale at the beginning of the session provides family members with an opportunity to assess their level of distress in a non-invasive manner. The Outcome Rating Scale also provides the therapist with a beginning opening statement. The Session Rating Scale provides the family members with a nonthreatening means to state their thoughts about whether they were listened to and provides the therapist with insight as to how the client feels the session went. The scales assist the therapist and client to recognize if the therapeutic change is happening and provides a

mechanism to engage in conversation if change is not taking place. The Session Rating Scale provides the means to assess the therapeutic alliance. All of these are activities that enhance client therapist relationships.

There are 31 staff in the Youth Community Counselling Team. Relationships between staff are built by dividing the staff into two teams. The teams meet regularly with their team members to review cases. Team members support each other in working with difficult situations by group case consultation. Opportunity is provided for members to connect on a personal basis and a sense of humor is appreciated. Personal development training meetings are held monthly and involve both teams.

The reflecting team is made up of family therapists and outreach workers that choose to be a member. The consulting therapist position, the therapist that brings the family to the team, rotates so that each team member has an opportunity to be the consultant. Being the consultant therapist with the team assisted me in feeling more of a team member than any of the other team building practices. It is a process where I felt the support and acceptance of the team. The process is supportive both for the consultant and the family.

Clinical Supervision

Using new therapeutic approaches requires time to learn the new skills; access to ongoing training; and supervision to assist the clinician in integrating the new skills. To assist me as an intern in the Youth Community Counselling Program, I was provided with clinical supervision from an approved American Association of Marriage and Family Therapy (AAMFT) supervisor which was a great benefit in integration of this model of practice. I was provided two hours of supervision per week. The format of the supervision involved the following:;

- A review of taped counselling sessions.

- A review of the Outcome Rating Scale and the Session Rating Scale.

- Learning to conceptualize assessment in terms family dynamics from a structural solution-focused family therapy model.

- Assistance in developing the interventions.

Profile of Assigned Clients

The following is a brief description of the youth and families I was assigned. The client profile with respect to income, race and family composition of my caseload may not be representative of the population that receives services from the Youth Community Counselling Team.

1. Referral Source-Mother

Presenting Problem-Daughter, age 15 acts out when does not get her way.

Family Composition-Blended family. Caregivers moved in together in the last month.

Employment Status-Both parents work. Self-described as low income.

Service Request-Family Therapy

2. Referral Source- Kids First and Ministry of Social Services.

Presenting problem-Thirteen year old daughter returned home from foster care. Reported behavioural issues, lies, steals, violent in the home and has been diagnosed with Oppositional Defiant Disorder, Attention Deficient Hyperactive Disorder and a sleeping disorder.

Family Composition- Blended family. Mom has 4 children from 3 previous relationships and. 2 children age 1.5 and 2.5 from present common-law relationship.

Employment Status- Male partner works, mom stays at home.

Service Request- Family Therapy

3. Referral Source- Addictions Worker that had contact with youth at school.

Presenting Problem-15 year old son wants to talk to someone regarding anger and depression.

Family composition- 19 year old adopted son. 15 year old son from marriage.

Employment Status- Dad full time employed. Mom part time.

Service Request- Family Therapy

4. Referral Source- Family Doctor

Presenting Problem- 12 year old boy with a history of behaviour problems in school and yelling

matches with mom and indicators of self-harm thoughts.

Family composition- Two siblings 12 year old male and 18 year old sister.

Employment Status- Mom works full time, dad starting a business.

Service Requested- Family Therapy

5.Referral Source- Addictions Worker

Presenting Problem- 14 year old adopted son, associating with a negative peer group and drug

use. Concern that stress will impact mom's health (cancer in remission).

Employment Status- Both parents work full time.

Service Requested- Family Therapy

6. Referral Source- School Counsellor

Presenting problem- 17 year old female diagnosed with depression and prescribed medication by

family doctor.

Family composition- 19 year old son working and 17 year old female attending grade 12.

Employment Status- Both parents work full time.

Service Request- Family Therapy

7. Referral Source- Child psychiatrist

Presenting Problem- 13 year old attempted suicide in the family home.

Family Composition- 13 year old son and 9 year old daughter.

Employment Status- Dad works full time, mom full time student.

Service Request- Family Therapy

8. Referral Source- Addictions Counsellor

Presenting problem- 16 year old male on youth probation for arson.

Family composition- Biological family with one 16 year old son

Employment Status- Mom and Dad work full time.

Service Request- Family Therapy

9. Referral Source- Mother

Presenting Problem- 16 year old son's marijuana use.

Family composition- Biological mom and 16 year old son. Lone parent home.

