A DIVE INTO THE OCEAN OF COUNSELLING TO EXPLORE LEARNING TREASURE THROUGH THE USE OF THERAPEUTIC APPROACHES TO SUPPORT YOUTH, CHILDREN, AND ADULTS

A Field Practicum Report

Submitted to the Faculty of Graduate Studies and Research

In Partial Fulfillment of the Requirements

For the Degree of

Master of Social Work

University of Regina

By

Tanvi Dave

Prince Albert, Saskatchewan

December 2021

Copyright 2021: T. Dave
Abstract

This field practicum report reflects my experience in counselling at Catholic Family Services, Prince Albert. Throughout the practicum journey, I have received various opportunities to work with a diverse population to practice cognitive behavioural therapy and dialectical behaviour therapy with mindfulness, play therapy, and motivational interviewing. This practicum report will explain learning objectives and treatment approaches in these areas, followed by the most suitable case scenarios to demonstrate my learning goal and activities. This report includes a literature review on counselling therapy and how I extracted my learning experience from the challenges I encountered. Additionally, this report connects mental health and the importance of social workers in this busy demanding field. This report illustrates my skill set as a social worker and how I have utilized this opportunity to sharpen my skills to support adolescents, adults, and children. This report connects mental health as an ocean and my practicum journey as a diver to practice therapeutic approaches in counselling to explore and strengthen my learning.

*Keywords:* cognitive behavioural therapy, dialectical behaviour therapy, play therapy, motivational interviewing, counselling
Acknowledgments

This journey of completing the Master of Social Work program started with the support of the entire universe around me. I have been blessed with positive energy around me from the commencement. I would like to take this opportunity to thank everyone I encountered during my Master of Social Work journey. I came to Canada with a few dreams in my eyes, and completing a Master of Social Work was one of those few dreams. There was a time when my eyes were blurry, but I had to see through with my determination. This determination came from within and also from the people around me. This positive energy kept me going on this journey.

I started my Master of Social Work with the tremendous support of Dr. Miguel Sanchez. Dr. Sanchez not only listened to my challenges but also made me believe these challenges were worth facing. Dr. Sanchez validated and affirmed my determination and helped me to believe in myself. The outcome is right here, in that I had the opportunity to write this practicum report. I would like to thank Dr. Kara Fletcher, my academic, professional associate, for being the light in each phase of my journey. With Dr. Fletcher’s support, I could build up the determination to complete my practicum even during the unusual time of the pandemic. Dr. Fletcher kept me on track and guided me with time frames to be goal-oriented. I also would like to thank Dr. Gebhard, an academic committee member, for supporting me and providing her valuable guidance throughout this journey.

Additionally, I would like to thank Sheila Price and John Kreiser, professional associates, for guiding me throughout my practicum journey. The Catholic Family Services (CFS) team, Prince Albert, welcomed me and supported me with their valuable experience and knowledge in counselling. Sheila and CFS staff made sure that I was comfortable and included as a team member throughout my practicum journey.
As an individual, I have gained so many opportunities to recognize and challenge my strengths. Each challenge has strengthened me, but my husband taught me to be happy throughout each up and down. I would like to thank him for supporting me in each emotion I had during this journey. Along with my husband, I would like to thank the most loving part of our life: our upcoming addition to the family. I started this practicum journey with my upcoming one. I would like to thank my upcoming one for strengthening me and being cooperative during this journey. I also would like to thank my parents and sister for their support and encouragement.

I would like to acknowledge that my work took place within Treaty Six territory and the homeland of Indigenous Nations, including the Woodland Cree, Plains Cree, Swampy Cree, Dene, and the Dakota and Métis Nations (City of Prince Albert, 2021). I am grateful to have this opportunity to practice my social worker’s skills. This journey would not have been possible without my clients at Catholic Family Services. I would like to thank each of them for thriving during my experience. Each client encouraged my thirst to have more valuable experiences. I would like to thank each of them for letting me step into their lives and keeping faith in our counselling approach. My clients have provided me with such remarkable experiences to be proud of.
# Table of Contents

Abstract ........................................................................................................................................... ii  
Acknowledgments.......................................................................................................................... iii  
Chapter 1: Introduction ................................................................................................................... 1  
  Figure 1 ....................................................................................................................................... 1  
  Table 1 ......................................................................................................................................... 1  
  A Peek into the Intentions ........................................................................................................... 2  
  Social Work and Mental Health ................................................................................................. 4  
    Figure 2 .................................................................................................................................... 5  
  Learning Goal, Objectives, and Activities .................................................................................. 6  
Chapter 2: About Catholic Family Services ................................................................................... 8  
  Clinical Supervision and Case Management ............................................................................. 9  
Chapter 3: Certification: Trauma and Attachment Across the Life Span ..................................... 14  
  Therapeutic Relationship........................................................................................................... 15  
    Figure 3 ..................................................................................................................................... 16  
      Case Scenario 1 ..................................................................................................................... 17  
  Trauma and Adolescents ........................................................................................................... 18  
Chapter 4: Cognitive Behavioural Therapy .................................................................................. 21  
  Case Scenario 2 ....................................................................................................................... 22  
    Figure 4 ..................................................................................................................................... 23  
  Working with Adolescents ....................................................................................................... 25  
    Case Scenario 3 ..................................................................................................................... 26  
Chapter 5: Dialectical Behaviour Therapy with Mindfulness ...................................................... 28  
    Figure 5 ..................................................................................................................................... 29
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of Treatment Plan and Discussion with Professional Associate</td>
<td>30</td>
</tr>
<tr>
<td>Case Scenario 4</td>
<td>31</td>
</tr>
<tr>
<td>Chapter 6: Play Therapy</td>
<td>34</td>
</tr>
<tr>
<td>Children with Trauma</td>
<td>35</td>
</tr>
<tr>
<td>Refurbishing Non-Directive Play to Directive Play</td>
<td>37</td>
</tr>
<tr>
<td>Directive Play</td>
<td>40</td>
</tr>
<tr>
<td>Case Scenario 5</td>
<td>40</td>
</tr>
<tr>
<td>Figure 6</td>
<td>43</td>
</tr>
<tr>
<td>Chapter 7: Walk-in Counselling: Motivational Interviewing</td>
<td>44</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>45</td>
</tr>
<tr>
<td>Figure 7</td>
<td>45</td>
</tr>
<tr>
<td>Figure 8</td>
<td>48</td>
</tr>
<tr>
<td>Figure 9</td>
<td>49</td>
</tr>
<tr>
<td>Chapter 8: Social Work Practice with Equity and a Non-Judgemental Approach</td>
<td>51</td>
</tr>
<tr>
<td>Challenges and Critical Analysis</td>
<td>54</td>
</tr>
<tr>
<td>Case Scenario 6</td>
<td>57</td>
</tr>
<tr>
<td>Case Scenario 7</td>
<td>58</td>
</tr>
<tr>
<td>Just a Final Thought</td>
<td>60</td>
</tr>
<tr>
<td>References</td>
<td>62</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

Figure 1

*Learning Treasure*

![Image of an underwater scene with numbered points]

Table 1

*Key Points to describe figure 1*

<table>
<thead>
<tr>
<th>Entity</th>
<th>Key Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diver</td>
<td>Therapist</td>
</tr>
<tr>
<td>2. Diving equipment</td>
<td>Social Work skills set</td>
</tr>
<tr>
<td>3. Oxygen tank</td>
<td>Social work: Code of ethics</td>
</tr>
<tr>
<td>4. Ocean</td>
<td>Mental Health</td>
</tr>
<tr>
<td>5. Clear water</td>
<td>Cognitive behavioural -therapy with adolescents</td>
</tr>
</tbody>
</table>
This introductory boat will take us from shore to the middle of the ocean, where we will dive deep to explore learning treasures. In this chapter, we will review the practicum goals, objectives, and intentions of this journey. This practicum has contributed towards six credits of my Master of Social Work degree. I was looking for a placement to dive deep into counselling. The journey was a challenge, to begin with, due to the COVID-19 pandemic. My search was limited by COVID-19 restrictions. However, the search ended with an acceptance from Catholic Family Services, Prince Albert. It was my privilege to start this fieldwork practicum journey on August 31, 2020, ending on November 17, 2020, with infinite learning and experience. I worked eight hours per day at the practicum site from Monday to Thursday, with Friday allocated to work on literature review, reading, self-analysis, and report writing.

This report is a mirror image of 450 hours at the fieldwork practicum site; it is a photobook collection of learning experiences I had the privilege to capture during my fieldwork practicum.

A Peek into the Intentions

Social work is an ocean of knowledge and has various flows. One needs to be prepared and well equipped to dive into this ocean. My journey to explore this ocean started when I was in Grade 11. I was volunteering for various community organizations with my father. I found a glimpse of me attaching to the idea of helping people to help themselves. The more I became
involved with people, the more I enjoyed my time in the community. At that moment, a first goal was set, culminating in the completion of my Bachelor of Social Work.

My bachelor's degree enhanced my knowledge and provided an essential social work skill set. I then came to Canada to dive deeper towards achieving further goals. I had taken two counselling-related classes out of four elective courses to prepare for my practicum. The theoretical knowledge of various family therapies helped me to wet my feet. Another class increased my comfort with and understanding of couples’ family therapy. This class also ended my search for an academic supervisor: Dr. Kara Fletcher. Academic assignments in this course set the standard for my academic tenure. I was able to dive deep into the knowledge of various counselling therapies.

My professional employment has supported me to dive into academic work with the required gear. I provide client and strength-based counselling through my work with the Ministry of Social Services. My work experience has been chiefly with families and adults. I wanted to dive into clearer ocean water, specifically working with adolescents and children.

Little pieces of my experience in counselling helped me to put this puzzle together to ultimately meet with the director of Catholic Family Services, Louise, and a counsellor with the organization, Sheila Price. Subsequently, my diving instructors were in place with all the diving gear and a diver to start the practicum. It is essential to trust your instructor in the diving process. My faith in my instructor clicked in my first meeting with my professional associate. We exchanged our goals, objectives, and learning expectations with each other before starting the diving process.
Social Work and Mental Health

Social work is a field where your words need to be actionable. As social workers, we are dealing with people and their emotions, not with machines. I believe that as a social worker, my skill set derives from my philosophy of care. In my view, the philosophy of care is a mountain, and social work is a river that emanates from the mountain to serve the community. In this era, many have been experiencing various issues with mental health, and we all are trying to balance our lives, work, family, finance, and social events. Mental health is a required field in the community at large and the area of social work specifically. People are increasingly open to discussing mental health.

