RAINBOWS AND ROADBLOCKS:
A COUNSELLING JOURNEY AT EHRLO COUNSELLING SERVICES

A Field Practicum Report
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By
Nina Nyalowo
Regina, Saskatchewan
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Abstract

This practicum report reflects and summarizes my learning experiences as a student counsellor during a twelve-week field practicum placement at Ehrlo Counselling Services (ECS). This report outlines my learning goals and outcomes, as well as the challenges and successes I experienced throughout my practicum. It provides a literature review focused on acceptance and commitment therapy (ACT), cognitive behavioural therapy (CBT), and trauma-informed practice (TIP). This report briefly highlights lessons I learnt, and skills I gained from practicing motivational interviewing under clinical supervision, which enhanced my social work skills. Additionally, this report will discuss my insights, learning opportunities, ethical considerations, self-care, and de-colonization in counselling.
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Chapter One: Introduction

When I was younger, I was passionate about watching justice and criminology television shows because every show I watched had a resolution at the end. My young mind thought that life could be like this - if something was broken/bent, we could just fix it or replace it. I have since learnt that life is not quite like that; life is more complex than “fixing,” “resolving,” “punishing,” and “revenging” what has been broken. Studying social work appealed to me because social work does not aim to “fix”; it aspires to listen, advocate, support, empower and, where possible, rekindle peoples’ life spark. I liked social work because the code of ethics and ethical guidelines followed by social workers align with my values of social justice, respect for individuals, and service to humanity.

Counselling is commonly construed as a venue to fix people, things, and situations. While that holds some truth, there is more to it. Counselling is a relationship characterized by respect, trust, empathy, collaboration, and vulnerability. Counselling aims to provide a safe space for clients to explore, find, and clarify ways to cultivate and maintain a healthy well-being (Cracknell, 1987). When I began my journey toward obtaining my Master of Social Work (MSW) degree, I knew that I would have to do a field practicum to achieve my goal of developing counselling skills, so I searched for a practicum placement that would help me meet this need and obtain this goal. I chose Ehrlo Counselling Services (ECS) as my practicum agency because of its positive reputation among former students who had completed placements there. The warm welcome I got during my initial meeting with ECS helped me to feel like it would be a safe and accommodating environment for my growth journey.

My practicum placement spanned over four months, from January 5th, 2022, to April 28th, 2022. The primary focus of my field practicum placement with Ehrlo Counselling Services...
(ECS) was to develop counselling skills and cultivate a deeper understanding of clinical practice in social work with individuals of various ages dealing with diverse presenting issues. To start my journey in the counselling sector, I chose to focus on acceptance and commitment therapy, cognitive behavioural therapy, and trauma-informed practice.

This report will reflect my experience as a student counsellor at Ehrlo Counselling Services. It will include a literature review that describes acceptance and commitment therapy, cognitive behavioural therapy, and trauma-informed practice. It will articulate my observations and reflections from applying acceptance and commitment therapy, cognitive behavioural therapy, trauma-informed practice, and motivational interviewing. Additionally, this report will discuss ethical dilemmas and considerations and my insights on social location, self-care, and de-colonization of counselling.

**Practicum Goals and Learning Activities**

I had five primary goals for my practicum, which focused on helping me develop knowledge, acquire skills and practice techniques, and set a firm foundation for my future work in social work counselling. I performed various activities to help me achieve the following goals:

1. Acquire knowledge and understanding of cognitive behavioural therapy (CBT), acceptance and commitment therapy (ACT), and trauma-informed practice (TIP) while at Ehrlo Counselling Services. In order to achieve this objective, I conducted a literature review to increase my theoretical understanding of cognitive behavioural therapy, acceptance and commitment therapy, trauma-informed practice, and other theories and approaches that helped me to serve my clients better.

2. Develop skills and experience in counselling by applying cognitive behavioural therapy, acceptance and commitment therapy, and trauma-informed practice while at Ehrlo
Counselling Services. In order to achieve this goal, I observed my professional associate and other clinicians, and I later co-facilitated and independently completed intakes, bio-psycho-social assessments, treatment planning, and intervention processes. I also facilitated a presentation on grief during the dementia journey to the ECS team and participated in multiple training opportunities at ECS.

3. Develop competence in individual counselling as well as in case management. With clients’ consent, I observed face-to-face counselling sessions completed by my professional associate and other clinicians at ECS. I conducted ongoing counselling sessions and case management of clients assigned to me by my professional associate. I video recorded a session with a client’s consent for review and reflection on my learning and growth.

4. Develop an understanding of how to provide clinical services during the pandemic by utilizing various mediums of communication, such as telephone and video conferencing. I observed my professional associate and other clinicians having in-person sessions and using telephone and Microsoft Teams for virtual counselling. I had multiple opportunities to co-facilitate and conduct counselling sessions independently using all three mediums.

5. Cultivate self-awareness, integrity, and self-reflection in clinical practice. Throughout my practicum, I attended weekly meetings with my professional associate. I continuously reflected on my social location and my roles and responsibilities while engaging in clinical social work practice with the diverse populations at Ehrlo Counselling Services.

Practicum Setting

I was honoured with an opportunity to do my practicum at Ehrlo Counselling Services (ECS), a branch of Ranch Ehrlo Society. I first encountered ECS during a consultation meeting with my academic supervisor while trying to figure out the process of obtaining a field practicum
placement. I did my research and discovered that the ECS team has impeccable clinical skills, and they uphold trauma-informed, strengths-based, person-centered, and anti-oppressive approaches in their clinical practice; all of which sat well with my values.

**Ranch Ehrlo Society**

Ranch Ehrlo Society (RES) was founded in 1966 as a residential program to support six youth with complex needs (Pawson, 2004; Ranch Ehrlo Society, 2022). Since then, this program has expanded into an intensive, well-rounded, and highly specialized treatment for youth, families, and communities (Ranch Ehrlo Society, 2022). RES provides a wide range of programs such as family treatment and preservation, assessments and psychotherapy, early learning supports, emergency receiving services, treatment foster care, and education for children and youth with diverse needs (Ranch Ehrlo Society, 2022). They also offer group living for youth, vocational training, affordable housing, group living care for older adolescents and adults with complex needs, and community recreation programs for at-risk youth and community members (Ranch Ehrlo Society, 2022).

Ranch Ehrlo Society is grounded in, and upholds, the CARE Model (Ranch Ehrlo Society, 2022). The CARE model is a multi-level program that strives to improve the experiences of children and youth in care by providing developmentally-focused, family-involved, relationship-based, trauma-informed, competence-centered, and ecologically-oriented services (Ranch Ehrlo Society, 2022). Ranch Ehrlo Society and Ehrlo Counselling Services are devoted to upholding self-determination, competence, integrity, respect for individuals and the family unit, strength-based approaches, and trauma-informed practice. ECS’ values of respect, compassion, integrity, person-centeredness, and anti-oppressive understandings and approaches synched well with mine, and this made for a wonderful learning experience.
Ehrlo Counselling Services

Ehrlo Counselling Services (ECS) is a branch of Ranch Ehrlo Society. It is a non-profit organization that provides competent and high-quality counselling, assessments, consultation, education, psychoeducation, and training on various topics to the community (Ehrlo Counselling Services, 2022). ECS aims to provide preventative and early interventions and promote healthier well-being for children, youth, adults, and families all over Saskatchewan.

There are three departments within Ehrlo Counselling Services. I worked with the counselling team, commonly identified as Ehrlo Counselling. This department has one registered social worker, one registered counsellor and educator, five registered psychologists, several contract counsellors, and two administrative staff. The second department is the Cognitive Disabilities Strategy (CDS), which has two consultants. This team offers services to address some unmet needs that individuals with cognitive disabilities and their families face. CDS aims to bridge the gap between the current community services and needs that do not quite fit into eligibility lists. The third department is the Clinical Assessments Resource Services (CARS) which provides numerous services to residents (individuals and families) within Ranch Ehrlo Society. Some of the services include but are not limited to assessments, complex diagnostic psychological assessments, therapeutic crisis intervention certification, FASD support, speech and language pathology services, CARE training and certification, individual counselling, and psychiatric services.