Employment Status- Mom works full time.

Service Request- Family Therapy

10. Referral Source- Ministry of Social Services

Presenting Problem- 14 year old male in foster care.

Family Composition- Foster Care

Service Request- Individual

11. Referral Source- Ministry of Social Services.

Presenting Problem- 15 year old female in foster care, abandonment issues.

Family Composition- No contact with family.

Employment Status- Student

Service Request- Individual

12. Referral Source- Mother

Presenting problem-17 year old violent with peers.

Family Composition- Bio mom, step-dad, twin sisters age 12.

Employment status- Both parents work.

Service Request- Individual

Of the 12 referrals, 9 were from a professional person and 3 were from a family member. The 2 individuals referred were Aboriginal youth living outside of the family home. They did not attend counselling. The remaining 10 referrals were non-Aboriginals and there were no referrals for persons that had immigrated.

Examples of Direct Practice

The following are case examples from the caseload that I was assigned to exhibit how I incorporated the structural solution-focused family therapy skills in my clinical work. I chose three dissimilar family situations to demonstrate different elements of structural solution-focused family therapy. Pseudonyms have been used to identify the family members, to ensure confidentiality.

Family #1

The following is an example of a multi-problem, complex family that will require long term family therapy. This example highlights how the reflection team can be utilized when the therapist feels stuck or to facilitate a transfer to a new clinician. In this example I do not address the use of the Outcome and/or Session Rating Scale. Both the mother, Sue and the child, Jill completed the scales but did not seem to understand the purpose for the use of the scales.

The Saskatchewan Ministry of Social Service and Kids First referred Sue (mother) and Bill (common-law partner) to the Youth Community Counselling Program for family therapy.

Sue and Bill are in their 30's. Sue has 4 daughters, Jill age 13 and three other daughters aged 12, 10 and 6 years old from three previous relationships. Sue and Bill have 2 sons aged 2.5 and 1.5 years. Sue and Bill knew each other as teenagers and have been in a common-law relationship for 3.5 years. The family had moved to Saskatchewan from another province.

Both the Ministry of Social Services and Kids First noted that Jill's behaviour limited Sue and Bill's ability to care for the younger children as Jill reportedly has lied, stolen from her mother, hoarded and hid food and displayed sexualized and aggressive behaviours. It was reported that Jill was diagnosed with Attention Deficit Hyperactive Disorder and Oppositional Defiant Disorder; however no psychiatric or psychological reports were available.

The first issue was that both the Ministry and Kids First appeared to identify Jill's behavior as the problem in the referral information. Assessing this family from a family systems approach the referral would suggest that Jill's behaviours were a result of her being impacted by the stress in the parental subsystem; the fractured family relationships from being in foster care; and the lack of a good relationship with the mother's common-law partner, Bill.

In clinical supervision I completed a family genogram based on the file information to gain an understanding of the family dynamics, more specifically to determine which children had been born to which fathers and find out where and who the children now lived with. Prior to supervision, I obtained additional information from the initial phone call with Sue. The mother Sue, reported that Jill had recently hit Bill with a hockey stick. A hypothesis was not initially developed in clinical supervision as more information was required.

In the first interview with Bill and Sue, I completed the necessary forms including a release to share information with the Saskatchewan Ministry of Social Services and obtained a brief history from Bill and Sue. Sue stated that Jill had been placed in a psychiatric ward at age

5. In November 2008 all the children were apprehended in their home province because of concerns of neglect. The 2.5 year old son was apprehended at birth for the same concerns. Following this apprehension, Bill and Sue reported that they had threatened a law suit against Manitoba's Ministry of Social Services. The result of the threatened law suit was that the 12 and 10-year-old girls were returned from foster care and placed in the custody of their step-father in Manitoba. These girls were not returned to the mother, Sue. The other four children were returned from foster care to live with Bill and Sue in Saskatchewan. Manitoba Social Services did not provide information as to why the children were apprehended or the resulting placement of the children

Bill stated that he had been raised in foster care but provided few details. He indicated it was not a good experience. Sue acknowledged that she drank alcohol when pregnant with Jill, prior to realizing she was pregnant. Sue stated that her mother had used alcohol and drugs during the pregnancy with her. The first contact with the daughter Jill, was at the Dube Centre, the psychiatric wing of the Royal University Hospital. Sue requested Jill's hospitalization because she was concerned about Jill's safety and her behaviours. I was concerned that Sue and Jill may have neurological deficits related to Fetal Alcohol Spectrum Disorder that may impact the therapeutic process.

Hypothesis.