Rovinelli & Gitterman (2010) writes, in 1985, the New York Times reported that there was a “quiet revolution” in the provision of therapeutic mental health services with social workers vaulting into a leading role. Today social workers are the primary providers of mental health services for individuals with some of the most stigmatized mental illness. (p. 4)

The ice is breaking, though work and improvements are still required. People have started normalizing mental health in the community by understanding the importance of taking care of one’s mental health. The awareness has opened up doors for social workers to intervene to improve mental health.

The World Health Organization (2021) explains that health is not only about being free from disabilities or diseases; mental health is a state of well-being where individuals can recognize their abilities and create space to handle stress and challenges:

Emotional well-being is a specific dimension of subjective well-being that consists of perceptions of avowed happiness and satisfaction with life and the
balancing of positive and negative effects. Whereas happiness is based upon spontaneous reflections of pleasant and unpleasant affects in one’s immediate experience, life satisfaction represents a long-term assessment of one’s life.

(Keyes, 2013, p.7)

This concept has improved the understanding of the significance of well-being in our lives. It is an essential aspect of the therapeutic approach to understanding what the client wants to gain from the therapy in terms of happiness and well-being. A therapist's goal is to work where the client is at in terms of his/her well-being and where the client wants to be by the end of the session.

**Figure 2**

*Two-continuum model*

Note. Adapted from *Positive mental health and well-being*, by Canadian Mental Health Association, 2021

(https://ontario.cmha.ca/documents/positive-mental-health-and-well-being/)
As identified in figure 2, mental well-being is a crucial part of life. Therapy supports creating an environment to experience well-being even with a mental health condition. This new era of mental health awareness has given us a chance to re-evaluate our understanding of well-being and the importance of taking care of our mental health. We are normalizing attending to our mental health as part of our well-being. Social workers play an essential role in assessment, treatment planning, counselling, referrals, and working in a multidisciplinary team. Social workers serve individuals, couples, families, youth, and children to support their mental well-being. The clinical social worker’s role is to advocate for the client’s mental health and work on case management (Rosenberg & Mizrahi, 2009).

Learning Goal, Objectives, and Activities

The goal of my fieldwork practicum was to gain graduate-level social work and counselling skills and knowledge through clinical counselling with youth, children, and families needing support to improve their mental health. I achieved this goal throughout this journey by utilizing and gaining knowledge around counselling therapies, primarily cognitive behavioural therapy, dialectical behaviour therapy, and play therapy, to support children, families, and youth. This goal and objectives were accomplished with the help of the following activities:

• Familiarizing myself with Catholic Family Services’ working approach, therapeutic models, and programs offered to children, youth, and families

• Learning about Catholic Family Services’ walk-in counselling program

• Learning about the intake process and range of counselling modalities practiced at Catholic Family Services

• Observing and practicing client-centered therapeutic approaches used at the agency by professional staff
• Reviewing literature and practicing Cognitive Behavioural Therapy with a diverse population and carry a caseload of 4-5 youth and/or children

• Reviewing literature to gain knowledge about Dialectical Behaviour Therapy by observing professional staff at Catholic Family Services

• Engaging with children and youth as part of the counselling process to advance therapeutic relationships

• Demonstrating and recognizing principles and values of social work in the field of counselling

• Participating in and observing group programming offered at Catholic Family Services as available in fall 2020

• Keeping a daily journal to track and reflect on the learning process, including professional learning, personal learning, next day’s objectives and plan, critical analysis of the day and areas of improvement

These activities supported me to stay on track and goal-oriented throughout the practicum. Every day the sun rises with new challenges and opportunities. In social work, it is essential to welcome the sun’s rays and transfigure them into support. These activities were the backbone of the journey, which supported me in achieving my goal.
Chapter 2: About Catholic Family Services

Catholic Family Services (CFS) provides counselling services to the community of Prince Albert. The goal of this agency is to serve the community to strengthen mental well-being. CFS provides counselling services to adults, families, children, couples, and youth with different religious and cultural beliefs. CFS’s therapeutic approach covers relationships, conflict resolution, family violence and abuse, depression and anxiety, eating disorders, grief and loss, separation and divorce, addictions, personal growth/enrichment, trauma, and parenting. CFS has hired counsellors with master’s level degrees. CFS also understands the need for walk-in counselling for people in desperate need. CFS has devoted one counsellor to walk-in counselling, using solution-focused and single-session therapy to address urgent community needs (Catholic Family Services, 2020).

In addition, CFS offers life improvement programs such as STRENGTHENING FAMILIES, PARENTING FROM THE HEART, CALMING THE STORM for teens and adults, and CLIMBING THE ROCK. CFS also provides RIDING THE WAVE, TAMING THE TIGER, ONE HEART TWO HOMES, GOOD GRIEF, AFTER THE STORM, BRIDGES, AND STEPPING UP. These programs are designed to positively impact individuals’ well-being and support them in managing challenges in their lives.

CFS works in collaboration with various ministries, community agencies, and employment services for funding. These collaborations are designed to lift the financial burden from clients so that anyone with any financial background can access services to improve their mental health. CFS charges fees based on a sliding scale to determine the appropriate cost based on financial need. CFS provides freedom to counsellors to support clients and waive their fees if a client cannot make the payment.
CFS has policies and procedures in place to support clients’ privacy and confidentiality, including regarding referrals from different agencies such as the Ministry of Social Services, Ministry of Social Justice and the YWCA, as well as referrals from doctors, employers, and community organizations. Policies and procedures at CFS are designed to provide space for children to open up therapeutically and considers custody-related conflicts.

CFS has adapted to provide services in line with COVID-19 restrictions. CFS has been offering sessions to support clients online, over the phone, and in person (as per provincial guidelines). CFS has been constructing and advancing changes within the agency to support COVID-19 guidelines.

CFS designs case consultations each month apart from their monthly meetings. All counsellors participate in this case consultation. As per the meeting agenda, each counsellor presents a challenging case and discusses the strategy, therapy approach, and resources. Such kind of consultation helps to understand the client better, human psychology, and appropriate approach to improve clients’ mental health.

Clinical Supervision and Case Management

To begin this exceptional diving experience, I had a meeting with my professional associate, Sheila Price. We worked on a contract to help both of us achieve our respective goals and objectives. We had few meetings to lay out what my expectations were to learn from this diving experience. Sheila made sure to convey my goal and objectives to the other staff within the agency to help me develop an appropriate caseload. My first week began with the literature review, reviewing agency policy, learning agency history, learning how clients approach the agency, and learning how intake and walk-in counselling operates. Moreover, I also focused on regular counselling sessions, agency-wide therapeutic approaches, agency goal and values,
confidentiality, and custody related issues, paperwork before and after a counselling session. Sheila provided me with several books to review cognitive behavioural therapy (CBT) alongside other therapeutic approaches, dialectical behaviour therapy, activities to utilize in CBT, DBT, and play therapy, and books related to attachment and trauma. After thoroughly reviewing the literature to ground my learning in professional working styles as a counsellor, we discussed some of Sheila’s ongoing clients to understand Sheila’s therapeutic approach.

We sat together and went through Ministry of Social Services referrals to allocate me with a caseload size of two clients per day. We were mindful of having adolescents and children as part of my case list to meet my learning objectives. Our agenda was clear to begin with in terms of clinical supervision. Sheila had provided me with an open-door approach, where I could seek her support whenever I needed her. Specifically, we planned to discuss the therapeutic approach based on the case before seeing each client. Sheila would ask for my thoughts, ideas, and approach for a particular case scenario, and then she would suggest her views and thoughts to support the client’s best interests. After completing an hour-long session with a client, I would sit again with Sheila to discuss challenges, what went well, what could have been done differently, and the impact of the session on my learning objectives. Additionally, we allocated an hour for a weekly meeting to discuss progress and upcoming challenges. Sheila provided me with a safe environment where I could be vulnerable with my challenges and practice to improve my skills. Sheila made sure to encourage my therapeutic approach and thoughts, even encouraging me to interrupt her sessions in case of emergency if no other counsellor was available to support. This openness provided a transparent approach to prioritize the client’s safety.
Besides my professional associate Sheila, I was fortunate enough to learn from John Kreiser, an individual with more than 30 years of counselling experience. John contributed his time to understand my goal and objectives and support my diving experience in counselling. I was privileged to spend my time with John and learn various approaches to counselling. Other counsellors within the agency equally opened their doors to me if Sheila or John were not available. This tremendous support enabled the learning needed to achieve my practicum goal and objectives.

Within the first two weeks of my practicum, I had five counselling sessions per day, which included both my regular clients and walk-in clients. Sheila would check-in for my self-care and my mental wellness to support my case management. Some clients in CFS were transient for several reasons, so we thought to keep me with a good caseload size to continue my learning experience without interruption. In case of a no-show appointment, I would work on intakes applications.

**Intake Applications and Walk-in Counselling**

Intake application was a significant part of the agency’s operations. In the intake application process, a client would contact CFS and leave their contact information. Then a counsellor would return the call to take their intake application. This process served to gather basic information about the client and give the client space to determine their session time and payment arrangement as per their preferences. The intake procedure was devoted to best help the client by assessing whether the client was in need of immediate attention. In some situations, the client is in crisis and might need immediate counselling before being scheduled with a regular counsellor. CFS had created the intake application procedure to accommodate such kinds of sensitive scenarios. I had several occasions where I provided immediate attention to clients with
a session before their regular counselling. This learning was a significant part of my diving exercise.

For example, I had returned a call for an elderly client residing on a farm, far from the city limits. This client requested that I contact her during a specific time when her spouse was not at home. I had the chance to make sure that she was not in any immediate harm at this point. Then I called her as per her request to set up counselling appointment. She explained her need for counselling and how she wanted to take care of her mental health by seeking support. I provided a session to her for her immediate mental health need, which she appreciated.