Ehrlo Counselling Services has a diverse clientele that includes children, adolescents, adults, couples, and families. ECS provides therapeutic support for numerous presenting issues such as anxiety, depression, low motivation, anger, trauma, grief, self-harm, suicidal ideation, parent/child challenges, couples’ communication problems, relationship problems, bullying, and
stress, to mention a few. ECS receives referrals from various sources, such as the Ministry of Social Services, Ranch Ehlro Society programs, Employee and Family Assistance Programs (EFAP), as well as self-referrals. ECS provides different funding and payment options to ease access to its services. Options range from self-pay, sliding scales, coverage by insurance companies, payment support from government agencies like the Ministry of Social Services, and others.

**Counselling Process at Ehrlo Counselling Services.** Hackney and Cormier (2005) proposed a five-stage model for the counselling process: initial stage; problem assessment stage; goal-setting stage; intervention stage; and evaluation and termination or referral stage. These phases can be, and have been, adapted in different ways by different scholars and clinicians. Nichols (2014) classifies the counselling process into these stages: the initial telephone call where an overview of the presenting issues is discussed; the initial interview/session; the early phase where goals and previous attempts to achieve goals are explored; the middle phase where new action plans are created; and finally, termination. Ehrlo Counselling Services modified these stages into: the intake process, the initial assessment, the treatment/intervention phase, and termination.

**The Intake Process (Initial Telephone Call).** The intake process is the first point of contact for individuals searching for counselling services (Sutton, 2021). At ECS, the intake coordinator receives referrals and calls the potential client to collect demographic information, current employment or education status, funding options, and referral source. During the call, the intake coordinator inquires about substance abuse issues, suicide ideation and suicide attempts, and self-harm. They also ask for a brief description of the client’s reasons for seeking counselling or assessments. The final step in the intake process is to inform the individual that
they will be added to the waitlist, and they are informed of the current wait times, which at the
time of my placement were approximately a month to two months long. Ehrlo Counselling
Services holds weekly intake meetings during which counsellors are briefed on people looking
for counselling. The counsellors pick clients based on their own areas of expertise to ensure
competent support. I had a few opportunities to make intake calls, and I attended weekly
meetings. All clients that I worked with during this practicum were assigned to me during intake
meetings, and two came from intake calls I made myself after consultation with my professional
associate.

**The Initial Assessment.** This is the first session between the counsellor and the client(s),
and it sets the tone for the client's counselling experience. At ECS, the counsellor starts by
reviewing consent to treatment forms, confidentiality forms, and fee agreement forms during this
session. Before the COVID-19 pandemic restrictions were lifted in February 2022, counsellors
also reviewed a consent for in-person services form with all clients. This consent form asked for
consent from the client stating that they were okay with Ehrlo Counselling Services staff
reviewing a COVID-19 symptom and contact checklist. This document informed the client of the
steps ECS took to ensure the safety of both clients and staff. The form also requested that clients
inform their counsellor if they were sick or isolating so that the session could be rescheduled or
switched to a virtual or telephone platform.

The initial assessment stage also involves building rapport and an alliance with clients
(Nichols, 2014) as the counsellor gathers bio-psycho-social information from them. I observed
that some clients were more open, so they shared information easily with fewer prompts. A few
clients were more reserved, so strong communication skills were necessary to help build rapport.
In these initial sessions, I focused on learning about what brought the client to counselling and
inquired about their treatment goals. Sutton (2021) relates that this stage focuses on listening for and assessing the problem. I did my best to validate clients’ experiences and acknowledge their courage in coming for counselling. Nichols (2014) states that clinicians should avoid jumping to conclusions and instead listen carefully and validate the client's feelings.

**Treatment/Intervention and Action Stage.** The Ehrlo Counselling Services team emphasizes and ensures that all treatment goals and action plans are created in collaboration with the client. During this stage, counsellors check in with clients to see how successful or challenging it was to implement their action plans, coping skills, and behaviour modifications in-between sessions. Corey (2013) stated that during the treatment/action phase, it is important to encourage clients to integrate the newly learnt coping skills into their daily routines. This is important so that when the time between sessions starts to get longer, the client is well equipped to handle stress or distress by using the knowledge they would have attained during counselling sessions (Corey, 2013; Davies, 2021a).

This stage is very subjective to the client’s age and needs. For some people, talk therapy is appropriate, while others find it hard to just talk without doing something with their hands. I found it helpful to pay attention to the client’s needs so that they found counselling to be comfortable and safe. One of my clients preferred to colour in a coloring book as we talked, while another preferred to talk only because they found doing activities while talking to be distracting.

My comfort level at the beginning of my practicum was higher with adults, so that is where I started. My first three assigned clients were aged 20, 34, and 53. As time went by, I observed my professional associate working with teenagers. Eventually, I worked up to counselling individuals under 18 years of age by starting with an 18-year-old. Later I had the
opportunity to work with an 11, 16, and another 18-year-old.

During my counselling learning journey, I noticed a big difference between working with 11, 18, 20, 38, and 53-year-old individuals. I have heard people say every client is different, but I did not comprehend the magnitude of the differences. I realized that the counsellors need to be different with each client to build rapport because clients are at different developmental stages. Meeting the client where they are at requires counsellors to be chameleons. They must monitor and adjust their tone of voice, posture, and techniques to shape the session to the client’s needs.

**Evaluation and Termination.** Termination in counselling occurs when the presenting issue is resolved (Nichols, 2014). Clinicians should always complete progress evaluations before discussing termination with clients (Nichols, 2014). Evaluation is where the counsellor and the client examine the client’s progress and discuss what has changed or improved, what needs to change, remain, or be added to the client’s goals and action plans to effect their desired progress. Sutton (2021) states that while termination may not seem like a stage in the counselling process, it is vital and should be planned for properly. The reasoning and timing of terminations must be discussed with clients so that there are no misunderstandings about the end of the counselling relationship.

For the clients with whom I had planned terminations, I collaborated with them to evaluate their treatment goals and coping strategies. I explained that if they felt they needed more support at the end of my practicum, they would be connected with another counsellor. Typically, before termination, sessions are spaced out so that there is more time between sessions for the client to apply skills they have been working on during sessions (Davies, 2021a). I could not do this with my clients because they still needed more intensive support. As a result, the majority of clients that I worked with during my practicum transitioned to my supervisor when my placement was
I did make efforts to turn the termination phase into a celebration and customized it for each client. Before their final session with me, I asked each client what they would like to include in their final session. The responses varied, but I made sure to express my appreciation to each of them for agreeing to work with me. For some, I handed out therapy completion and appreciation certificates. For another, we talked about crime shows and a wishlist of summer adventures. For my youngest client, we ended our sessions by playing with edible paper and edible ink.

In this chapter, I discussed my practicum goals, practicum setting, and the counselling process at Ehrlo Counselling Services. The next chapter discusses a literature review of trauma-informed practice and my understanding of trauma. It will portray how I fulfilled my goal of integrating trauma-informed practice into my clinical social work practicum.
Chapter Two: Trauma-Informed Practice Framework

A solid understanding of theoretical frameworks provides a firm foundation for competent and ethical work, and it provides social workers with a sense of direction and purpose (Maclean, 2021). My main focus during my practicum was trauma-informed practice. However, I also used anti-oppressive, strength-based, and person-centered practices in my clinical work. For this report, I will only discuss trauma-informed practice and summarize what I learnt about trauma and the importance of upholding trauma-informed values.

Trauma-Informed Practice

There has been a shift in how we view trauma in that we no longer view it as black or white (Antunes, 2018). Previously, definitions of trauma were derived from the type of event, but over time, people started looking at the type of experience that the event created for the individual (Olds, 2021). Trauma-informed practice (TIP) is grounded in the premise of asking “what happened to you?” rather than “what is wrong with you?” (Trauma-Informed Care Implementation Resource Center, 2021). TIP aims to help people understand how their past influences the present (Knight, 2015). TIP helps clients develop coping skills to deal with dissonance that stems from the trauma they have experienced (Knight, 2015).

The Four Rs of Trauma-Informed Practice

Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) produced a report that defines the four R’s (realize, recognize, respond, and resist re-traumatization) as the fundamental principles for trauma-informed practice. The first ‘R’, realization, calls out to clinicians to realize what trauma is and how it affects people on micro, meso, and macro levels. The second ‘R’, recognize, relates to recognizing the signs of trauma that will differ from person to person. The third ‘R’, respond, speaks to actions that agencies and
systems can take to reflect trauma-informed principles and values in their service delivery and policies. The fourth ‘R’, \textit{resist re-traumatization}, calls for adequate training and knowledge of trauma, its triggers, signs, awareness of boundaries, communication (non-verbal and verbal), and physical factors like room set-up (tight spaces, sitting too close, no windows) (SAMHSA, 2014).