In clinical supervision it was hypothesized that the hoarding of food, hiding things and the stealing, combined with the placement in foster care suggests the possibility of attachment issues and/or problems related to fetal alcohol syndrome effects (FASD). The fact that Kids First was involved suggested Sue had limited parenting skills or was overwhelmed caring for 4 children at different developmental stages, or that she was having difficulty managing changes in

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the family, the return of the children from foster care and the birth of two more children. There were several unanswered questions regarding Bill and his role in the family and how he felt about Jill's acting out. My questions were: What was it like for Sue to have the children in foster care, how does she find time to reconnect with the two girls that had been in foster care? Is this a stressed parental subsystem that is triangulating Jill? Or is Jill difficult to handle due to mental health illness or due to Sue's use of alcohol during pregnancy or due to the parent child relationship fracture from foster home placement. Any one of these factors would impact Jill's ability to control and change her behaviour.

Structurally the initial plan was to work with Sue and Jill together to assess and enhance their relationship based on the ruptured relationship hypothesis. In my initial session with Sue and Jill it was apparent that there was structural damage to their relationship from the foster home placement.

In the second interview I met with Sue and Jill together initially, then with each of them separately and then together at the end of the session. This was a structural strategy to reduce the mother-daughter conflict, yet gain some insight into their relationship and their ability to change. The next structural move was to work with Sue and Bill alone to assess their relationship and to reduce the triangulation of Jill. As well as, I intended to continue to work with Jill individually to assess her ability to change; to assess her role in the conflict; and to develop a therapeutic alliance.

The session with Sue and Bill confirmed that the parental subsystem was struggling and they had closed and rigid boundary, cutting them off from the community. The family had no friends or support system outside of the family and resisted any outside involvement such as respite care for the children. Bill acknowledged using marijuana on a daily basis and said he was

experiencing withdrawal. He was not using because he could not afford to purchase marijuana, due to the family's financial difficulty. Bill had just started a new job and Sue was a stay at home mom. His withdrawal symptoms included angry outbursts, and a low tolerance for Jill's behaviour. Sue was overwhelmed with Bill and Jill's conflict as she felt she was stuck in the middle. They argued frequently and pushed each other's buttons. Sue and Bill stated that Jill would not complete her household tasks and was disrespectful to the Bill by swearing at him. The more chaotic the family system became the more options I suggested, the more closed and self-protective the system became. Bill discontinued counselling because he was missing work as the family finances were desperate. However I continued to have sessions with Sue and Jill.

In the first few sessions with Jill she said little, refused to sit in the camera's view and complained about having to come to counselling sessions. Consequently Sue, her mom, had to fight with Jill to bring her to sessions. As the therapeutic relationship developed between Jill and myself, she stated she looked forward to the sessions and even walked from school to attend the sessions on her own. I used a solution-focused perspective to develop the primary intervention with Jill. She played hockey and when she was on the ice, she controlled her behaviour, which was an exception to her behaviour at home. We developed a hockey metaphor that helped Jill expand on the positive behaviours at home to reduce her conflict with Bill and Sue.

It became clear as I worked with the family that the parental subsystem was filled with anxiety and that Jill's behaviour was mainly due to being triangulated by the parents; "If she would put away her stuff and do the dishes, Bill wouldn't react." Jill's school further confirmed this because she exhibited none of the problematic behaviours that she displayed in the family home while in school; keeping in mind that she attended a structured school that was developed for slow learners.

Because Bill did not attend counselling, the ability to work with the parental subsystem was limited. As a solution-focused strategy I complimented Sue on her commitment to her children, her ability to handle stress and her commitment to counselling displayed by her regular attendance. The intent of the compliments was to highlight her successes and increase her motivation. The family remained intact but it was obvious that therapy needed to be long-term commitment and this family would need to be transferred to another therapist, given that I had less than two months remaining in my internship.

The solutions were limited and in some of the sessions I felt therapeutically stuck. I asked Sue to attend a session with the reflecting team and she agreed. My purposes were to introduce her to the team, so that the team would be aware of her situation so as to facilitate the transfer to a new therapist; for Sue to hear from a group of therapists, several voices are more empowering than one; and me to obtain some therapeutic direction from the team in my work with her.

Reflecting Team.

I met with the reflecting team prior to the session to provide the background information and provide the reasons that I had invited Sue to attend. I conducted the interview with the team watching behind a one way mirror. In the reflection part of the process the team validated Sue's struggle and her goal of having a violent free home. The theme of the comments from the reflecting team was that Sue might need to make a decision with respect to her relationship with Bill. Bill blamed Sue for the marital difficulties, the conflict with Jill, and his explosive temper. Bill's ongoing marijuana use suggested he did not have same marital and parental goals as did Sue. Sue had little to say back to the team. Sue and I agreed that we would review the video tape of the session in our next session. In the review she chose a therapist from the reflecting team and the transfer process was initiated.