Some case scenarios also provide immediate attention to clients with suicidal thoughts. I had a few clients with whom I could make suicide assessments as per CFS policy and procedure. The intake applications also included information related to the client’s goals for their counselling sessions, which helped refer them to a counsellor for regular sessions. Additionally, it was vital to identify the custodial situation in the intake application if the client was not an adult. I came across some custody-related challenges when it came to counselling for children and adolescents. I had a few opportunities to implement confidentiality procedures in such cases. CFS maintained a clear stand when it came to joint custody of children and counselling for children. In such a case, both parents’ permission was required for counselling purposes.

I had an opportunity to see walk-in clients for counselling as well. In walk-in counselling, I was provided with the client’s background and concerns to discuss. CFS provides three free sessions to walk-in clients. Clients can be referred to a regular counsellor for ongoing sessions if they require further sessions. I utilized motivational interviewing for a walk-in client as my primary therapeutic approach. Walk-in counselling taught me to build a therapeutic relationship with my clients in a minimum amount of time. At the start and end of each session, clients were
expected to fill out an outcome rating scale and session rating scale. This helps to evaluate the client’s mental health before a session and explore how the session was helpful to them at the end. The evaluation result goes into an online database for the agency.
With the support of my professional associates Sheila and CFS, I was privileged to participate in training for trauma and attachment across the life span offered by Eboni Webb, Psy.D., HSP. The training focused on the breathing exercise approach to accumulate strengths to stay focused in training. This exercise encouraged us to be mindful of what we have in front of us. This mindful approach aims to help the client and counsellor to perform individual tasks. Each of the three training modules focused on how the nervous system works in the brain and its association to trauma. It is important to understand brain structure in order to understand clients and their situations with trauma. The training also covered how our brain loses the ability to distinguish real versus imaginary after a traumatic experience. The module explained emotional vulnerability and types of invalidation. It added how trauma activates the reaction of a person. Specifically, how dialectical behaviour therapy works with emotional dysregulation.

The training discussed adolescents and their unique neurological development. Adolescents have outstanding constructions of emotional highs and lows. Adolescents’ brains think logically, but keep logic away from emotions in traumatic experiences. This response has high significance in understanding the approach used to support adolescents who have experienced trauma. The training also explained developmental and attachment trauma. The training focused on the biosocial model to learn to cope with trauma: more traumatic situations reduce the tolerance window. It is essential to create a safe space for treatment by building positive emotions for clients. The highlight is, emotions are there to serve us, not to enslave us. For example, sadness: instead of working on happiness, work on how to withdraw the feeling of sadness. The training focuses on how body postures impact emotions. For example, head down and crossed arms posture use different brain parts than head up and unfold arms. It sums, how
we hold our body shapes how we tell our stories. Some coping methods include a tool kit for clients, for example, building a sense of love and belonging, emotional literacy, resting in your emotions, and exploring how different activities help emotions, such as art, sensory products, and music.

Moreover, the modules explained the importance of boundaries. Clients often do not recognize boundaries which creates dysfunction in relationships. It is vital to reinforce effective boundaries by observing others, understanding limits, and remembering your values and safety in each case. This training supported me to better understand my clients’ neurological structures and their experiences with trauma. It validated my therapeutic approaches and relationship to support clients with their mental health. The training helped me to recognize how to be aware of my values, situations, and sense of presence with clients to support them constructively. This training echoed the guidance of my professional associate, Sheila Price, in what she had fed me throughout the journey. The highlight of this training was to focus on attachment theories across the life span and utilize an understanding of a client based on their attachment.

**Therapeutic Relationship**

As a social worker, my skill set to build rapport with my client has been established from the get-go. Having empathy and compassion for clients and their situation is an ongoing process for a social worker. I cannot move forward with my learning and experience without basic social worker skills and principles. The inner ability to have empathy for a client was the foundation of my learning experience. During the practicum, I was able to strengthen the therapeutic relationship with my clients. I learned to have different ways to approach each therapeutic relationship. All clients come from different socio-economic conditions. The diverse population I
had encountered in my practice was very significant in establishing therapeutic relationships with respect to clients’ cultures, beliefs, and values.

As per Goelitz and Stewart-Kahn (2013, p.179), four factors can help to establish a healthy therapeutic relationship, as indicated in figure 3:

**Figure 3**

*Factors contributing to establish healthy therapeutic relationship*

- Promote safety and trust
- Become allies
- Establish Trust
- Sensitive to influences that erode safety and trust

Feltham (1999) explains that it is a massive deal for clients to share their emotions with anyone else. It is challenging for clients to open up their hearts and be vulnerable in front of a stranger. Protecting the client’s thoughts and emotions without judgment is essential to building a therapeutic relationship. During my practicum, most of my clients were in their adolescent years. They were referred through the Ministry of Social Services, often either placed in a foster home or a group home. Many of the adolescent clients I worked with came from past and/or present experiences of trauma. Clients with trauma are more vulnerable in society to trust someone to share and express their feelings. It is a challenging scenario for an adolescent to share their thoughts as they are battling trauma within themselves. Adolescents facing trauma usually experience a storm of thoughts. In such a scenario, a counsellor needs to create a trustworthy space to open up. This can be done by giving adolescent clients sufficient time and decision-making power whenever possible. Working alongside the client to match their pace
plays a significant role in establishing a therapeutic relationship. I have observed that most of my adolescent clients have faced numerous challenges at their group home, school, and family. Coming from such kinds of battles, it is essential to establish an environment for adolescent clients to feel safe and not judged.

Sanders and Wills (2003) suggest establishing a collaborative relationship where both client and therapist respect each other mutually. It is important to observe each other to provide different perspectives on problems the client is facing. Developing each other’s skills can support problem-solving in an effective way. The collaborative approach helps to get into the depth to work on different ideas. It is a necessary process where the client’s contribution and the counselor’s suggestions, ideas, and approach are equally required. Clients can share their vision of the situation. The counsellor then helps the client identify hidden visions and explore different ways to look at the situation (Sanders & Wills, 2003, p. 51).

I encountered several challenges throughout my practicum. The below case scenario outlines one of the best-case scenarios within the context of therapeutic relationship learning.

**Case Scenario 1**

I had a client who was 13 years old and was placed in a group home through the Ministry of Social Services. The primary concern we were supposed to be discussing was self-harm. From the beginning, the client was upset and not willing to be in counselling sessions. My challenge was to establish a therapeutic relationship with the client to work around what the client wanted. We had spent a few sessions building up a safe and trustworthy relationship by giving her an open environment to decide to be part of the counselling session. The client chose not to talk about anything. Based on CFS policy, it was essential to lay down the significance of confidentiality between us. It is crucial to avoid a power struggle and essential in building an
environment where the client can feel safe and feel the acceptance in the room. After the first session, I discussed strategies with my professional associate Sheila to work on improving the therapeutic relationship with non-verbal clients. One of the interesting takeaways from the discussion was understanding where the client is coming from. The client had a traumatic history of being away from family and was placed in a group home where she was not willing to stay. In addition, as a counsellor, I provided her with a space where she was able to make a willing decision to stay quiet and had a place in our session without any judgment or harm.

In the following session, we were able to work on what the client was expecting from the session. As a counsellor, I discussed what the referral form and Ministry of Social Services had asked us to discuss. The client was able to discuss self-harm when the client was ready. As a counsellor, I was also able to create some space for the client to relax, following her indication that music was a calming process in her life. In summary, we had a few sessions together to become allies to work on the client’s own concerns. We reached the point of being able to form an alliance between us to have a healthy therapeutic relationship. During each session, I learned to be careful with my choice of words and pace to keep up the momentum of our therapeutic relationship to support my client. Our alliance provided me with different challenges and concrete learning on how to have a therapeutic relationship with non-verbal clients.

**Trauma and Adolescents**

As a practicing social worker, I have had opportunities to work with adults experiencing past trauma. During this diving process, I had new opportunities to dive deep to learn and be comfortable with adolescents experiencing trauma or who had experience with trauma. I had plenty of opportunities to utilize my social work skills, as having a therapeutic relationship is a significant preparatory step prior to diving in with adolescents.
The term "trauma" originates from the Greek term *trōma*, which means "wound" (Merriam-Webster). The recognition of the role of traumatic experience on psychological problems can be traced back to Freud, who theorized that the "hysteria" he observed in many female patients was, in fact, a form of dissociation -- defined as cutting oneself off cognitively or emotionally from earlier experiences of trauma. (Wilkin & Hillock, 2014, p.185)

Trauma can leave a crucial impact on one’s emotions and thought processes. Specifically, adolescents are more vulnerable to these impacts, having experienced trauma early in their lives. Similarly, it can be difficult for adolescents to work on their emotions in such situations.

Nicholson et al. (2010) explain trauma doesn’t only impact one’s psychological wellbeing but physiological wellbeing as well. Trauma can invite challenges to coping with routine life problems. Some may be able to face those challenges. However, people with traumatic experiences may not be able to manage ordinary issues. People with traumatic experiences may lose the skills needed to address their problems and routine life decision-making (p. 30).

Adolescents face particular challenges in managing stressful environments. They are often not able to process their thoughts in order to handle the challenge. Instead, they tend to lose the capability to put effort into managing it. This psychological impact of trauma requires a careful therapeutic approach. A counsellor needs to support the client with the best approach to help the client face and manage their challenges.

My experience working with adolescents with trauma was challenging in a way, but it provided valuable learning. I worked with adolescents residing in a group home or a foster home; building a therapeutic relationship with adolescents in these contexts was a positive challenge. Heineman et al. (2013) illustrate how children residing in foster care are often perceived as bad
children as they have less capability or awareness around how to express their feelings. They are often assumed to be incapable of succeeding with therapy or other tasks in their lives. Subsequently, these children are often given to a therapist with high expectations of making the child “better” (p. 17). This is only achievable if the therapist focuses on the child based on the child’s own abilities and goals. The therapist can’t let any societal assumptions interfere with the client’s welfare. Therapists often carefully pay attention to an adolescent to provide a safe environment without any harm or judgments. The therapist should provide empathy and compassion to the child/adolescent to put their thoughts and emotions forward to cope with daily challenges.