\textbf{What is Trauma?}

When we talk about trauma, we think about the experiences when a person felt overwhelmed, trapped, and powerless (Olds, 2021). Trauma is an emotional reaction to a tragic experience (American Psychological Association, 2022). The Canadian Centre on Substance Abuse and Addiction (2014) defines trauma as an event that overwhelms an individual’s coping capability. Trauma is the event’s impact on our nervous system; it is the lingering residue that surfaces sporadically (Olds, 2021). Trauma is when an experience rewrites our brain in a negative direction (Olds, 2021). Trauma in a person looks like personality; trauma in a family looks like family traits; and trauma in a society looks like culture (Menakem, 2017).

\textbf{The Three Es of Trauma}

The Substance Abuse and Mental Health Services Administration [SAMHSA] (2014) suggests that there are three parts to defining trauma which they classified as the three Es of trauma; namely: the event, the experience of the event, and the effect of the event. \textit{Events} are the actual or extreme threat of physical or psychological harm (SAMHSA, 2014). These events include anything harmful to the body, nervous system, or sense of safety (Antunes, 2018). The experience of an event is very individualized. How we understand the event and how it affects us determines whether or not it is traumatic. A traumatic event will impact us differently depending on the stage of life we are at. Antunes (2018) states that childhood experiences of trauma will impact a person differently than an adult or teenage experience. Whether the event is intentional
or accidental will also impact our experience (Antunes, 2018). We must also consider the differences between experiencing trauma for the first time and experiencing trauma on multiple occasions. Our relationship with the source of trauma also impacts how we experience it. The closer we are to the source (person, location, event), the more intense the experience will be (Antunes, 2018).

*The effect of an event* can be short or long-term. Short-term effects include shock and denial, while long-term effects include erratic emotions, flashbacks, and relationship dysfunction. Some people also experience physical symptoms like headaches and nausea (American Psychological Association, 2022). The individual may not recognize the connections between the traumatic event and their distress symptoms in stress management, relationship building, attention, and thinking (SAMHSA, 2014).

**Dimensions of Trauma**

The Centre of Excellence for Women’s Health (2013) created a *Trauma-Informed Practice Guide* in which they examined five dimensions of trauma: single incident trauma, complex/repetitive trauma, developmental trauma, intergenerational trauma, and historical trauma. A single incident trauma relates to an unexpected and overwhelming event like an accident or natural disaster (Centre of Excellence for Women’s Health, 2013). A complex or repetitive trauma could be ongoing abuse, domestic violence, or dealing with the ongoing effects of war. These types of trauma often involve being emotionally or physically stuck in the situation (Centre of Excellence for Women’s Health, 2013). Developmental trauma results from exposure to early repetitive trauma involving neglect, abandonment, physical abuse or assault, emotional abuse, or witnessing violence or death. This trauma often interferes with healthy attachment and development (Centre of Excellence for Women’s Health, 2013). Intergenerational trauma relates
to the psychological or emotional effects experienced by people who live with trauma survivors. In this situation, coping and adaptation patterns develop in response to trauma and are passed from one generation to the next (Centre of Excellence for Women’s Health, 2013). Historical trauma refers to the cumulative emotional and psychological damage over the lifespan and across generations stemming from massive group trauma. Examples of events that would create this trauma include genocide, colonialism, residential schools, and slavery (Centre of Excellence for Women’s Health, 2013. These five dimensions of trauma identify and explain the different ways trauma manifests in people’s lives. They also indicate that each dimension will have a different level of impact on an individual.

**Trauma Responses**

A trauma response is an emotional response to a terrible event (American Psychological Association, 2022). Trauma affects how a person perceives the external world, how they feel in the world, how they move through their internal emotional states, and how they live in their own body (Olds, 2021). When someone is in a trauma response state, they have no access to personal resources that typically empower or comfort them (Olds, 2021).

The polyvagal theory suggests that trauma responses stem from three pathways: the dorsal vagus, the sympathetic nervous system, and the ventral vagal (Dana, 2018). The sympathetic pathway is located in the middle part of the spinal cord and is responsible for mobilization. It responds to danger cues by releasing adrenaline, which fuels our fight-or-flight response (Dana, 2018; Porges, 2011). The dorsal vagal, one part of the vagus, is responsible for immobilization, and it responds to cues of extreme threat or danger by disconnecting our connection and awareness to the present so that we are ‘frozen’ or ‘numb’ (Dana, 2018), or in a dissociated state (Perry & Szalavitz, 2006). The other part of the vagus, the ventral vagal
The ventral vagal pathway, is responsible for engagement and connection, so it responds to cues of support and safety by engaging in social connections. We feel safest when grounded in our ventral vagal pathway (Dana, 2018).

Porges (2011) states that the sympathetic pathway or the dorsal vagal pathway will activate when we experience a harmful event, a threat, or a trigger. The sympathetic pathway can be described as an alarm system designed to trigger an immediate response (survival mode), and all resources are mobilized to fight or flee (Dana, 2018). Olds (2021) states that when someone is in survival mode following a traumatic experience, they will either feel hyper-arousal, where they may feel hyper-alert or flooded with anxiety (fight/flee response), or they may feel hypo-arousal, where they shut down, feel numb, disconnected, or isolated (freeze response). Porges (2011) posited that during a “freeze” or hypo-arousal state, which he refers to as “immobilization” (p. 14), the body inhibits movement to focus its resources on raising our pain threshold. He related that we experience various physiological changes during this state, such as a deceleration of heart rate, a drop in blood pressure, and cessation of breathing.

**Importance of Being Trauma-Informed**

People who have experienced trauma often seek counselling to work through their trauma. Therefore, trauma awareness needs to be the core value in service delivery. Individuals will not seek help if they feel uncomfortable or judged (Carello & Butler, 2015). Trauma-informed practice (TIP) helps clinicians reduce clients’ chances of being re-traumatized (Hopper et al., 2010). TIP emphasizes the importance of integrating safety into counselling and therapeutic relationships. TIP highlights five values that are essential to every human service sector: safety, trust, choice/self-determination, collaboration, and empowerment (Harris & Fallot, 2001).
Ehrlo Counselling Services (ECS) aims to uphold trauma-informed practice by maintaining the values of safety, collaboration, empowerment, trust, transparency, and peer support. Trust is essential when working from a trauma-informed perspective. It relies on transparency and honesty (Carello & Butler, 2015). Ehrlo Counselling Services shows transparency by acknowledging that the treatment results are not definite. ECS recognizes that the counselling process may cause emotional dysregulation. When that happens, the counsellor does their best to provide support or calls on a peer counsellor to assist. ECS provides training opportunities and supports professional development opportunities that enhance the team’s competence and knowledge in trauma-informed practice.

I observed that peer support has a tremendous impact on clinicians’ well-being. During one of my conversations with two social workers who work for the Ranch Ehrlo Society, they mentioned that they sometimes engage in a “stress dump” during which they talk about stressful things, they debrief sessions and air out any tension they have. The idea behind this ‘dumping’ activity is to ensure that they are not sponging up everything they absorb during interactions with clients and other team members during debriefs. This manner of peer support was identified as self-care, and it was stated to be an effective way to minimize vicarious trauma, compassion fatigue, and secondary traumatic stress. Vicarious trauma is the transformation in a person’s perspective of the world as a result of interacting or working with people who have experienced trauma (White, 2006). Secondary traumatic stress is defined by Beck (2011a) as an “occupational hazard” for helping professions (p. 2). According to White (2006), compassion fatigue is a natural cost of working with people’s trauma. Clinicians may experience symptoms like avoidance, pessimism, and hyper-vigilance when they are experiencing vicarious trauma, secondary traumatic stress, or compassion fatigue (White, 2006).
This chapter summarized my understanding of trauma and trauma-informed practice. It portrayed the ways that Ehrlo Counselling Services works towards maintaining a trauma-informed approach for their clients and staff members. The next chapter will describe a literature review of the therapeutic approaches I applied during my practicum.
Chapter Three: Therapeutic Interventions

When I was creating my practicum goals, I highlighted that I would be focusing on acceptance and commitment therapy, as well as cognitive behavioural therapy. As I grew into my counselling shoes, I found myself also leaning on other therapeutic approaches to best serve my clients’ needs. As a result, I ended up focusing quite a lot on motivational interviewing in order to enhance my communication skills. I also used dialectical behavioural therapy (DBT) briefly (under clinical supervision) while working with a specific client with borderline personality disorder. In that situation, I found it necessary to integrate some specific tools and strategies from DBT to ensure that I was best meeting her needs.