Family #2

This is an example of utilizing structural solution-focused family therapy with a family that contained a secret throughout the therapy process. It provides a classic example of the youth being the symptom bearer. Pseudonyms have been used to identify the family members.

Sally and Jamie are working parents with their 17 year old daughter Helen, attending grade 12 and 19 year old son Sid, working full time nights. The referral was from a school counsellor requesting follow-up services for Helen because the counsellor was leaving the school. In the referral the counsellor reported that the parents were arguing; that mom did not understand Helen's depression and when Helen struggles with low energy, her mother would react in anger. Of note here, is this referral is stated more from a family systems perspective than the previous referral. The referral did speak to Sally and Jamie's arguing.

The first interview was with the mother, Sally and her daughter Helen. Jamie, the father was unable to attend due to work. Sally and Helen completed the Outcome Rating Scale. This was my first time using the scale in a session. Both scored in the distress area. Helen stated that she had been prescribed medication for depression by the family physician and the medication was not alleviating the depression. Helen had had several serious medical problems one of which was a permanent condition, but could be controlled with the required physical exercise. The family had recently relocated from another province and both parents were in lower paying jobs, and were financially stressed. Sally described no major issues with her older son, Sid but did state that Sid was robbed at knife point about 9 months ago and now went out less.

Hypothesis.

The initial hypothesis was that the parental subsystem was stressed, and the daughter may be triangulated, with some question about the impact of the knife robbery on Sid. I requested

that Sid attend the second session to gain further information on the family structure and to assess the impact of the robbery.

In this session I requested that the Sid complete the Outcome Rating Scale for himself and for his impression of Helen's functioning. Sid's score for Helen was similar to her own. The siblings briefly discussed their relationship because with him working nights Sid was not very aware of Helen's struggles, as they had little contact. There was no indication of stress between the siblings, and at the same time limited mutual support. Sid did report that his relationship with his dad was stressed. Sid was planning on moving out of the house; however his plans were without his father's knowledge to avoid his anger. Sally was aware of this avoidance strategy. Helen stated that she did not want her father Jamie to come to her with his problems. Sally commented that her husband had not changed since their marriage and provided little other information. Had I been more experienced in family therapy I might have tracked this statement to gain a clearer picture of Sally's perception of her relationship with Jamie. Sid reported he was not experiencing problems since the robbery other than being more cautious where he went a night on his own.

The hypothesis was now further confirmed that the parental subsystem was not functioning as a parental unit. The family is at a life transition stage with Sid moving out and Helen finishing high school. Sally was aligned with Sid as she supports the move without Jamie's knowledge. The father, Jamie seemed aligned with Helen, his daughter because he comes to her with his problems. In the session, Sid and Sally triangulated Jamie. The triangulation was indicated by the statements that Jamie has not changed since the marriage and keeping Sid's move out of the family home a secret from Jamie.

The least resistant structural shift appeared to be with Helen and Jamie, because the parental subsystem seemed disengaged. I asked Sally and Helen if Helen would agree to meeting with Jamie in counselling and both agreed to that plan. Jamie's work situation had stabilized and he was now available. I scheduled a session for Jamie, the father, and Helen.

In this session Helen was very clear with her father, Jamie that it was uncomfortable for her to have him come to her with financial and marital issues. Jamie readily agreed. I suggested to Jamie that the next step in the counselling was for marital counselling. Jamie again agreed. An appointment time was set for Jamie and Sally to come in together with the condition that I would call and confirm this next step with Sally. I contacted Sally and she agreed to the marital counselling. On the day of the marital session Jamie phoned and informed me that I was confused about providing marital counseling. Marital counselling was not going to happen, instead, Helen was coming in because her anxiety was unmanageable.

Helen attended, completed the Outcome Rating Scale which indicated that she was not in enough distress to warrant counselling. However, Helen reported that she was concerned that her depression may return as she was experiencing anxiety related to lack of exercise and boyfriend related issues. My hypothesis was that something had occurred within the parental subsystem primarily based on Helen's increased anxiety and Jamie sabotaging the marital session. Helen provided no insight as to any marital issues. My therapeutic focus was individual and focused on her symptoms. With more experience in family therapy I may have spent more time discussing the family structure rather than slipping back into symptom discussion.