In many cases, I did dedicate attention to building a pace based on where my client was at and what the client was expecting to achieve from the session. As previously mentioned, distributing the power in the room supports the therapeutic relationship. This has directly impacted the quality time in a session, as the client was able to articulate concerns and could equally participate. Upon establishing a therapeutic relationship, it was easier to find a fitting approach for the client or experiment with an approach that could best support the client.
Chapter 4: Cognitive Behavioural Therapy

As part of my objectives for this practicum, I had the opportunity to practice Cognitive Behavioural therapy (CBT) with adults and youth. Cognitive Behavioural therapy has been proven to be one of the most effective therapies to support individuals experiencing various difficulties in improving their mental health. CBT is an evidence-based therapy proven through research to leave positive effects on the client (Whittington & Grey 2014). Throughout my practicum, I had many opportunities to practice CBT with clients with various mental health conditions such as anxiety, depression, and trauma.

CBT explores the connection between thoughts, feelings, and behaviour. Upon establishing a therapeutic relationship, it is important to carry forward the relation throughout the session. As a counsellor, CBT helped me to connect clients’ thoughts, feelings, and behaviours to support them. CBT focuses on cognitive behavioural interventions by applying learning principles to support clients towards change (Van, 2013). Additionally, Van (2013) connects CBT with experiments in the kitchen. An experienced chef follows the cookbook; however, they can also prepare a meal with her/his basic knowledge and taste. CBT has the potential to support the client and therapist to work towards the client’s goals by experimenting and exploring what works for the client. Van (2013) further explains CBT attempts to achieve client goals by changing thinking process to change behaviour. Once the client’s thinking process has been changed, it reflects on the emotions and behaviour/action. CBT focuses on how the thinking process influences a client’s perception of her/his life. A client’s thinking results in an action. A client’s thought comes from emotions and previous situations in his/her life. CBT emphasizes a change in the thinking process to create different actions/behaviours and emotions towards a situation. It produces a result based on what the client wants to change in his/her life. As a result
of this, clients also experience a change in perspective that makes sense to them to change their behaviour.

As Whittington and Grey (2014) elucidate, CBT follows a structure to work effectively and collaboratively with the client. Initially, the structure involves discussing an agenda determined by the client’s priorities. This agenda is a collaborative task with the client, and it is important to have the therapist’s agreement. The therapist gets an insight into the client’s week, highlights on what worked well, learning and homework. Following the agenda, CBT recommends a brief discussion of the client’s life-challenging event and any homework concerns. The therapist discusses homework with the client to decide what works for next steps to support achieving a goal. Finally, the CBT structure collects client feedback regarding what was helpful and what was not (Whittington and Grey, 2014).

Whittington and Grey (2014) consider homework an essential part of CBT. They explain homework helps the client to be cognitive and observant of their behaviour and thoughts. It also encourages the client to pay attention to an important event they may want to discuss in the next therapeutic session. Research has proved the positive impact of homework in CBT. In CBT, homework is usually set up collaboratively with the client. The homework task will be discussed in the following session with the client. Homework helps the client share the responsibility in therapy, where the client’s participation encourages the client to actively work towards needed change.

Case Scenario 2

I had an 18-year-old male client. This client’s goal was to gain confidence by facing current challenges in his life and to be happy. He was a new dad and living with his girlfriend. He wasn’t sure how he was feeling, but he wanted to feel happiness in his life. He had been
living with his parents prior to moving in with his girlfriend. When he was with his parents, he was a happy person, but he had to move out as his elder siblings achieved their professional goals and moved out independently. He was getting involved with verbal fights with his girlfriend due to his actions. CBT helped to explore the client’s current challenges and his thinking process around them, including how he could develop his thinking process to work on his emotions and behaviour as identified in figure 4 below.

**Figure 4**

*Reconstruction of thoughts*

![Reconstruction diagram](https://www.therapista.com/therapy-guide/cbt-psychoeducation)

*Note.* Adapted from *CBT Psychoeducation*, by Therapist Aid, 2021

(hps://www.therapista.com/therapy-guide/cbt-psychoeducation)

Working around this client’s emotions presented a challenge as the client was not expressing very much. However, therapeutic relations developed after few sessions to build a
safe environment for him to express and exchange thoughts. The client expressed how his current situation of being a new dad was impacting his thoughts and the relationships around him. CBT helped to connect his thoughts to the emotions and feelings he had been experiencing. These emotions influenced his behaviour with people around him, including his girlfriend, parents, and siblings. It also affected his confidence and energy. He shared about his past life living with his parents and relationship with his family. The technique of exploring these thoughts and connecting with emotions and behaviour helped the client to change his thinking process. Eventually, this led him to reconstruct his thoughts, which supported the client to change them towards positivity to bring happiness in his life. We discussed a different perspective to see his current situation differently and lessen sadness in his life. Ultimately, he was on a path to regain happiness, which lifted his confidence to face challenges.

As part of CBT, this client was given some work to do at home. He observed his thoughts while he was with his family members and observed his thinking process and emotions to make them positive. He was asked to implement his positive thoughts and emotions into action by contacting people he hoped to reconnect with to have happiness in his life. This client eventually texted one of his family members and spent a weekend with his sibling. This gesture helped him to reconnect with his family member, and that increased his confidence. He felt his worth in the family. He stated that he felt confident when he knew that his family members were with him and wanted him to be part of the family. The validation from his family helped him to regain the confidence to have a happy moment. At the very end of each session and at the start of a follow-up session we used to discuss what worked well for him and what did not to support his goal. It helped him to contemplate his thinking process to have different emotions. Reflection on each session also helped to be goal-oriented and supported the treatment plan.
As Whittington & Grey (2014) explain, there are different types of cognition; core beliefs, dysfunctional assumptions, and negative automatic thoughts. This client had some core beliefs, and he wanted to find self-worth in his family by receiving validation from them. He believed that his siblings were well-to-do, and they didn’t find his existence vital as he had not achieved a lot in his life. CBT helped to change this thought patterns to see things differently. CBT challenged him with a different perspective to change his own beliefs and locate his self-worth.

**Working with Adolescents**

My practicum objective was to practice cognitive behavioural therapy with adolescents. Working with adolescents was like diving in the middle of the ocean where there is crystal clear water to explore sea treasure. At the same time, diving in the middle of the ocean was adventurous too. Adolescents’ minds process clearly; however, it can be challenging to establish rapport with them. One has to proceed carefully and accept them without any judgments. During my fieldwork practicum, I encountered various opportunities to work with adolescents. Most of my adolescent clients were referrals from the Ministry of Social Services. I primarily encountered three mental health conditions among my adolescent clients: anxiety, trauma, and anger management. Working with these conditions, I had the opportunity to experience the significant impact of psychoeducation in CBT. Adolescents have clarity in their minds, but working with adolescents involves a process of clearing any blurry vision by offering a different perspective. I implemented this learning through experiencing the delicate side of CBT with adolescents.
Case Scenario 3

I had a 16-year-old client with anxiety. This client was initially seeing another counsellor. In the first session, I discussed a counsellor's change and asked her permission to have regular sessions with me. We went through agency policy and confidentiality prior to starting the session. With her permission, we went through what she had achieved during previous sessions and what she was hoping to achieve from upcoming sessions. She had used different techniques to deal with her anxiety and was continuously working on it. At that point in time, she was going through some family issues and was fearful of a house break-in. In addition, she had been seeing paranormal things. She added that she had social anxiety as well.

After reviewing what she hoped to achieve from counselling, I asked her what she was interested in discussing. She decided to work on the anxiety around house break-ins. She provided basic information about her home location, which was on the farm. We did some brainstorming around the visible vulnerability of a break-in. She mentioned that her house is an old house, and not of great monetary value, and they are on farm, so someone would think that an old couple is residing in the house. She added that their front yard is empty. Considering this, I asked her what supports her anxiousness about house break-ins. She answered that it had happened once in the past. Then we worked around safety measures they have in the house. She stated that they have small dogs and an alarm system in place, but someone can still force their way in. I asked her how those dogs and alarm systems could help just in case such a break-in happens. She shared that the dogs are very active and would be alert if something happens, and the alarm system will also alert in such cases.

I summarized our brainstorming and asked her a question: looking at the visible vulnerability of break-in and having safety measures in place, and considering only one past
break-in in the last 16 years, what were the chances of break-in incidents happening again in the next five years? We did the calculation together and figured the chances would be 0.3%. I let her sit with this information for a while, and she came back sharing that she had never thought about this situation in such a logical way before.

Cognitive behavioural therapy places emphasis on psychoeducation; it provides information to the client to be able to develop a new way of thinking (Morrow & Dupont, 2018). Psychoeducation highlights the practice of working on thoughts that can help to change emotions. It is important that the client practice a new way of thinking in their daily routine. Different ways of thinking will open up more opportunities to have emotions that will support coping with other emotions, such as fear, stress, and anxiety. Such cognitive distortions need reconstructive thoughts. Cognitive behavioural therapy helps the client identify cognitive distortions and rebuild them to think in a certain way to lessen negative emotions (Morrow & Dupont, 2018).