This chapter will provide a comprehensive summary of what I learnt about the approaches that I utilized most during my practicum placement: motivational interviewing, acceptance and commitment therapy, and cognitive behavioural therapy (CBT).

Motivational Interviewing

Motivational interviewing (MI) is an intervention that strives to promote change in clients by encouraging them to change their behaviours (Miller & Rollnick, 1991; Moral et al., 2015). MI is a collaborative conversation between the client and the counsellor that aims to elicit and explore a person’s reasons for seeking change in a non-judgmental and compassionate manner (Drew, 2020; Tirrell, 2020). MI helps clients sort through their thoughts, ideas, and ambivalent feelings about their situation and possibilities for change (Tirrell, 2020).

Motivational interviewing is rooted in four concepts: compassion, acceptance, partnership, and evocation (Drew, 2020). Compassion is where we prioritize the client’s needs, provide hope, and offer a warm attitude, reflective listening, and validation (Drew, 2020). Acceptance in MI differs from agreement or approval (Miller & Rollnick, 1991). Acceptance is a
non-judgmental and welcoming attitude coupled with active listening (Drew, 2020). Partnership is a collaboration between the client and the counsellor where all treatment goals and action plans are created with the client rather than for them (Drew, 2020; Miller & Rollnick, 1991; Moyers, 2014). Evocation is the act of listening for and eliciting the client’s desires, abilities, reasons, and needs for change (Drew, 2020).

Motivational interviewing includes four processes: engaging, focusing, evoking, and planning (Drew, 2020). The first three are crucial in the counselling process. You cannot get into planning if the client is not engaged in the counselling process, or if they have not identified goals and reasons for change. Engaging is getting to know the client and what they are experiencing (Drew, 2020; Tirrell, 2020). Engaging the client comprises building rapport and setting a steady foundation for the therapeutic relationship (Tirrell, 2020). Focusing is where counsellors help clients decide on the direction of the conversation and the goal they wish to work towards (Drew, 2020; Tirrell, 2020). Focusing involves asking questions like: “what changes are you considering?”, or “what seems like the most important thing to work on right now?”. During this step, agenda maps can be used to allow the client to make choices and decide where to begin. Evoking is the process of eliciting the client’s motivation for change (Tirrell, 2020). Here, the client shares their ideas and feelings about why and how they might change or achieve a goal. The major task in the evoking process is finding out the client’s ‘why’ for seeking change. Miller and Moyers (2017) suggest that paying attention to the client's change talk during the focusing stage is essential. This includes looking out for their motivations and the possibility of change. Planning is the final step, where the client identifies actions that they will take in to achieve their goals and effect change (Drew, 2020). It may be helpful to use a change journey map that lists the changes the client wants, reasons they want to make the changes, steps
they plan to take (when, where, how long), things that may interfere, people who can help, alternative plans, and ways in which they will know that the plan is working (Drew, 2020).

One of the particular techniques that I like from motivational interviewing is creating a discrepancy (Drew, 2020). MI suggests that when clients seek help, they are at a stage where they notice a discrepancy between their present situation and their goals (Miller & Rollnick, 1991). A discrepancy is a gap between where the client is, and where they want to be (Miller & Rollnick, 1991). Counsellors can use the discrepancy as a tipping point towards change by highlighting the gap and amplifying it until it overrides the client’s attachment to their current maladaptive behaviours (Drew, 2020; Miller & Rollnick, 1991). Using discrepancies is a step in counselling that aims to guide the client to realize that ‘the problem is more serious than I thought’ and ‘I need to do something about it’. This is the step in counselling where the counsellor introduces the iceberg metaphor (Drew, 2020). The iceberg's surface represents the costs, benefits, and importance of changing. The bottom of the iceberg is the unknown so that is the area of focus for counselling. The counsellor’s goal is to unpack the hidden pieces beneath the water: the client’s goals, values, dreams, and hopes (Drew, 2020). This MI technique was a great tool to incorporate alongside cognitive behavioural therapy and acceptance and commitment therapy techniques.

Using motivational interviewing was not something I planned when I created my practicum proposal. However, I found plenty of situations where the MI skills were valuable. I applied motivational interviewing skills further along in my practicum when I was much more confident in what I was doing. I found it helpful to use these techniques to solicit information from the client in a conversational way rather than in an interview-like manner. MI emphasizes four basic communication skills summarized by the acronym OARS: open-ended questions,
affirmations, reflections, and summaries (Drew, 2020; Tirrell, 2020). Open-ended questions encourage more meaningful discussion and allow the counsellor to provide direction with room for the client to give their unique input (Drew, 2020; Tirrell, 2020). Affirmations are great for recognizing strengths and reinforcing change talk and behaviour (Tirrell, 2020). Reflective listening bridges the gap between what you think you heard the client say and what they actually meant (Drew, 2020). Summaries are deeper reflections that tie together what the client has been sharing. Summaries are similar to taking loose flower stalks and making them a bouquet (Drew, 2020).

Motivational interviewing is an approach that posits that clients are the experts on how to change their circumstances (Moyers, 2014). I liked motivational interviewing because it upholds the client as the bus driver, and the counsellor is the navigation support. The truth is that clients will not always follow the counsellor’s guidance because they have another route in mind that works better for them, and that is okay because they are the ones living their life outside the one hour they spend with us in the session. MI teaches you to accept the client’s perspective and understand their behaviour without agreeing with or approving it (Miller & Rollnick, 1991).

The above section summarized highlights from motivational interviewing that strengthened my social work communication skills. The next section of this chapter will discuss acceptance and commitment therapy, and summarize some of the skills I used while working with clients at Ehrlo Counselling Services.

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) is part of what is known as the *third wave* of therapies (Davies, 2021a). The first wave was behaviour modification, the second was cognitive behavioural therapy, and the third was dialectical behaviour therapy, mindfulness-based
cognitive behavioural therapy, and acceptance and commitment therapy (Davies, 2021a; Harris, 2019).

The letters in the ACT acronym stand for accept, commit, and take action (Harris, 2019). Harris (n.d.) relates that acceptance and commitment therapy (ACT) gets its name from one of its core messages: accept what is out of your control and commit to action that improves your life. ACT emphasizes the importance of committing to actions that improve one’s life, change behaviour, change attitude, and do things differently to get different outcomes (Harris, 2007; 2019). ACT is founded on two principles: mindfulness and values (Harris & Aisbert, 2013). Mindfulness is described as a state of awareness and openness, and values are your “heart’s deepest desire for how you want to behave as a human being” (Harris & Aisbert, 2013, p. 44).

ACT aims to help people live rich and meaningful lives while accepting the pain that is inevitably a part of life (Harris, n.d.). The objective of ACT is not symptom management; rather, it is mindful and value-based congruent living in which an individual effectively handles the inherent pain and dissonance that comes with life (Davies, 2021a; Harris & Aisbert, 2013; Harris, 2019). Harris (n.d.) states that as human beings, we experience physical, emotional, cognitive, and spiritual dissonance as normal parts of life, and he refers to these moments as being reality gaps. Reality gaps are disparities between the reality of what we have or the situation we are in, and what we want (Harris, n.d.). Harris states that the bigger the reality gaps, the more pain we feel. Harris (2007; 2019) talks about the happiness trap, which he defines as the misconception that life should be free of pain and discomfort. There are several happiness myths that keep clients stuck in reality gaps (Harris, 2007; 2019). For example, the misconception that happiness is the natural state for human beings, or that the more we have of idolized things, the happier we are. When we have what we want, we expect to be happy and
stay happy. However, this is not the case because, like the weather/seasons, our emotions and moods are constantly oscillating, and therefore, we cannot experience one emotion alone all the time (Davies, 2021a; Harris, 2007; 2019).