I suggested to Helen that for the next appointment I meet with her and her mom. This structural move was based on Jamie's cancellation of the marital session. I expected resistance with marital counselling. At this session, Helen completed the Outcome Rating Scale and the

scores were above the distress cut off. This indicated that Helen was not in enough distress to warrant counselling. Helen confirmed that she was exercising regularly, studying and that the anxiety had dissipated. Sally scored the Outcome Rating Scale indicating distress. Sally stated that Helen is doing much better. Sally acknowledged that she is more attentive to Helen because she did not realize that when Helen went to her room that it was an indicator of depression. Sally, as a young girl, spent a lot of time in her room doing activities and did not realize when Helen was isolating herself by going to her room, she was depressed. Sally commented that Jamie had joined Alcoholics Anonymous because of an incident that occurred and he decided to quit drinking. Sally refused to expand in front of Helen. I commented on Sally's Outcome Rating Scale scores indicating that counselling was warranted and discussed individual counselling with Sally. Sally declined.

When I reviewed this family in clinical supervision, both the clinical supervisor and I were surprised that Jamie had joined Alcoholics Anonymous. There had been no indication of his alcohol use or family issues related to his alcohol use. In hindsight this family secret may have been the basis for Jamie sabotaging the marital session. This is a lovely example of the necessity of context and knowing all the facts. This family system was clearly self-protecting and closed as is often the cases where there is alcohol abuse in the family and Helen was merely the symptom bearer.

Family # 3

This example presents the following:

- The impact that the reflecting team can have with a family.
- How quickly a family can access their personal resources when a situation is addressed from a solution-focused family therapy approach.

- The impact of unresolved life transitions.

The family consisted of the parents, Jim and Elsie and two siblings, Jack aged 12 and Alice aged 7. Jim worked full time and Elsie was in the last year of an under graduate degree. Jim and Elise had Jack, while in grade 12. The referral was from a child psychiatrist because Jack had attempted suicide. The child psychiatrist reported in her clinical notes that the parents instituted a succession of groundings with the final threat of placing Jack outside of the family home. The psychiatrist was providing follow-up services with Jack on thought stopping techniques (cognitive therapy). I was scheduled to be the consulting clinician for my first reflection team. When I contacted the family to set the first appointment, I discussed their willingness to meet with the reflecting team and they agreed. We discussed whether Alice, the youngest daughter, should attend. Their preference was to not include her in this session because she was not aware of the full details of Jack's attempted suicide. I agreed.

I met with the reflecting team prior to the session and provided the intake information. My clinical inclination with a suicide referral was to focus primarily on a suicide risk assessment. The team suggested that I expand this approach to assess the reoccurring interaction patterns that had led to this outcome and work with the family from a structural solution-focused family therapy approach. I conducted the interview with the team behind the mirror. The family members completed the Outcome Rating Scale and I requested that the parents each score themselves and to score Jack on how they felt he was doing. Jim scored Jack, his son, as being in some distress. Jim scored himself above the Outcome Rating Scale cut-off, suggesting that he was not experiencing enough distress to warrant counselling. Elsie scored Jack at a higher level of distress than Jim had. The difference in scores indicated a difference of opinion on how their son Jack was functioning emotionally.

Both parents' scores were above the Outcome Rating Scale cutoff, indicating that counselling was not warranted. Had I been more familiar with the Outcome Rating Scale, I might have discussed their scores that indicated counseling was not warranted, following a suicide attempt by their son. In hind sight one might expect that the parents would have been in a higher level of distress following the suicide attempt. Further exploration of the scores may have revealed information about the families coping pattern and/or how they framed the event. Regardless, that was not the direction I took.

Jim and Elsie discussed their inability to correct Jack's behaviour. Jim described himself as a strict parent and Elsie stated she would be quiet then explode at Jack. They reported that Jack lied, did not do his chores, and spent more time playing video games than they felt was appropriate. They further reported that Jack's difficult behaviors began after the birth of Alice, who was 7 years of age. Their ability to enforce their consequences with Jack continued to be undermined by both sets of grandparents. The parents would enforce their consequences, such as no video games and Jack would visit his grandparents and be allowed to play video games. The consequences became more severe in reaction to their son's behaviour and this became the reoccurring pattern. The ultimate consequence was threatening to place him outside of the family home. There were no discipline issues with Alice. Jack was quiet in the session but did manage to express that the morning of the suicide attempt he was angry and often felt sad.

The team, the family and I switched places, with the team now in front of the mirror. The team strategically provided the following feedback to the family:

- The team complimented their courage for meeting with the team and openly discussing their struggles.

- The team also suggested that because they were young parents both sets of grandparents assisted them in the early years of their parenting and did not recognized that Jim and Elsie were now capable of parenting.

- The team stated parenting has a soft and hard side and that the use of a carrot can be more effective to enhance positive behaviours than using punishment to correct behavior.