As part of psychoeducation, I suggested this client keep reconstructing thoughts in different emotions and activities as well. Eventually, this will support working around her social anxiety. Psychoeducation plays a large role in cognitive reconstruction to support adults in facing their current and future challenges. With clear thoughts, clients can reconstruct negative thoughts into positive thoughts. An agenda behind this notion was to let her practice reconstruction of thoughts so that her emotions around paranormal things could be addressed whenever she was ready to work around them.
Chapter 5: Dialectical Behaviour Therapy with Mindfulness

Dialectical behaviour therapy was another essential aspect of my practicum learning objectives. This fieldwork practicum gave me a tremendous opportunity to learn something so new. I had spent significant time reviewing the literature to understand dialectical behaviour therapy (DBT) thoroughly. Dialectical behaviour therapy was gold that I found from a shipwreck during my diving process. I never knew that DBT would help me to sail through smoothly in therapy. DBT is an evidence-based, structured therapy that provides a road map to the therapist and client to navigate through clients’ emotions. DBT is proven to be effective in assisting clients with severe emotional regulation problems. DBT also supports the client with coping skills to deal with emotions. DBT motivates the client towards change with the help of two powerful elements of therapy: validation and acceptance. DBT balances acceptance and change to work around a behaviour, as shown in figure 5. When you validate clients for certain behaviour, it helps the client to accept the situation and move towards change. (Stanley & Brodsky, 2013). It can be a back-and-forth process; when a client feels validated, a therapist can move towards change, and when a client is struggling with change, a therapist can come back to validation and acceptance (Pederson, 2015).
As Stanley and Brodsky (2013) explain, “Dialectics is a philosophical concept that includes several assumptions: (a) all things are connected; (b) change is inevitable and continual; and (c) opposites can be integrated to develop a closer approximation of the truth” (p. 6). Dialectical behaviour therapy has developed a set of therapeutic skills including mindfulness skills, emotion regulation skills, interpersonal effectiveness skills, and distressed tolerance skills (Neacsiu et al., 2010). Among all skill sets, mindfulness attracted me and fit well with my approach. Mindfulness is also related to Buddhism's religious philosophy. Likewise, meditation is part of the Hindu religion to relax your body in the moment. As a child, we were taught meditation in school. It was a peaceful process to relax your body and be in the moment, so this concept of mindfulness sat well with me. DBT approaches mindfulness in a slightly different therapeutic way. However, the core message is the same: to be in the moment and focus on the current situation. The practice of mindfulness trains the brain to be in the present moment without worrying about the past and/or without fearing the future (Stanley & Brodsky, 2013). For example, while sitting down and relaxing, one would be asked to feel his/her breathing. It can demonstrate the importance of being in the moment and not paying attention to our routine and its significance in our lives. It supports the client to accept themselves by observing the
smallest things around them. As per Pederson (2015), mindfulness is being awake and aware of the current situation, observing things like a child. A child would look into your eyes and follow your hands, your movements, surrounding voices, and activities. Mindfulness suggests a deep breath: observe, feel, smell, and listen to your current activity.

**Importance of Treatment Plan and Discussion with Professional Associate**

As DBT was a brand-new approach for me, I had profound discussions and close supervision from my professional associate. In the first session we shared policy, the procedure of treatment, and confidentiality. Additionally, the client would share their basic information and their goal or what they hoped to achieve from the therapy session. The first session would also address any self-harm or suicidal behaviour, if present. It is vital in DBT to address safety before getting ahead with the treatment plan. In the first session, I would ask the client’s permission to share his/her basic information with my professional associate to seek support. Then I would discuss my treatment plan with my professional associate to implement DBT. It is also crucial in DBT to share the treatment plan with the client to make sure that we are on the same page and heading towards what the client wants to achieve. After establishing a treatment plan, I would attend the session and analyze my skills and session with the help of my professional associate to improve my skills. Such analysis and discussion helped me to have different perceptions of DBT and implement my newly-developed skillset to support the client. The treatment plan and discussions with my professional associate helped me to stay on track with the client.
**Case Scenario 4**

I worked with an adult client with self-blame, depression, and wanting to feel happy in her life. She identified as a person with emotional dysfunction. The first session involved gathering information and explaining policy and procedure to her. She gave me permission to share her case scenario with my professional associate for extra support and guidance. She shared that she was a single woman and her two children were in her ex-husband’s care, but children visited her over the weekends. She had been married to her ex-husband for 22 years before they divorced. She shared that her relationship with her other family members was complicated. She had been very much involved in substance abuse in the past. This is why she was distanced from her family and ex-husband. She had been blaming herself for some decisions she had made. Her addiction had also impacted her relationship with her siblings to the extent that her siblings did not notify the client to attend their mother’s funeral. She had now been sober for two years, but the feeling of blame was following her. We discussed her goals as follows:

A. To forgive herself for past mistakes

B. To spend quality time with children

C. To be happy

Following discussions with my professional associate, I created a treatment plan to use DBT in her treatment with mindfulness. DBT emphasizes therapeutic relationships. In this case scenario, it was essential to have a relationship to allow the client to have open space to share. This client appeared to have so many sad emotions, which is why my professional associate suggested I create open space for my client to trust me. I took care and time with my client to create a safe environment for her to express her feelings. The treatment plan was to prioritize her goal to achieve one by one according to her priorities.
DBT emphasizes validation to support the therapeutic relationship. Validation created a non-judgmental space for this client. I validated her with responses emphasizing that her response in a given situation was the most she could do to cope with the situation (for example, addiction). In each session the client expressed her emotions through crying and subsequently being sorry for her outburst. In this case scenario, the challenge was to manage validation with change. After discussing with my professional associate, I learned to stay focused on the treatment plan. I learned that a therapy session is undoubtedly a place to express feelings, but it is essential not to get trapped. In this scenario, DBT suggests validating the client with an explanation; a therapy session is a place for her to express her feelings, and she is doing the best she is able to do. I also explained it is normal to cry out her feelings and these sessions are a safe place to express her emotions. This validation supported her to feel safe and also helped strengthen the therapeutic relationship. It also supported the client to move towards change as she was being heard and her emotions were being addressed. Validation and acceptance also helped her to forgive herself and reduce self-blame.

Furthermore, we established a mindfulness skill set to spend quality time with her children and be happy. As per the custodial schedule, she would get her children over the weekend. She had a disturbed relationship with her ex-husband, who was working out of the city and away for 15 days of the month. Meanwhile, her ex-husband’s niece would take care of her children while he was away. This arrangement made the client feel guilty about not being able to play her part as a mother. Her feeling was validated with this response: “you want to be a mother figure to your children, but unfortunately, you are bound to do so due to legal arrangements. However, you do have children over the weekend, as you mentioned earlier, you may want to make best out of it.” We discussed applying mindfulness to enjoy her time with her children to be happy. I
explained how to be aware of oneself while spending time with her children, suggesting she make conscious efforts to notice her breathing, feeling her children and their smile and laughter. I also suggested she try not to think of anything else while playing with her children. I advised her to bring herself back intentionally to the present moment right away in case of any thought occurrence. Moreover, I suggested she feel her children’s happiness and feelings to be with them, advising her to do so at least for ten minutes a day.

She practiced mindfulness and came back with some improvement. She was able to exercise mindfulness for 15 minutes with her children whenever they were around. Along with our sessions, she increased time span to practice mindfulness in her routine activities. In one session, she came back stating she had seen some improvement with her feelings when she was with children. She also added that her children were also enjoying time with her. However, she expressed that she was not able to handle her emotions when the children would leave. After discussing her feelings and validating them, I asked her what would help her to feel better once the children were gone for the week. She stated that she would like to take a bath to feel better. We discussed how she could practice mindfulness while taking a bath. I suggested she feel the warmth of the water, the smell of the candle, slow music, and candlelight. This would support her in the moment and relax her body to feel her surroundings without trapping her into any thought process.

Before ending my therapeutic sessions with her, we discussed a treatment plan to improve her feeling of happiness and reduce distressing thoughts by practicing distress tolerance and emotion regulation skills. I also referred her to a different counsellor with her permission to carry forward as my practicum time was ending.
Chapter 6: Play Therapy

My fieldwork practicum objectives also included gaining foundational counselling skills to work with children. Working with children was like exploring a cave in the ocean, as children’s emotions are down deep and hidden in the cave. It is a significant task for a diver to surface these emotions. Most of the children waiting for counselling were residing in a group home and referred through the Ministry of Social Services. My practicum journey with children was part of a lifelong experience for me. During my Bachelor of Social Work in India, I had few opportunities to work with children, aside from organizing some activities to promote the health and safety of children during my bachelor’s degree. I had never worked with children specifically in Canada. It certainly was a different experience to work with children therapeutically. In the hunt for my learning treasure, I had to dive deeper into the ocean to get the precious emotions of my young clients. This learning experience was a surprise in my treasure box. I took this fieldwork opportunity to learn more about children and used a therapeutic play approach to improve their mental wellbeing.

VanFleet et al. (2010) explain play as a process chosen and directed by the player, following their instincts, ideas, and interest with their reasoning to play. Play can be a process for a child’s development and enjoyment. Play therapy creates a safe environment for children where they can safely land their emotions. A therapeutic relationship can then be created to support the child’s wellbeing. Play therapy has been defined as a way of communicating with children to bring their emotions, expression, and social functioning on par with their development to resume further growth and development (VanFleet et al., 2010). Play therapy supports children in modifying their behaviour and gives them surroundings within which to express their emotions more healthily. I had the opportunity to utilize some directive play and
non-directive play as part of play therapy. During my practicum tenure, I often tried to use non-directive play to create a therapeutic relationship with my clients. In some cases, I opted to use directive play to let the children clients express their emotions and modify their behaviours more healthily.

Generally, I used non-directive play therapy for children around the ages of six to nine and directive play therapy for children around the age of ten to thirteen. My reasoning for using non-directive play therapy with younger children was to set them free and create some trust between us. Children in this age group had been apprehended at a very tender age, and they had little to no understanding of their surroundings. Their surroundings at the group home were generally physically safe but sometimes they needed much more emotional safety as well. I found it essential to give them such an environment to create emotional space to express their feelings through play. Sometimes, to my surprise, some children around the ages of five or six knew what was going on and why they had been apprehended and what would happen next if their parents did not follow the case plan to have them back in their care. These clients made me think that their innocence went missing into the system and needed more skills to express their emotions. I used to play some games as part of non-directive play therapy, such as ping-pong, board hockey, snakes and ladders, and various puzzles.

**Children with Trauma**

Before getting into directive and non-directive play, I needed to understand the children’s experiences with trauma. I was encountering a very particular population in our system. My young clients lived in specific and/or collective atmospheres where they might have seen different violent situations, substance abuse, criminal or illegal activities, neglectful behaviour, and abusive situations. On top of these traumatic experiences, some children had been
apprehended and placed in a group home. Children with traumatic experiences later often have psychological disorders, such as post-traumatic stress disorder (PTSD), depression, anxiety, Attention-Deficit / Hyperactivity Disorder (ADHD), and oppositional defiant disorder (ODD) (Lubit et al., 2003).