Another myth is the expectation that happiness means that all other emotions do not exist. We are inclined to think that if someone is not happy, they are defective (Harris, 2007; Harris & Aisbert, 2013). We tend to pathologize emotions like anger, anxiety, fear, guilt, grief, worry, and stress. Acceptance and commitment therapy encourages people to accept their emotions, moods, sensations, memories, and thoughts, especially those that are out of their control. ACT encourages people to take action to change or modify what is within their control rather than remain stuck by only noticing that the problem is there. In other words, if we want something to change, we should assess whether it is within our control or not. If it is within our control, we should take committed actions to effect change. If it is not within our control, rather than fight or avoid it, we should accept it as a natural part of life and ensure that we are safe and anchored amidst the storm of these events. The biggest lesson from ACT is that these things are not constant.

Harris (2007) states that ‘noticing’ is the first step to any type of work in acceptance and commitment therapy. Noticing entails bringing one’s attention to thoughts, feelings, emotions, memories, sensations, events, and situations that cause distress (Harris, 2007). It also draws one’s attention to their values and things that are important to them. We can also use noticing when working collaboratively with the client to create goals for counselling sessions and outside counselling sessions. In ACT, noticing can be done when establishing the client’s values, when starting the defusion process, when working on acceptance (notice things that are within and out of your control), contact in the present moment (notice things in the here and now), and in
committed action (looking at the consequences of actions and noticing their impact on the client’s goals and aspirations).

Core Processes in Acceptance and Commitment Therapy

ACT has six core therapeutic processes that are interconnected and constantly overlapping: values, committed action, self as context, defusion, acceptance, and contacting the present moment (Davies, 2021a; Harris, 2019). Values, acceptance, and committed action have to do with the ACT principle of values (Harris & Aisbert, 2013), whereas defusion, contact with the present moment, and self as context have to do with the principle of mindfulness (Davies, 2021a; Harris & Aisbert, 2013).

Values refer to what an individual wants to do with their life, what they stand for, how they want to treat themselves and others, and a person’s desired qualities (Davies, 2021a). Harris (2019) compares values to a compass; they direct our journey through life. Acceptance means making room for painful feelings, sensations, urges, and thoughts. When we accept tough situations, we drop the struggle with them, give them breathing space, and allow them to be as they are. Acceptance does not mean we have to like them or want them; we just have to recognize them for what they are and allow them to pass (Harris, 2019; Harris & Aisbert, 2013). Committed action is about doing what it takes to see changes in one’s life and well-being (Davies, 2021a; Harris, 2019). It is about helping clients find effective actions that align with and are guided by their values (Gagnon et al., 2016; Harris, 2019). Committed action requires an individual to live by their values in spite of difficult situations, thoughts, and feelings. Committed actions include problem-solving, setting goals, stating and writing action plans, obtaining necessary life skills, and behaviour activation (Harris, 2019).

Harris (2019) describes the self-as-context as the aspect of ourselves that is aware of what
we are feeling, sensing, thinking, seeing, or doing. Self as context relates to the aspect of our identity that never changes even though our moods, feelings, thoughts, memories, and sensations vary throughout the day and throughout our lives (Davies, 2021a). The self-as-context is the road that these elements drive through (Davies, 2021a). Defusion is rooted in the premise that thoughts, feelings, moods, and sensations are temporary and ever-changing events that should not be tied to a person’s identity. Defusion is about separating ourselves from our thoughts, feelings, situations, and memories to see them as being more or less than pictures, sounds, or words (Harris, 2019). Acceptance and commitment therapy encourages people to know the difference between what and who they are versus what their experiences are so that they are not pushed around or defined by them. Defusion requires us to take a step back to watch our thinking patterns instead of getting tangled up in our thoughts (Harris, 2019). Contacting the present moment requires us to deliberately connect with and engage in whatever is happening in the present (Davies, 2021a; Harris, 2019). It entails bringing our awareness to either the physical world around us, the psychological world inside us, or both (Harris, 2019). Davies (2021a) states that the contact in the present moment stage of acceptance and commitment therapy is the final step because the client is secure in knowing that they will not be destroyed by spending time in the here and now.

**Client Goals in Acceptance and Commitment Therapy**

Clients will come to therapy with various types of goals. Some of them are emotional goals, behavioural goals, fuzzy goals, and dead man’s goals (Davies, 2021a; Harris, 2019). Acceptance and commitment therapy aims to convert emotional, fuzzy, and dead man’s goals into behavioural goals because therein lies committed action. Behavioural goals describe what someone wants to do, for example, “I want to be physically active” or “I want to eat healthier
meals” (Davies, 2021a).

Emotional goals describe how someone wants to feel, for example, “I just want to be happy” or “I want to stop feeling anxious”. One way to redirect the client’s emotional goals (I want to be happy or I do not want to feel anxious anymore) is by validating what the client is feeling and paraphrasing the goal: “it sounds like you want to develop some skills to help you handle your anxious feelings and thoughts so that they do not bother you as much anymore”. Dead man’s goals are what Davies (2021a) refers to as goals that a corpse can do better than a human being. For example, “I want to stop being angry at my family.” Davies states that the counsellor’s objective in such cases is to reframe the goal to one that is more feasible. He states that it may be helpful to ask the client: “what would be different if anger was no longer a significant problem for them?”; ”what would they do differently?”; “how would they know that anger was not an issue anymore?”. Finally, fuzzy goals are goals that are not clear to the client (Davies, 2021a). In other words, they do not know what they want. Davies suggests stating to the client that it is okay not to know what they want and that the therapy room may be used as a safe place to explore and discover what sort of life and values the person has, then look into action plans to obtain them.

Harris (n.d.) talks about the ABCs of behaviour as a place to start when working with clients to determine their goals. He states that behaviours are neither good nor bad. To understand and modify behaviour, we should look at the antecedent and the consequence of the behaviour. The antecedent refers to thoughts, feelings, memories, sensations, and situations that trigger behaviours (Harris, n.d.). Consequences are performed or seen after the behaviour in question has happened. Knowing the antecedents and consequences of a behaviour helps us know the function of the behaviour. The goal of ACT is to evaluate whether or not behaviours
are helping the client live a rich and meaningful life, or if they are keeping them stuck in the happiness trap (Harris, 2019).

**Mindfulness in Acceptance and Commitment Therapy**

Mindfulness in the ACT approach is understood within the four core processes: contact with the present moment, defusion, self-as-context, and acceptance (Harris, n.d.). With contact in the present moment, mindfulness refers to being present and engaging in the here and now and noticing what is happening (Davies, 2021a). In defusion, mindfulness refers to using skills to separate oneself from distress-inducing thoughts and emotions and responding more flexibly to these thoughts and emotions (Harris, n.d.). In acceptance, mindfulness refers to opening ourselves up to make room for our experiences and allowing them to flow through us (Harris, 2019). Finally, within the self-as-context core process, mindfulness refers to what Harris (2019) calls the observing self, which is the part of us that notices events, interactions, thoughts, and feelings.

A challenge to integrating mindfulness with clients is the rigid association of mindfulness with certain programs or activities like meditation, religion, yoga, and others (Harris, n.d.). The other challenge is that we often rely on avoidance and maladaptive coping strategies to cope with our realities because the present holds so much pain and duress (Harris, 2019). In such cases, mindfulness can be overwhelming and may lead the client to dive deeper into experiential avoidance, or they may shut down and stop coming to therapy (Harris, n.d.). In other cases, therapists may observe clients dissociating from their feelings, and here the client may feel numbness and emptiness (Harris, n.d.). A place to start could be guiding them to notice the numbness, notice where they feel it in their body, notice times when the numbness is more prominent or less prominent, notice what is it like when the numbness is more prominent, and
then notice what is it like when it is less prominent. As they explore and slowly accept the numbness and emptiness, you can weed out some of the feelings buried deep in their body.

Therapists should know that some clients may avoid feeling their feelings in their bodies. They might resist experiential exercises because mindfulness requires them to look into their bodies to examine what is in there. Harris (2019) suggests that therapists could start by guiding clients to be mindful of their external environment. They could start with noticing their senses and how they interact with the outside environment. What do they see, hear, feel, smell, and touch? Harris (n.d.) suggests using safe sensation exercises like having the client squeeze their hands together and notice how that felt in different body parts. If the client is able and willing, you can also ask them if any thought came to their mind while they did this. Mindfulness and experiential exercises are crucial elements in acceptance and commitment therapy because they recognize that distress is not just stored and felt in our minds and hearts but also in other parts of our body (Harris, n.d.).