We switched places and the family members summarized what the team had presented. The family completed the Session Rating Scale. Elsie's score indicated a therapeutic alliance. Jim scored the Session Rating Scale below the cut-off, indicating a problem with the therapeutic alliance. Jack scored the Session Rating Scale above the cut-off, indicating a therapeutic alliance. In this situation I did not review the Session Rating Scale with the family. The team and I discussed Jim's score on the Session Rating Scale. It was suggested that the score could be discussed at the next session with Jim and this may bring forward a theme of his criticism of others.

Hypothesis.

The hypothesis was that the family had struggled with three life transitions. The first transition was the birth of Jack when they were still teenagers. Jim and Elsie did not have the opportunity to consolidate the marital subsystem and to negotiate their relationship with both sets of grandparents. The second life transition was the birth of Alice, at which point the parent's were unable to renegotiate their relationship with Jack. The third life transition was that Jack was becoming a teenager and the parents were struggling with assisting him in developing his independence.

I met with the parents for three sessions after the reflection team session. In each session Jim and Elsie discussed a structural shift they had made that corresponded to the reflection

team's feedback. Elsie was more patient with Jack and explained the reason for her request to Jack and did not react in anger. Jim recognized that Jack was anxious around him because of his strict parenting style. Jim made some shifts in his parenting style and allowed Jack more freedoms that fit Jack's developmental stage. Jim and Jack became more involved in joint activities. Jack's self esteem increased and because he felt better about himself he was doing his homework and household chores. Elsie and Jim talked with their parents about being less involved in Jack's care. My role as the family therapist was to validate the structural changes Jim and Elsie made. Jim's scored the Session Rating Scale in the second and corresponding sessions above the cutoff suggesting a therapeutic alliance.

Ethics

Ethical Dilemma

An ethical dilemma in social work is when a social worker finds themselves in a situation between two opposing principles whereby by choosing a course of action supporting one principle, it contradicts another principle or social work value. What one social worker views as an ethical dilemma may not necessarily be viewed the same by another social worker. Even in the same workplace or in response to a similar situation, because social workers respond to ethical guideline from their personal moral code. An ethical dilemma may result from the conflict between the social work code of ethics, organizational expectations and legislation (McAuliffe, 2005).

The first ethical dilemma that I faced was the confidence to provide competent clinical services to youth and families utilizing structural solution-focused family therapy, because this was not a model that I was competent in using. As value 6 of the Canadian Association of Social Workers (CASW) states "Social workers uphold the right of clients to be offered the highest

quality of service possible" (p. 8). My concern was, that I was not in a position to provide the best possible service to the clients as I was in a new work environment and not familiar with the therapeutic model. From discussion with my clinical supervisor it became apparent that by informing clients I was a student, and was receiving clinical supervision, I would meet the obligation of providing the highest possible service to clients. It was further discussed with my clients that those who required counselling after the completion of my internship would be referred to another therapist within the team. Two families required ongoing services and were assigned to other professionals within the team. To ensure the referral process went as smoothly as possible I took the following steps:

- I reviewed all cases with the clinical supervisor monthly so that the supervisor was aware of situations that may require ongoing counselling.

- Two months prior the end of my internship I discussed with the families that required ongoing counselling a process to facilitate the referral process such as meeting the new mental health therapist.

During the internship I did not face a situation where I felt I was in or could be in an ethical dilemma. The consistent discussion of cases in clinical supervision reduced any risks of ethical dilemmas. In one case, that involved a number of agencies, we had regular case conferences with the Ministry of Social Services, the family and other collateral agencies to keep the Ministry informed of progress and any potential child abuse concerns.

Values

Principles of human rights and social justice are fundamental core values of the profession of social work. The Canadian Association of Social Workers Code of Ethics (CASW) summarizes these values and provides the principles to direct social workers professional

behaviour: the core social work values are; 1) respect for the inherent dignity and worth of persons, 2) pursuit of social justice, 3) service to humanity, 4) integrity of professional practice, 5) confidentiality in professional practice, and 6) competence in professional practice (CASW, 2005, p. 4).

The value statement of the Youth Community Counselling Program (YCCP) is to improve the quality of life for children, youth and their families by providing counselling and adhering to best practices. The Youth Community Counselling Program is committed to collaboration, respecting cultural diversity and "privileging the voice of our clients" (Mental Health and Addiction Services, 2010, para. 1). These value statements are congruent with the social work value of respect for the inherent dignity and worth of persons and integrity and competency in professional practice. The Youth Community Counselling Program facilitates these value statements in the following ways.