As per Schwartz (2011), “a trauma is a physical or psychological threat or assault to a child’s sense of self, safety or survival or the safety of another person significant to the child” (p.3). This traumatic experience affects a child’s growth and development. A therapist must provide appropriate support to prevent such trauma and support a child to cope with traumatic experiences. Additionally, Schwartz (2011) confirms that among the nearly 10,000 Canadians who participated in a survey documenting past maltreatment experiences, 21% of females and 31% of males had been physically abused, and 13% of females and 4% of males had been sexually abused. A 2008 national survey found 85,440 cases of children being physically abused, sexually abused, neglected, emotionally maltreated, or exposed to intimate partner violence. This means that based on substantiated child welfare investigations, 1.4% of Canadian children had experienced significant maltreatment. These numbers demand work around the prevention of child abuse, child neglect, and maltreatment. They also require a skill set to support children coping with unfortunate traumatic events of their lives.

The symptoms of PTSD can be very long lasting. Half of victims recover within three months, but many remain ill for a year or more. Symptoms may re-emerge following a subsequent trauma, life stresses, or reminders of the original trauma. Adults who were sexually or physically abused as children show significantly higher rates of PTSD (72%–100%) than children who were not abused (21%–55%). (Lubit et al., 2003, p. 129)
Lubit et al. (2003) further explain that children with traumatic experiences face devastating impacts in their adolescence and adulthood as they develop further relationships. Children with trauma often express their emotions through anger and impulsive behaviour. In addition, Putman (2006) illustrates maltreatment to children and exposure to domestic violence increases school problems. Putman (2006) contends child maltreatment impacts neurological, physiological, and psychological development. The impacts can be lifelong and affect a child’s routine activities.

Children with traumatic experiences need tremendous support to cope with these experiences and generate neurons to create new healthy experiences in their lives. Taylor et al. (2020) link trauma to mental illness. Traumatic experiences lead to biological changes in the body’s stress-sensitive system and create psychological conditions, including cognitive appraisals, memory, and coping responses. It is imperative to explore the risk factor of trauma-related mental illness to support children with coping methods. Dealing with a traumatic experience in childhood may lessen worse effects of trauma during adulthood.

**Refurbishing Non-Directive Play to Directive Play**

With time and experience working with children, I strategized to include snakes and ladders as a directive play as part of play therapy. Many of the children I worked with were not going back into their parents’ care soon, especially children whose parents could not follow the case plan or visitations for many reasons. It was not very comforting for children to understand their parents’ situation and accept the reality. Moreover, this reality impacted children’s emotions for example, feeling sadness, disappointment, anger, lonely, hurt, and frustration. I worked with a few children who liked to play snakes and ladders. After a few games, I thought it would be more strategic to understand their emotions and their thoughts through the game. I used
a strategy to refurbish snake and ladder into a directive play therapy. I used the snake as a down point in life and the ladder as hope in life. Therefore, if someone got to the snake, parents were caught up with something and could not attend visits and/or were not able to follow the case plan due to some reasons. Likewise, each time anyone got the ladder, this signified that some days are good in life and the child would return to their parents once the parents could resolve the problems they were facing and follow the case plan. Getting on a snake and then getting on a ladder indicated that all days are not the same; if they are sad today, one may express his/her painful emotions. Likewise, landing on a ladder meant there would always be hope to get up, and one could express his/her happy feeling.

A refurbished snakes and ladders game helped the children to identify their emotions. Children were more likely to share their emotions with me through this game. Some of the children also expressed an increased understanding of waiting for their parents to work on a case plan. Overall, this task was challenging as I had to make it simple for children. I tried to untie all the emotional knots to let the child’s brain be free to express feelings. Play therapy provided the base to let the child enjoy life and understand their own emotions simultaneously. It helped to build therapeutic relations as well to carry onward on journey to achieve their goals.

Many children clients struggled to communicate with group home staff. Some children clients were not able to express how they were feeling in a particular task or situation. As a result of not expressing what a child was feeling, a child would be getting into a fight with fellow children and become angry with the staff. With these clients specifically, I used to play a puzzle. This puzzle contained 600+ pieces, which is hard for a child to work through. I would strategically offer this puzzle to a child if he/she wanted to play a puzzle and let the child work on it. I received different outcomes from different children considering their emotions and the
way they expressed their emotions. One child tried his best for almost 30-40 minutes of the
session to fix the puzzle,

   Therapist: How are you feeling right now?

   Child: umm… I am enjoying this, I guess. I think I can do this. I need a few more minutes.

   Therapist: You are determined to fix it, and you are feeling joyful (giving a name to his
   feeling)

   Child: I am trying (with a smile)

   This helps the child to express his feeling of joy in an activity.

Then I would ask the child’s permission to have a small chat before further engaging in play. I
would validate how he communicated his feeling and how he could communicate with fellow
children and the staff at the group home. Then I would ask the child to think of a situation where
he felt he was enjoying something and share his feeling of joy with the staff.

Some children would lose interest when they could not fix it:

   Therapist: How are you feeling?

   Child: This is a lot; I am bored (with a flat face).

   Therapist: You are not enjoying it because it is too much!! (Giving a name to her emotions
of not enjoying the activity)

As mentioned above, I would ask the child’s permission and validate her expression of the
emotion of being bored and discussed how she would communicate with the staff and fellow
children when she is bored.

Some children would get frustrated as they are not able to fix it.

   Therapist: How are you feeling?
Child: I do not want to do this; I want to go home (frustration on his face)

Therapist: You are frustrated.

Child: Yeah! No one can fix this puzzle; it is hard. I have homework to do at home.

Similarly, I would ask the child’s permission and ask how he can communicate in a healthy way when he is frustrated with something.

**Directive Play**

Upon creating a safe environment for a child, we worked with emojis. An emoji is a picture of happiness, anger, sadness, fear, joy, worried, surprised, shocked, love, upset. We used to play tic-tac-toe with these emojis, where a child would share his/her understanding of a particular emoji and a situation when they felt that emotion.

My clients were coming from severe past trauma and current isolation in a group home. Most of my children clients struggled to express their emotions more healthily and had behaviour difficulties. Some children had reached the extent of expressing their different feelings with only one emotion: anger. Notably, in this case, I used an iceberg to let them visualize their situations and emotions. It is significant to understand and identify hidden feelings to express them more healthily. This iceberg proved to be the most helpful tool for the child to identify and understand hidden feelings. As mentioned in figure 6, there are often hidden feelings, which come out as anger. For some children, anger is the only feeling they know to express; for others, anger is the only feeling to get people’s attention. For some children, anger is the only feeling to convey a message; for others, anger is a very convenient way to express themselves.

*Case Scenario 5*
I had a young client (possibly with delayed development) in therapy to support him in expressing his emotions and managing anger. He used to get involved in physical fights with fellow children in the group home. Particularly with children exhibiting anger issues, some children have never been allowed to express their feelings. Some were never given a chance to learn to express themselves, as they have been surrounded by people who suppress their feelings. Other children never received attention from their parents. In such traumatic situations, children start to hide their emotions, and then their feelings are isolated. Thus, a child needs to recognize his/her emotions and healthily express those emotions.

It took time for both of us to establish a therapeutic relationship in a session. I had to give him time and power to decide to participate in a session for the first few sessions. He used to come to the session with a phone and would stay on it for most of the allotted time. After a few sessions, he started to open up a bit. I took the opportunity and made a deal with him to spend 15 minutes with me and 15 minutes on the phone. The time on the telephone reduced after a few sessions. The therapeutic relationship was indeed a challenge, but our deal supported it, and he participated somewhat. We started to talk about games he was playing on a phone. He would show me his haircut pictures and his style videos, and I would therapeutically validate his gesture of sharing.

One day, he came with a group home worker, and I was called out to see the group home worker. The group home worker stated that my client’s mother had a visit scheduled to take him to a birthday party, and his mother did not show up. So my client was not ready to attend the session, and they still brought him in. As soon as he entered the building, he smashed a sign in the building out of anger. I talked to my client and asked him if his hand was all right, and he just nodded positively. He looked down in tears, I asked him if he would like to spend time with me,
and he shook his head negatively. We cancelled the session and rescheduled it for the following week. When he came back, we discussed how his week had been. I asked his permission to address the incident that took place the previous week. I started the conversation by stating, “it must have hurt your hand when you punched the thing!” He smiled and said, “no, I was not hurt at all.” I asked his permission to elaborate on the thoughts in his mind at that time and introduced the anger iceberg, as shown in figure 6. I asked him to highlight what he was feeling before coming to the session. He stated that he was sad and disappointed that his mother did not show up.

These two emotions, disappointment and sadness, were suppressed by anger, which was all he knew how to express. I conveyed that his gesture was not appreciated to express his rage by damaging the building property. He also apologized for that. Then we further discussed his feelings and how to express them more healthily in the future. In the following sessions, we worked on triggers to identify anger and coping methods.
Figure 6

Anger Iceberg

Note. Adapted from Anger iceberg, by Therapist Aid, 2019

(https://www.therapistaid.com/therapy-worksheet/anger-iceberg)
Chapter 7: Walk-in Counselling: Motivational Interviewing

The walk-in program was a significant part of the agency. The walk-in program provides support to clients in emergent situations. CFS has a contract with the YWCA to provide online walk-in counselling every Tuesday via Zoom (video conferencing platform). Additionally, walk-in counselling provides therapy to clients experiencing emergent emotional needs and/or who have been referred through a doctor/agency. When I joined the program, CFS staff had been using both single-session therapy and solution-focused therapy. I was responsible for most walk-in clients during my practicum. I asked my professional associate’s permission to use motivational interviewing in my walk-in sessions. CFS provided three walk-in sessions, and if the client needed help, they would then be referred to regular counsellors. In my other work, I had provided support to my clients using motivational interviewing. My clients’ aims were predetermined at this workplace, primarily to achieve the ultimate aim of finding employment. I decided to use motivational interviewing (MI) for few reasons: a) I wanted to use my MI skills to practice in a different setting than my workplace; b) To sharpen my MI skills out of the workplace setting and add variety to my skill set; and c) To keep the momentum of my MI skills to resume work after completing my practicum. In support of this latter goal, I also perform the role of MI mentor at my workplace, where I share my motivational interviewing knowledge and experience with my coworkers in a group learning circle format.