**Metaphors in Acceptance and Commitment Therapy**

Acceptance and commitment therapy uses many metaphors, which can be used during different stages of the counselling process. Metaphors are a wonderful way of providing a different perspective to clients (Hayes et al., 1999). Some can be used to teach the client mindfulness, some can be used for reframing a client’s experiences, and others can be used to teach the client how to practice defusion. A few examples of my favourite metaphors are discussed below.

The *press pause* metaphor can be used during sessions when clients are feeling flooded or overwhelmed (Harris, 2019). Here the counsellor asks the client right at the beginning of the session for permission to press pause if they notice the client feeling flooded. The pause allows
the client to slow down, take a few breaths, and reflect on what they are thinking, feeling, or talking about (Harris, 2019; Hayes et al., 1999). The *guitar* metaphor relates to clients' committed actions to achieve their counselling and life goals (Harris, 2019). This metaphor instructs that practice makes perfect. One cannot learn how to play the guitar by thinking/reading/talking about it but rather by slowly practicing it daily (Harris, 2019). I used this metaphor with clients to explain the small steps to apply coping strategies and self-care activities outside counselling.

*Dropping the anchor* metaphor is a mindfulness tool for emotional dissonance (Harris, 2019). It challenges the client to pause and notice their internal climate. The client notices their feelings, acknowledges them, and labels the feelings. The client is then encouraged to tune into the body and choose a movement (sit upright, alter their breathing, straighten their spine, stand up, shake their hands). The final step is to engage with the external environment through their senses (notice things you see, smell, touch) (Harris, 2019). It is very important to debrief this activity, especially with clients who are working through trauma. Doing this activity at the end of a session is problematic because clients need time to process being tuned into these three dimensions. Clients also need to prepare for occurrences during the week where they might feel hyperaware. The debrief is a good time to discuss coping strategies for the week.

I used the *beach ball* metaphor (Harris, 2019) with clients to explain what happens when we try to suppress our feelings and thoughts. I explained that fighting our internal experiences is like trying to hold a beach ball underwater; nothing good comes from doing that. Another metaphor I liked was the *sky as the self* (Davies, 2021a). Here, the sky represents the client. The clouds are the events that happen in their life, and the weather changes are the different ups and downs that inevitably come along. This metaphor emphasizes that everything eventually passes,
but the sky remains the sky. In the same way, the client will go through many things, but they will remain the person they are; that is to say, they are not defined by their experiences (Davies, 2021a).

I found it easy to relate to acceptance and commitment therapy (ACT). I particularly enjoyed using the metaphors and found it helpful in several sessions to combine techniques from ACT with cognitive behavioural therapy (CBT) techniques. In this next section, I will describe cognitive behavioural therapy and share some CBT techniques I used while working with clients at Ehrlo Counselling Services.

Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) is an evidence-based therapeutic intervention based on the understanding that three key factors impact people’s well-being: thoughts, emotions, and behaviour (Teater, 2013). Cognitive behavioural therapy asserts that negative thoughts contribute to psychological and emotional distress and maladaptive behaviour (Vonk & Early, 2009). CBT investigates the connections and disruptions between emotions, thoughts, and behaviours (Fenn & Bryne, 2013). It strives to define and correct cognitive distortions and alter negative automatic thought patterns (Dattilio & Hanna, 2012). CBT aims to reduce clients’ distress and dysfunctional behaviour by exploring and addressing how their thoughts, emotions/feelings, and behaviours contribute to their presenting issues and affect their quality of life (Fenn & Bryne, 2013; Teater, 2013).

Implementing Cognitive Behavioural Therapy

There are three stages used to implement CBT: assessment, interventions and action plans, and evaluation (Teater, 2010). During the assessment stage, the therapist learns about the client, their thoughts, emotions, and behaviours (Davies, 2021b). Teater (2013) discusses that the
A-B-C model can be used in the assessment stage to discover the *activating event*, the *beliefs* the client has about the events, and the *consequences* of their beliefs; which are reflected in the client’s behaviour, emotional state, and thought patterns. When doing an assessment, therapists should note how often, how intense, and how long the negative thoughts, feelings, and behaviours occur in reaction to the activating event, and how often they experience the activating event (Teater, 2013).

The next stage is the intervention and action plan which is worked on in collaboration with the client and is based on what is discovered in the assessment stage. Depending on the client, their presenting issue, and their readiness to work on the issue, the type of plan may involve tackling the problem itself or starting with coping skills and self-care routines to get them ready to address the issue. CBT interventions include social and emotional coping strategies (Davies, 2021b; Sheldon, 1998); cognitive restructuring (Frojan-Parga et al., 2009); reinforcement, modelling and role-plays (Sutton & Barto, 1998); behaviour activation and scheduling (Gillihan, 2018); and relaxation techniques (Payne & Donaghy, 2010).

The evaluation stage involves checking in with the client to see if they notice changes in frequency, intensity and duration of the negative thoughts, emotions, and/or maladaptive behaviour (Davies, 2021b; Teater, 2013). It also entails asking the client what techniques worked, what did not work, what was easy to try, and what was hard to try (Davies, 2021b).

**Using Cognitive Behavioural Therapy with Clients**

Cognitive behavioural therapy strives to change thinking and behaviour patterns that impede positive outcomes (Davies, 2021b). Negative thoughts are powerful and can arouse negative feelings, leading to maladaptive behaviours that influence the way we live our lives and the decisions we make (McKenzie, 2008). CBT highlights these connections using techniques
like the cognitive triangle (Davies, 2021b). CBT challenges negative automatic thoughts and cognitive distortions by rationalizing them and comparing them to reality (Davies, 2021b).

CBT works with clients to detect automatic thoughts or beliefs that contribute to the premature disruptions of goal attainment and well-being (Davies, 2021b). This is done by noticing the patterns between an individual’s emotions, thoughts, and behaviours. Davies (2021b) states that we should also consider biological and situational factors when looking at things that cause automatic negative thoughts and things that can help ease distress. For example, biology and physical factors like exercise can boost one’s mood, and situational factors like resolved living arrangements or income assistance can ease stress, depression, and anxiety symptoms (Davies, 2021b).

Cognitive behavioural therapy emphasizes the importance of homework and practice as a prerequisite for success (Gillihan, 2018). CBT asserts that for any progress to be made in a client’s life, they need to apply and practice the skills obtained during the counselling sessions. Some examples of homework include building distress tolerance skills, emotional regulation skills, co-regulation strategies, interpersonal relationship skills, mindfulness, and self-management skills (McKenzie, 2008). Davies (2021b) advises therapists to educate clients on the importance of using coping strategies when things are going well so that they can lean on these skills readily when experiencing dissonance and discomfort.

Cognitive behavioural therapy emphasizes client autonomy and self-determination at all stages of the counselling process (Beck, 2011b). The client has the choice to engage or disengage in the counselling process, they have the choice and power to partake in the strategies being suggested, and they have the choice to observe the patterns between their emotions, biology, situations, thoughts, and behaviour (Beck, 2011b; Davies, 2021b). Beck (2011b) states that it is
important to uphold autonomy and self-determination in the counselling process. However, therapists should also integrate accountability because the therapeutic relationship is collaborative and demands active participation from the client and the clinician (Beck, 2011b). Active participation in counselling requires that the client does their best to practice the skills they are learning in sessions, and the therapist holds them accountable in a non-judgmental manner (Beck, 2011b; Davies, 2021b).