Inherent Dignity and Worth of Persons

The Youth Community Counselling Program (YCCP) provides a wide range of counselling services each with the goal to improve the quality of life for children, youth and their families. Youth behaviours are viewed as the result of the struggles of the family. Therapeutic techniques are based on the premises that individuals have personal resources and solutions; and respect and value of the person and the family. The YCCP is committed to collaboration with other professional and service providers. The YCCP provides services regardless of race and sexual orientation. The program has the limit of providing services to youth under the age of 18 and in some program areas age 19. Youth that are older can receive services through Adult Mental Health.

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By utilizing the Outcome and Session rating Scales and the therapeutic basis of the scales, the program promotes client self-determination by following a client-directed outcome informed counselling approach.

Best Practice

The value of providing best practice and practice-based evidence is facilitated firstly by using family therapy with child and youth related mental health issues. Research has shown that family therapy for youth mental health issues such as substance abuse and conduct disorder is the most effective therapeutic approach (Nicholas, 2011). Secondly, the Youth Community Counselling Program provides regular case consultation through the use of the team meetings, regular training using the monthly in house personal development training and the opportunity to attend training session provided by the Child and Youth Provincial Training Coordinator. Thirdly, the Program's clinical supervisor is a certified American Association for Marriage and Family Therapists (AAMFT). AAMFT has developed a set of core competencies and values that direct the practice of family therapy (Hanna, 2007).

Pursuit of Social Justice

The pursuit of social justice requires social workers to be involved in the community by being a member of community groups and/or interfacing with community based organizations that work on behalf of marginalized populations. With this involvement, social workers can become aware of discrimination faced by marginalized groups in their attempts to access services, and community barriers in accessing community resources. Involvement in the community provides the momentum to work for change within one's organization or to utilize the political influence of the organization to lobby for change in the community. My impression

is that the pursuit of social justice is not a component of the role of social workers within the Youth Community Counselling Team, as the primary focus of the social workers was their case load with little apparent involvement in the community. However, this role, in part may be filled by the Outreach Team. I will comment further on this issue under the heading Future Concerns.

Barriers

Agency Barriers to Clients

The Youth Community Counselling Team social workers and psychologist do an exceptional job of assisting the client group they work with. The waiting list appears to be effectively managed and therapists did not complain of overwhelming caseloads. However, I did note some general barriers to service for lower income families, Aboriginal and Immigrant families.

1. Child Care Services

The multi-problem family that I worked with did not have access to child care which meant mom had to bring her two young children to the sessions. Child care services would have made the counselling time more effective. In house day care or an arrangement with a day care provider may assist some low income families with accessing service.

2. Staffing

Out of the 5 full-time positions in the Youth Community Counselling Team, 2 of the part time staff were in temporary positions. They maintained a case load and if their positions were not continued, in the new fiscal term, their case load would need to be disbursed among the remaining staff. This could be disruptive in the continuity of services for clients and would potentially impact the morale of staff that are in temporary, non-permanent positions.

3. Office Hours

The Program hours are 8 am to 5 pm, therefore access for working parents could be limited if their employer did not allow for absence or flexible hours.

4. Literacy and Fluency in English

The referral process is effective if given the client is fluent in English; has a phone and is able to articulate their situation in writing. These issues were not discussed in any of the team meetings, nor during any other time in the practicum. Consequently the inability to complete the form could be a barrier to receive services.

Future Concerns

The following comments are based on my involvement with a small caseload over the period of 8 months with the Youth Community Counselling Team. The caseload I was assigned may not be representative of the client population of the Youth Community Counselling Program. To use an analysis based on family systems theory, the Youth Community Counselling Team program, is somewhat of a closed system with, 75% of the referrals of my cases were from professionals either working within the Saskatoon Health Region or from professionals such as doctors and school counselors who were familiar with the program. A small percentage of the clients on my caseload were self-referrals. Two of the clients that I was assigned were Aboriginal youth living in foster care, none were immigrants and one family's income consisted of employment and social services supplement. This might suggest that the agency has a limited profile within Aboriginal, immigrant and less fortunate communities.

The social work staff appeared to have limited involvement in community or in social justice issues. Their primary focus was keeping up with their client case loads. The lack of

involvement within the community may limit the agencies social worker's awareness of Saskatoon's social trends and struggles of marginalized groups.