I was organizing Zoom sessions every Tuesday afternoon to provide walk-in sessions to YWCA clients. CFS’s counsellors used to attend YWCA sessions in person before the COVID-19 pandemic. However, an arrangement to have online Zoom sessions was made to respect restrictions due to COVID-19. I had opportunities throughout my practicum to attend regular walk-in sessions, using motivational interviewing to support each client’s emergent needs.
**Motivational Interviewing**

As per Miller and Rollnick (2013), motivational interviewing is like a dance where therapist and client collaboration focuses on change. MI works with a client who is ambivalent about something in his/her life. MI contends that arguments both for and against change reside within an ambivalent person. MI guides the client to work in favour of the change as per the client’s wish. MI is a client-based approach, where the therapist supports the client to explore ambivalence and then guides the client towards change based on the client’s strengths and goals. MI evokes what already exists in the client.

Miller and Rollnick (2013) explain that the spirit of MI relies on four foundational components, as indicated in figure 7.

**Figure 7**

*Spirit of MI*

These components are used in each ongoing conversation to create professional collaboration between therapist and client. The spirit of MI supports the conversation to guide
clients towards change. The spirit of MI suggests having behavioural expression to support the client. For example, empathy: “I understand your situation” vs. behavioural expression: “You have faced a rough time, which has made you strong.” Behavioural expression supports actionable words. Miller and Rollnick (2013) suggest including the spirit of MI in each of the therapist’s reflections and behaviour expression as follows.

Compassion

Compassion can be demonstrated by promoting the client’s welfare and putting the client’s agenda before your own. An example client: ‘I want to lessen my caffeine intake to sleep less during the day.’ It is crucial to support the client to reduce the intake instead of cutting caffeine off from the day only because the therapist thinks caffeine is not suitable for health. It is essential to work around what the client’s agenda to support them to achieve their goals.

Partnership

MI is a collaborative approach like a dance, where someone leads the conversation without tripping or stepping on toes. For example, when a client is all over the map and comes with so many goals to work on, a therapist can create a collaborative conversion by guiding the client to funnel down to one change goal for the walk-in session. The therapist partners with the client to determine a change goal that they are most prepared to initiate and might be ambivalent about.

Acceptance

Acceptance is accepting the client along with everything the client brings to the table. MI suggests accepting the client without having mental models for that person. Acceptance can be demonstrated with the help of four components as follows:
**Absolute Worth.**

Focusing on the client’s worth by demonstrating that each human has strengths within them. As an example:

Therapist: “Please tell me something about yourself which would be important for me to know as your therapist.”

Client: Umm…. I don’t know what to say….! I just woke up and came for this appointment… ummm… I am single… looking for a place to stay…

In this situation, the therapist gives time to the client to think and process. Absolute worth can be demonstrated by believing that whoever enters our office is carrying abilities and strengths.

**Accurate Empathy.**

Taking an active interest and listening the client to see the world through the client’s eyes.

For example:

Client: “I do not want to miss school, but my mood does not let me get up from my bed.”

Therapist: “You feel tied up even though school is something that matters to you.”

**Autonomy Support.**

Honouring the client’s choices and decision-making. Acceptance involves believing that the client knows him/herself the best.

Client: “I want to spend more time with my kids instead of fighting with my ex-spouse.”

Therapist: You are choosing to spend quality time with your children.”

**Affirmation.**

Identifying and validating clients’ strengths and abilities.
Client: “I do not want to be angry with my kids; I tried several ways to keep them happy.”

Therapist: “You have the ability to gather your resources to keep your children happy.”

**Evocation**

Focusing on clients’ strengths, desires, hope, and resources. Clients already have motivation and resources within themselves; evoking helps the client to identify them and uphold that motivation to support their change goal.

Furthermore, Miller and Rollnick (2013) identify four processes to guide the MI conversation towards change, as described in figure 8.

**Figure 8**

*Motivational Interview Processes*

![Motivational Interview Processes Diagram](image)

**Engaging**

“Engaging is the process by which both parties establish a helpful connection and a working relationship” (Miller & Rollnick, 2013, p. 26). Engaging relies heavily on the spirit of MI to establish a therapeutic relationship. For example, the client might share: “I am sleeping a lot, my anxiety and depression are throwing me off, I wish I had a routine.” The therapist might respond: “Your mental health is essential to establish a sense of routine in your life.” This
response demonstrates how the therapist listens to the client’s heart and focuses on what the client is hoping to achieve to move forward.

**Focusing**

“Focusing process helps to clarify direction, the horizon towards which one intends to move. What changes are hoped to arise from this consultation” (Miller & Rollnick, 2013, p. 26). Focusing is a significant aspect to guide the client to move forward. It is crucial to funnel down to one goal to create a neuropath towards evoking process. This will support the conversation to stay on goal. It will give a helicopter view to the client with all changes they want to make and then funnel it down to one change goal, as mentioned in figure 9. It will support the client’s thought process to break down all goals and then work on one at a time.

**Figure 9**

*Funnel down to a change goal*
**Evoking**

Miller & Rollnick (2013) consider evoking a significant part of motivational interviewing. It is a process of arguing in favour of a change – to evoke the client’s thoughts, values, strengths, past successes and leverage change talk with the help of open-ended questions and reflections. Typically, a therapist will explore why the client wants to make the change and how to increase the confidence to support the client’s change talk. Miller & Rollnick (2013) suggest scaling for importance and confidence and using open-ended questions to evoke the client’s thoughts and reflections to listen to the client’s heart. Example of scaling for importance; ‘on a scale of 0 to 10, where 0 is less important and 10 is very important, how important is it for you to work on depression?’

**Planning**

Miller & Rollnick (2013) illustrate planning as the last phase of motivational interviewing. Planning can put thoughts into action and to move towards the change goal. Miller & Rollnick (2013) suggest planning collaboratively with the client to work on the planning. Two visible clues suggest working on planning: first, when a client’s change talk increases, and second, when a client is taking some steps towards the change goal.

During this practicum, I sharpened my motivational interviewing skills with diverse populations and various issues to support and guide clients to move forward in their lives. MI also supported my learning to keep negative mental models aside and utilize positive mental models to guide the client.
Chapter 8: Social Work Practice with Equity and a Non-Judgemental Approach

My social worker skill set provided diving equipment to practice the diving process under the water in this practicum. The code of ethics played the role of my air tank. The code of ethics is like air; invisible but necessary to have built within to support equity and non-judgemental behaviour towards clients. The Canadian Association of Social Workers acknowledges that core social work values are followed by principles to guide social workers to practice in the community. It is essential to carry these values and regulations throughout the practice. The Canadian Association of Social Workers (2005, p. 4) identifies six values, and I have integrated all values throughout my practicum as follows.

Value 1: Respect for the Inherent Dignity and Worth of Persons

As a social worker, I have constantly scanned the situations and people I have encountered using a human rights lens with a filter of equity. It was achieved by respecting clients’ diversity with respecting their age, culture, tradition, colour, language, and socio-economic condition. For example, my youngest child client was six years old. As a therapist, I explained what counselling is, what we would do during our time, and the purpose behind our time together. It is essential to demonstrate respect for child clients by explaining to them and asking their permission before entering their space. I also used simple language to explain privacy and confidentiality to respect the child client’s understanding.

Value 2: Pursuit of Social Justice

A social worker’s role relies on the principles of social justice. I had made sure to utilize my knowledge of community resources to refer my clients when needed. Social workers play a role in the community when it comes to serving people with marginalized opportunities, disadvantaged situations, and people with vulnerability in society. It is essential to have their
human rights and basic needs protected. For example, I had a client with depression. In the first session, this client identified her basic need for shelter and food. It was significant to provide her with resources to meet these basic needs before working on anything else. It was essential to provide her with an equal opportunity to be in a specific state of mind to address the most immediate needs. 

**Value 3: Service to Humanity**

Social workers provide services based on clients’ needs. As humans, we all have our own goals, values, and assumptions. We carry our agendas with us in social work, but we provide services based on the client’s agenda. We put the client’s choices and welfare before our own. In each session, I practiced respecting the client’s choices and believing that the client knows themselves the best. For example, the biggest dilemma I encountered was when I had clients with substance abuse and mental health issues as a social worker. These two factors go hand-in-hand when it comes to the client’s psychological well-being. In some situations, the client would not be prepared to work on substance use, while according to my agenda, it is equally important to work on substance use as to work on mental health. To make appropriate decisions, I gave my clients clear choices explaining how working on substance use would also support their mental well-being. I would then give them time to consider the information before making a decision. This practice supported the client’s welfare as well as their decision-making.

**Value 4: Integrity in Professional Practice**

It is significant to value what we do and do it responsibly. Social workers practice with integrity by being honest with clients and valuing our work. For example, I saw a client for counselling at the practicum site, and I also encountered the same client at my work site. I had to honour the integrity of my work at my work site as well. I asked the client’s permission to have
her case with me, and explained that she could decide to have a different worker. I also assured her that I would be non-judgemental based on what I knew about her life. Practicing integrity in our profession also helps build a therapeutic relationship with a client. It supports the session to have transparency within which to exchange ideas and thoughts.

**Value 5: Confidentiality in Professional Practice**

This is a significant aspect of practicing social work. We are in an information technology world where information is stored on paper and in computer databases. We tend to be so casual with the information we receive from our clients. It is very much our responsibility to store information wisely and securely. For example, I asked my clients’ permission to share their case scenarios with my professional associate and fellow counsellors if needed in meetings. While sharing any complex case scenario at lunchtime or in any kind of meeting, I also made sure to be careful of what I was sharing.

**Value 6: Competence in Professional Practice**

The world is engaged in innovation. We are waking up to a new invention every day. It is essential to keep up and stay updated with resources to constantly develop our ethics and values. For example, I completed my practicum during the COVID-19 pandemic. To adapt, I held therapeutic sessions arranged through phone, in-person and online as well. It was challenging but essential to develop my skills to practice counselling through different methods. It was also a necessary adaptation to maintain client’s safety and my own safety during the pandemic.

Overall, carrying each value in my code of ethics as an oxygen tank during my diving process supported therapeutic relationships meaningfully. The code of ethics also resolved dilemmas experienced on several occasions throughout my practicum.
Challenges and Critical Analysis

Throughout my fieldwork practicum, I recorded my challenges and critical analysis of every day’s experiences at the practicum site. Evaluating my day and skills helped me to improve my work around what I intended to learn and practice to shape my skill set. In my teenage years, I used to maintain a journal. I would record my learning, motivation, aims, hopes, and things to work on. This habit supported me to shape myself and become a more organized person with values. In the context of my practicum, I wanted to record my challenges and critical analysis to create a better version of my skills every day. Below, I have outlined significant challenges and analyses of my practicum.