**Cognitive Distortions**

Cognitive distortions are thought patterns that exaggerate, assume, magnify, undermine, or disregard the meaning and intent of actions, words, and behaviour of oneself or others (Davies, 2021b; Rector, 2010). Some cognitive distortions include selective perception, where individuals selectively perceive certain negative aspects of a situation (Davies, 2021b). All or nothing thinking is where people think in extremes and have only two options for any given subject: good/bad, black/white, perfect/terrible (Burns, 1999; Davies, 2021b; Therapist Aid, 2019). Magnification or minimization is where a person magnifies their shortcomings and minimizes positive attributes, or they blow certain aspects out of proportion and minimize the significance or benefits of certain events or actions (Burns, 1999; Davies, 2021b). Jumping to conclusions is where people assume that others are reacting a certain way based on unbacked assumptions and reach purely arbitrary conclusions (Burns, 1999). Catastrophizing is when a person imagines a chain of events that might happen but are unlikely to happen (Davies, 2021b; Therapist Aid, 2019). Emotional reasoning is when people believe something is true because they feel it (Burns, 1999; Davies, 2021b; Therapist Aid, 2019).

During some sessions, I used a list of common cognitive distortions, the cognitive triangle, and thought challenging worksheets to explain thought patterns and how they affect
one’s feelings, mood, and behaviour. For one client, anger was an issue that came up in their relationship with family members. This client tended to ruminate about what they wish was different about their family, and as a result, they would feel cheated, angry, and upset with their family members. Part of the work I did with this person was helping them realize the memories, events, conversations, and actions related to their family members that aroused regret, disgust, shame, and anger. We also identified current situations in their life that made them think about things in the past that could (should) have happened differently.

Once we learnt their cycle, we made a plan to disrupt the cycle at different points (thoughts, feelings, and behavior stages). During the thoughts stage, we worked on assessing and acknowledging thoughts. The next task was to use logical evidence-based reasoning, guided discovery, and cognitive restructuring to cool down some of their hot thoughts. During the emotions stage, we talked about labelling feelings, deep breathing, speaking to someone about how they are feeling, or journaling about their feelings and what aroused them. For the behavioural stage, we discussed setting boundaries and having some levelled responses they could use to express their opinion without escalating. We also talked about using ‘I’ statements when expressing feelings and feedback to others.

**CBT Interventions for Presenting Issues**

Cognitive behavioural therapy examines presenting issues on cognitive, behavioural, biological, environmental, and emotional levels (Davies, 2021b). Biological interventions involve inquiring about medical histories, recommending exercise, hygiene maintenance, checking on diet, medications, and sleep (Davies, 2021b). Environmental interventions involve evaluating support systems (friends/family), work, education, shelter, conflictual relationships, and life changes (Davies, 2021b). Behavioural interventions include diary keeping, where the
client logs their thoughts, actions and feelings; scheduling, where the client arranges activities into their week; and goal setting, where the client sets a small goal to achieve and assess things that may stand in the way (Davies, 2021b). Emotional interventions include labelling feelings, creating outlets for emotions (crying, screaming into a pillow, having a safe space like the shower to be vulnerable), and mindfulness (Davies, 2021b).

Davies (2021b) discusses some cognitive interventions, such as logical evidence-based reasoning, which involves testing thoughts and feelings by examining evidence for and against them. Burns (1999) refers to this as a cost-benefit analysis. Hypothesis testing relates to encouraging the client to assume the stance of a scientist. The client is challenged to view their negative thoughts and beliefs as hypotheses that can be tested (questioned) rather than as concrete facts (Davies, 2021b). Guided discovery involves asking the client questions to guide them towards discovering distortions in their thinking (Davies, 2021b). Self-instructional training is where individuals instruct and support themselves through a difficult situation (Davies, 2021b). For instance, someone with anxiety could talk themselves into preparing for an exam (I can do this, I just need to keep calm and breathe deeply) and congratulate themselves when it is over. Cognitive restructuring is where the client learns how to identify hot thoughts and cool them down using logical evidence-based reasoning (Davies, 2021b; Gillihan, 2018). Graded questions involve breaking up all or nothing thinking patterns by asking them to rate a thought or feeling on scale ranges (Davies, 2021b). Burns (1999) refers to this as thinking in shades of grey rather than thinking in black or white.

This chapter discussed the approaches that I utilized most during my practicum placement: motivational interviewing (MI), acceptance and commitment therapy (ACT), and cognitive behavioural therapy (CBT). I found it very helpful to use cognitive behavioural therapy
and acceptance and commitment therapy during my practicum because these approaches complemented each other. In many cases, it was easy to use both rather than try to use one at a time. For example, when working with one client, I used the CBT concepts of cognitive distortions to explain some of the thinking patterns the client had, and then I used defusion techniques to help the client separate themselves from their thinking patterns so that they could observe the impacts of these thoughts and the antecedents. I also found it helpful to use the acceptance aspect in ACT to encourage clients to accept what is out of their control.

The next chapter will explore some of the presenting issues that clients identified, and it will contain a summary of techniques I used to support the clients I worked with during my practicum placement at Ehrlo Counselling Services.
Chapter Four: Presenting Issues

During this practicum placement, I worked with clients whose ages ranged from 11 to 53, and they each had varying needs. Presenting issues included anger, grief, depression, anxiety, coping with stress, suicide ideation, self-harm, trauma, post-traumatic stress disorder, life transitions, borderline personality disorder, harsh inner critic, low motivation, and addictions. This chapter will discuss a few of the predominant presenting issues that clients brought forward. I will discuss some of the skills, metaphors, and techniques I used from acceptance and commitment therapy, cognitive behavioural therapy, and other therapeutic frameworks to support clients.

Trauma

Trauma is a wordless story that the body tells itself about what is safe and what is a threat (Menakem, 2017). Most treatment interventions for trauma have an exposure element. This is when the person is asked to describe or re-experience the traumatic event safely during therapy sessions (Batten, 2021a). Trauma work enables clients to pay attention to the continuum of emotional experiences that result from trauma, such as shame, anger, guilt, fear, anxiety, disgust, grief, sadness, and others (Batten, 2021a).

From a trauma-informed acceptance and commitment therapy (ACT) approach, acceptance involves recognizing and acknowledging thoughts, feelings, current experiences, memories, and historical events (Batten, 2021b). Individuals who have experienced trauma can get understandably hooked on the past, and they may also be constantly worried about the future (Batten, 2021b). ACT uses mindfulness techniques like dropping the anchor amid crisis, mindful body scans, mindful breathing, self-compassion meditations, and sensory soothing to support clients as they cope with the residue from trauma (Harris, 2019; n.d.).
It is important to recognize that sometimes trauma affects people by causing them to move away from that matter to them (Batten, 2021b). A person may lose or lack clarity about their own values following a traumatic event. Acceptance and commitment therapy supports clients as they reclaim, discover, and reignite their values (Harris, 2019). When someone has experienced trauma, they may be stuck in a cycle of inaction, impulsive actions/choices, or avoidance. I liked using ACT because it tries to help people see themselves as a container for thoughts, feelings, memories, and bodily sensations (Batten, 2021b). This is very important because people who have experienced traumatic events often start to be identified by the trauma. In other words, the trauma becomes a part of their identity (Batten, 2021b). The goal of ACT is to re-individualize the person and restore their identity to one that is separate (defused) from their trauma. ACT doesn’t try to take the experience away from the person, but rather it strives to show people that there is more to them than the traumatic event.

**Autopilot**

Autopilot refers to a state of doing (Dimidjian & Goodman, 2019). We go into autopilot because our brain is wired to be in survival mode (Neff & Germer, 2018). As human beings, we go into autopilot mode because our mind tends to focus on potential problems that need, or may need, solving (Neff & Germer, 2018). Autopilot can help us juggle multiple tasks at the same time and carry us through difficult situations. However, autopilot becomes disadvantageous when it is our primary mode of living. Autopilot may deprive us of fully experiencing pleasurable moments in our lives (Dimidjian & Goodman, 2019). Dimidjian and Goodman (2019) suggest that an antidote to autopilot is a “being mode” which refers to a state of practicing mindfulness in everything we do. They state that when we are on autopilot, we do things without engaging our senses or our mind. However, if we are practicing mindfulness, we notice how our
senses and thoughts react to, and interact with, our activities.

Mindfulness is often defined as intentionally paying attention to the present moment without judgment (Greenberg et al., 2012). It refers to accepting the present moment and present experiences (Neff & Germer, 2018). Mindfulness is also described as the readiness to come into contact with an experience rather than avoid it or cope with it through repression (Greenberg et al., 2012). Mindfulness has been found to ease distress in individuals’ physical and psychological well-being (Jayawardene et al., 2016; Khoury et al., 2013; Parsons et al., 2017). Mindfulness practices aim to guide an individual into a state of awareness and openness of what is in the here and now within and outside themselves (Dimidjian & Goodman, 2019; Harris & Aisbert, 2013).