Saskatoon's population profile is ever evolving both due to the increasing Aboriginal population and immigration. Anderson (2005) completed a socio-demographic study of Aboriginal population in Saskatoon and noted the following trends. If the Aboriginal population growth continues at the present growth level that by 2011, the Aboriginal population would be 20% or, one in every five people. Single parent Aboriginal families triple the number of non-Aboriginal single parent families. Approximately 48% of Saskatoon's Aboriginal residents are under the age of 20. In 2001, 52% of the Saskatoon Aboriginal population lived below the Low Income Cut Off. Aboriginals struggle with maintaining their language and culture. These are factors that increase the risk for Aboriginal youth acting out and interfere with Aboriginal families' ability to maintain a healthy family environment. Due to these problems, the Aboriginal population could potentially benefit from the services provided by the Youth Community Counselling Team.

The Saskatchewan Government has an immigration strategy whereby immigration is seen as vital to address labour shortage and stimulate economic growth (Government of Saskatchewan, (2011). In the 2006 Census, "…one in five Canadian residents were born in another country" (Vanier Institute of the Family, p. 12). One can only imagine the struggles that an immigrating and refugee family will have adjusting to a new country, culture and language; struggles that will challenge the immigrant and refugee family's ability to maintain a healthy home environment. Immigrant families balance making the necessary changes to adapt to Canadian society with maintaining stability by adhering to traditional customs and values of their country of origin.

As Saskatoon's population profile evolves, agencies such as the Youth Community Counselling Team (YCCT) will need to adapt to the changing population of Saskatoon. The YCCT needs to develop an awareness of the social problems Saskatoon is facing and develop ways to address these problems. This may mean a stronger presence in the community with increased involvement in community groups, more significant outreach programs, reviewing their hiring policies to reflect the city's population, and cultural training for staff.

One example of an organization that extends itself beyond the family is Just Therapy. Just Therapy originates in the Family Centre in Lower Hutt, New Zealand. Practitioners in the family centre noted that many of the families requesting service experienced stress and lived in communities contaminated by poverty, racism and sexism. The practitioners observed that the therapy was useful for short term symptom relief but did not resolve the underlying conditions of society that contributed to family problems; when families returned to their communities and the symptoms returned. The approach used by Just Therapy is based in the concept that therapy must work beyond the family and program staff "is simultaneously involved in family therapy, community development, policy advocacy, and social policy research (Frankel & Frankel, 2007, p. 59). Waldegrave, 2003 (as cited in Frankel & Frankel, 2007) comments that therapists are on a regular basis exposed to the pain of those that are marginalized and that they are ethically obligated to make public what they have been exposed to; to facilitate public awareness; and impact social policy (Fankel and Frankel, 2007). Social workers need to be reminded that because of our code of ethics, we are duty-bound to engage in social justice activities by increasing public awareness of issues of injustice and to facilitate policy changes.

Conclusion

Social work has been a vanguard for services for families and in fact social workers spearheaded the family therapy movement (Hartman & Laird, 1983; Nicholas, 2011). Prior to the family therapy movement in the 1950's psychological problems were treated in individual therapy. Family therapy was developed to assist families by changing negative interaction patterns; dysfunctional communication; and family structure by paving the way for new ways for family members to interact. The notion of family therapy implies dysfunction in the family and acknowledges the context the family lives in. Family system therapists may not always integrate community work or community based work in their practice. Over the years family therapy has evolved due the influences of postmodernism and other theories such as feminism. Today, family therapy practitioners are more frequently using the term systemic therapy, in that "The systemic approach is essentially a contextual approach – seeing and treating people in context" (Asen, 2002, p. 230). Understanding and treating people in the context in which they live is necessary to ensure the treatment provided is effective. However, the concepts of family therapy, as practiced by the Youth Community Counselling Team, does not necessarily translate into community development, advocating for policy change, increased awareness of social justice or involvement in social policy research. When one considers the changing face of Saskatoon's population with increasing Aboriginal and Immigrant population and increasing poverty and homelessness, The Youth Community Counselling Team does not appear to serve populations that have the greatest need for services, and populations that are the most disadvantaged. For social workers, to meet their ethical obligation of social justice the Youth Community Counselling Team needs to consider a shift from the primary intervention being with the family to a more visible presence in

the community by addressing and advocating to address social issues that contributes to family problems faced by the most marginalized populations.

Reflecting back on my practicum this learning experience has helped me to develop a deeper understanding of family dynamics; an understanding of families' struggles; knowledge about the outcome of unresolved struggles; familiarity with family therapy and developed some skills to assist families. As with any theory or method of therapy it will takes time to further my knowledge and incorporate the concepts of family therapy into my clinical social work.

On the surface, I will take the knowledge about the concepts of structural solution-focused family therapy; client-directed and outcome informed therapy; and the Outcome and Session Rating Scales and incorporate them in my clinical social work practice. I will pass this knowledge to social workers that I supervise as we discuss and consult on children, youth and families that we work with.

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