A Broken Link

Cognitive Behavioural therapy focuses on adolescents’ thoughts and behaviour and their parents/caregivers’ input. CBT believes that specifically for adolescents’ thoughts and functioning, it is important to have their parents’ input. Parents may have ideas of adolescents functioning around the problem area. Parental input helps to understand the family relationship and what parents have tried to address to work on a problem. The therapist does not rely on the parents’ views to assess adolescents’ personal feelings and moods. However, it is beneficial to collect information on surrounding people’s thoughts about the problem the adolescent is experiencing (Verduyn et al., 2009). Conversely, my adolescent clients were residing in a group home as they had been apprehended from their parents. Thus, it was not possible to have parents around to be part of the team. In such cases, a therapist has to rely on their case information from the group home, and sometimes group home staff are not aware of what adolescents are going through. This makes the situation difficult for adolescents without any support at home. As a
therapist, I read the case report; however, I relied explicitly on what my client was bringing to the table and developed a treatment plan according to the client’s information and needs.

**Mental Models and Confidentiality**

Another challenge was related to confidentiality and my mental models. I had a few clients at my practicum site who were on social assistance and/or the parents of my adolescent clients were on social assistance. Those individuals and/or parents were also my clients at my other workplace. It was challenging to keep my mental models aside in such a situation as I had additional information about the client/parents. I tried to leave my mental models out, which may serve me negatively. I used to keep positive mental models in my pocket. I also would ask the client whether he/she would like to continue with the session, or prefer to be placed with a different counsellor. I also made sure that the client would be comfortable if they chose to continue the session by confirming that they would not be judged based on what I know about them or their financial situation. This played an essential role in establishing a therapeutic relationship with transparency between us.

**COVID-19 Restrictions**

COVID-19 had a significant impact while working with children. Engaging with a mask on was a bit challenging with children. As a result, launching therapeutic relationships with children was one of the most challenging parts of my practicum. Children with traumatic experiences are very hesitant to engage with new people. I spent significant time with these children clients to establish a therapeutic relationship. However, having masks on and playing with them was hard for the children, and slowed the process of developing trust. Wearing masks
was essential. To create a trusting environment, I discussed what counselling is and provided them with the plan for the session to make them comfortable.

A Report of Concern from Group Home Worker vs. Client’s Concern

As mentioned earlier, I had clients referred from a group home with concerns that the group home workers wanted addressed through therapy. During the session, I would be transparent with my clients about what the report conveyed and would ask my client if they agreed with it and/or had any different concerns to address or any comments. Sometimes, the client disagreed and wanted to address a different concern. In this case, I would go with what the client was wanting to achieve from the session. The transparent conversation helped me and my client to generate reliance between us. As a result, clients would feel worthy of themselves as they have someone to listen to their concerns.

Adolescents from Group Homes without any Goal for Therapy Forced to Attend Counselling

Some adolescents from the group home were forced to attend therapy. However, they were not interested and had no concerns to address. In such situations it was challenging, to begin with, to establish a therapeutic relationship and carry on a treatment plan. I contributed most of my time to creating a trustworthy space to let the client share their thoughts, which didn’t necessarily address any concerns. This challenge taught me to keep an open mind for the client to attend without any judgments.

Limited Knowledge of any Clinical Diagnosis Client May Have

Clients residing in a group home might not be officially diagnosed but may show some symptoms of mental health issues. The referral form also does not provide any information from the Ministry of Social Services or other agencies. Sometimes, clients do not reveal any clinical
diagnosis information in initial sessions. As a result, sessions begin without having an appropriate treatment plan. A treatment plan is an essential aspect to staying on track during the session. As mentioned earlier, a treatment plan helps to focus on the client’s priorities and hopes. Working on client’s goal helps the client find motivation within as they see themselves working on their desired goal. However, a lack of accurate diagnosis disturbs the agenda. In such cases, the therapy session occurred without any goal. This was a challenge to addressing what the client is hoping to work on. I learned to keep the conversation goal-oriented as much as possible.

**Case Scenario 6**

A client came for therapy to work on depression. After the first few sessions, she revealed that she also has bipolar disorder but does not take medication regularly. I took this disclosure as a positive step in our therapeutic relationship as the client had trusted the therapist to share this medical diagnosis. However, managing depression and bipolar disorder requires different approaches. I had to mix two approaches to support the treatment plan. During the session, I thought to utilize CBT with DBT mindfulness to support the client’s mental health. I had a few sessions with this client, but it was challenging to utilize both approaches and stay on track. We worked on relating the client’s thoughts and emotions as part of CBT. Then we worked on bipolar disorder with DBT mindfulness. DBT helped the client to accept her current situation. Then CBT allowed her to reconstruct her thoughts to change her current situation. We worked on how to be in the present time when the problem occurs and reconstruct her thoughts to change her emotions. It was challenging as a therapist to blend in these two approaches when I had less knowledge of the client’s medical diagnosis.
Being All Over the Map

Sometimes, I felt like I was all over the map. I was not leading the client; instead, I was letting the client lead me. I tried to be focused on a change goal and the therapeutic relationship while working with my clients. However, in some sessions, I could not bring clients back to work on the decided agenda. As a result, we were all over the map and distracted from the goal. There was a time when I felt so disoriented and was not working strategically.

Case Scenario 7

I had a 21-year-old female client wanting to work on her anxiety, stress, and anger. She decided to work on stress. However, in the middle of our discussion, she would come up with different conversations about her boyfriend and their fights, addictions, boyfriend’s friends, cheating, and getting her child back in her care. I realized that she had various challenges in her life. We spent a few sessions together, but we were neither moving forward nor working on a goal. To address this, I had to do some self-analysis with my professional associate. We discussed how I was feeling disoriented, and Sheila challenged me to find out if I felt comfortable working with a person experiencing psychological disabilities. My professional associate also challenged me to self-check if I was moving ahead of the client, but the client was not yet ready to proceed further. My professional associate suggested that I discuss this client’s case study with another counsellor experienced with people with significant psychological disabilities. After discussing with another counsellor, I could take some tips to work in my sessions.

Moreover, I re-evaluated my emotions and skills to work with this client. I realized that I needed to slow down and be on the client’s pace. I learned to take small steps with this client and
use elementary language with her. I also learned to go back to our therapeutic relationship first and then work on a problem after. This gesture helped me set some boundaries with her when we are having a conversation about one issue she wants to work on. These challenges helped me lead the conversation towards the client’s goal.

**COVID-19 Restrictions**

I could not sit in a session to observe a professional therapist due to COVID-19 restrictions. CFS’s office setting is small to fit more than two people in a session to respect social distancing guidelines.

**Weak point**

Mostly, I had children referred through the Ministry of Social Services, residing in a group home. Personally, it was hard to see the children in rough situations and read through their case notes. However, I brainstormed and used mindfulness approaches to manage this, leveraging my social worker skills. Seeing these clients was especially tough as I was pregnant at the time. I focused on self-care by practicing deep breathing whenever needed after or before a session. I tried to make sure that I was debriefing with my professional associate to support my self-care. Working with children and adolescents brought so many insights from their traumatic experiences. It was essential to manage my emotions and support my clients to create an environment in which they could feel safe. My social worker’s empathetic skill set was very useful to support my clients’ emotions by validating them with empathetic behaviour. Being empathetic to my clients and myself was helpful to understand my clients’ and my own emotions.
**Time and transition created boundaries**

I had a remarkable experience working with adolescents and practicing CBT with them. CBT emphasizes having a therapeutic relationship with clients. To build a therapeutic relationship, it takes time for adolescents to feel safe to express emotions. In some cases, they were being moved from one group home to another place. Thus, sometimes the transition was a barrier for clients to continue with the therapy. My adolescent clients would be trying to find a foothold in a session, and the next day they were no longer attending therapy. Likewise, establishing therapeutic relations took time with a few clients, and by the time a trustworthy relationship was established, my practicum tenure was coming to an end. It impacts the client’s emotions when they know that they will have a new counsellor to continue with sessions.

**Limited equipment for play therapy**

Access to play therapy equipment was limited due to COVID-19 restrictions. Some children are more comfortable with various toys in play therapy, which is vital for engaging. We had limited access to toys, which took time for children to be at ease in counselling sessions.

**A risk**

Working in COVID-19 was a kind of a challenge itself, especially with my pregnancy. However, CFS followed the required measurements for the safety of therapists and clients. I was proud of myself and my fellow staff for taking this challenge with all safety measurements to support the community.

**Just a Final Thought:**

I have been privileged to be part of two diverse countries: India and Canada. These two countries are examples of “unity in diversity.” As a human, having equal opportunities and
resources to have a good quality of life and be progressive in life is significant. At the end of the day, we all are human with brains, hearts, and emotions. Looking at my entire journey from Bachelor of Social Work to Master of Social Work, I have summarized my observation of the community as follows:

Causes might be different, but suffering is the same,

Culture might be different, but problems are the same,

Approaches might be different, but the intention is the same,

The surroundings might be different, but care is the same,

People might be different, but feelings are the same,

Behaviour might be different, but empathy and compassion are the same...!
References


https://casls-primo-
prod.hosted.exlibrisgroup.com/permalink/f/2k7505/01CASLS_REGINA_ALMA51152205600003476

prod.hosted.exlibrisgroup.com/permalink/f/1ed24l6/TN_cdi_proquest_miscellaneous_71597090

prod.hosted.exlibrisgroup.com/permalink/f/2k7505/01CASLS_REGINA_ALMA51153279090003476

prod.hosted.exlibrisgroup.com/permalink/f/2k7505/01CASLS_REGINA_ALMA51240420240003476

prod.hosted.exlibrisgroup.com/permalink/f/1ed24l6/TN_cdi_proquest_miscellaneous_733960212


http://summit.sfu.ca/search/apachesolr_search/Quarterly%202011%20Volume%205.3


https://doi.org/10.1007/978-981-10-2348-4