Sometimes people dismiss mindfulness-based practices because they require a time commitment (Shankland et al., 2020). Harris (2019) states that mindfulness exercises should be customized for the client. Sometimes, the focus may need to start externally (rainbow walk) rather than internally (breathing, thoughts). A rainbow walk encourages the client to notice items in their environment that are in one or two rainbow colors. What did they notice that they never noticed before? Was it easy or hard for them to notice things? How did they feel when they noticed these things?

Anger

Anger is an emotional, verbal, and/or physical reaction to a person or an incident that has wronged or hurt you (Han et al., 2015). Anger looks different for everyone and stems from different issues. Anger can be felt towards oneself, loved ones, dead family members, situations, or systems. Anger is a natural emotion that acts as a self-defence mechanism when an individual is in a stressful situation (Han et al., 2015). Anger may be caused by different things: violation of boundaries, negative automatic thoughts, and assumptions we make about situations, or by other
people’s actions. Anger can be defined in terms of its severity, for instance, mild, moderate, and intense (Gillihan, 2018). Mild forms of anger can be described as feelings of annoyance or irritation, whereas intense anger may be described as rage or fury (Gillihan, 2018). Each description used to connote anger has a different meaning and, therefore, a different expression.

Han et al. (2015) wrote that anger expression styles are often categorized into anger-in, anger-out, and anger-control. Anger-in and anger-out came up a lot with my clients. Anger-in is where individuals internalize anger (Han et al., 2015; Smits & Kuppens, 2005). This manner of coping is done by suppressing one’s feelings and inhibiting one’s antagonistic action tendencies that often come with anger (Smits & Kuppens, 2005). Anger-out is characterized by the expression and/or projection of anger towards the target of your anger or towards other people or objects through physical acts or verbal acts like insults, criticism, or blame (Han et al., 2015; Smits & Kuppens, 2005). One client shared that when they get angry, they tend to be verbally and physically aggressive towards others and beat themselves up mentally. This client struggled with letting go of anger because of ruminations. Some of the factors that complicated their feelings of anger were the death of the people they were angry with. They felt that they had unfinished business and could not get resolutions or solace. One of their counselling goals was to work through anger and find safe ways to process and express it.

While working with this client, we talked about some ways to manage anger. Theses included: being aware of triggers, reminding oneself of the costs of excess anger, examining thoughts and being aware of rumination rabbit holes, being aware of emotions that are hiding behind anger, talking yourself down, questioning your explanations for other people’s behaviour, analyzing your assumptions, removing yourself from the triggering situation and any other catalysts, focusing on the present to disengage from rumination, learning and noticing anger
patterns, and breathing with your anger (Gillihan, 2018).

**Suicide, Suicide Ideation, Self-Harm, and Suicide Attempts**

Suicide is the act of intentionally causing one’s own death, and it is often related to complex stressors and health issues (Centre for Addiction and Mental Health [CAMH], n.d.). Suicide may be planned or impulsive (CAMH, n.d.). Suicidal thoughts arise when people feel lost, hopeless, and helpless (CAMH, n.d.). Some of the causes or risk factors for suicide include serious mental health issues, addiction problems, family history of suicide, history of previous suicidal attempts, impulsive personality, lack of support system, and access to weapons or other lethal means (CAMH, n.d.). Some of the signs and symptoms that people who are at risk for suicide will exhibit include a drastic change in mood and/or behaviour, sense of helplessness and hopelessness, expression of the wish to die or the disinterest to live, increased substance use, drastic changes in sleeping patterns, withdrawal from social networks, and giving away valuable items (CAMH, n.d.).

Straus (2007) states that there are different dynamics that underlie suicide attempts. For instance, suicide attempts may result from anger turned inwards. This is when individuals cannot express their feelings, thoughts, and frustrations outwardly for various reasons, so they enact the hostility that would otherwise be aimed elsewhere at themselves. Suicide attempts may also be an act of manipulation; a cry for help; a result of psychosis; a reaction to loss; a result of suggestibility or peer pressure; and a result of alienation (Straus, 2007). Straus (2007) states that similar to suicide attempts, there are underlying motivators for self-harm. These include self-punishment, trauma reenactment, punishing someone else, and relief from overwhelming pent-up emotions. For some individuals, self-harm may be a way to feel something (Straus, 2007).
Straus (2007) suggests some interventions for suicide attempts, suicide ideation, and self-harm. Interventions for an individual who has not attempted suicide before include assessing their current mood, behaviour, and cognitive state. It is important to assess the level of suicidal intent by asking about the frequency of thoughts, the presence or absence of a plan, access to items that could execute a planned or impulsive suicide attempt, and to ask if they are willing to create a safety plan and commit to following it.

For someone who has attempted suicide before, Straus (2007) suggests that the intervention could begin with the clinician assessing how the individual perceives their recent attempt, that is, whether they think it was lethal or not serious. She states that counsellors should inquire about how ambivalent the person is about living, how premeditated their attempts were in the past, their level of impulsivity, how many previous attempts the person has had, identify if alcohol or drugs were involved, what actions were taken following the suicide attempt, the reactions of the person’s support system, and if the person is willing to create a safety plan and commit to it. The Centre for Addiction and Mental Health (CAMH) (n.d.) states that it is important to encourage the person to talk about feelings, thoughts, and circumstances, and they encourage counsellors to seek support for themselves because it is important not to carry the weight of this information by themselves.

Interventions for self-harm should include inquiry about how long the person has been hurting themselves, why they do it, how often they do it, how they care for their wounds, what is happening before, during, and after self-harm, whether they want to stop or reduce self-harming actions, what have they tried before to stop it, whether they are willing to discuss coping strategies for urges, and if they are willing to commit to a safety plan (Straus, 2007). Straus recommends journaling as a good strategy to help individuals vent about what is brewing
internally. Journaling helps the client to document their pressures, feelings, and triggers. Other strategies may include positive substitution (where counsellor and client create a box of positive affirmations, photographs of pleasant memories, and letters written by the client to themselves); distractions and rituals that the person can do before ‘allowing’ themselves to self-harm, such as baths, walks, yoga, and speaking to a friend; grounding (such as meditation, use of ice cubes, rubber bands); recognizing and avoiding triggers; and developing self-care skills (Straus, 2007).

**Harsh Inner Critic**

Our inner critic manifests in different ways and at different times. For my clients, their inner critic was sometimes loud and clear, and other times, it was subtle and passive. Parker (2020) discusses three versions of inner critics: the inadequate self, the hated self, and the constructive self. The inadequate voice appears when you do not perform to the level of yours, others’, or what you perceive as others’ expectations (Parker, 2020). This voice makes you feel incompetent and inadequate. The hated self is aroused by body, education, financial, and employment standards (Parker, 2020). Individuals may express that they hate themselves because they do not feel up to par with societal standards of education, size, and beauty. The constructive self appears in the form of helpful self-criticism (Parker, 2020). For example, this voice points out mistakes, silly actions, missed opportunities and voices the *could have, would have* and *should have* scenarios in our minds.

Gilbert et al. (2004) state that inner critics can work towards correcting behaviour and improving oneself, but they can also work towards punishing oneself. Having a harsh inner critic can make someone feel anxious and/or depressed (Parker, 2020). A harsh inner critic may cause someone to engage in self-harming behaviours in an attempt to fix what is perceived or believed
to be an imperfection. Harsh inner critics can stir up feelings of shame, guilt, disgust, and internalized stigma (Castilho et al., 2017; Parker, 2020).

According to Neff and Germer (2018), mindfulness is one of the antidotes for inner criticism because it is grounded in self-compassion. Self-compassion is treating our inner critic the way we treat our friends when they are upset, angry, disappointed, and struggling (Neff & Germer, 2018). When riddled with self-hate, we can use mindfulness practices to offer our inner critic some compassion. In order to offer ourselves kindness, we must step outside our narratives of suffering and mindfully turn towards our pain (Neff & Germer, 2018). When we are trapped in negative thoughts and feelings, we need to separate ourselves from these thoughts to look into why they are here. Harsh thoughts and stern feelings are often reactions to stimuli that might be external or internal.

In addition to mindfully investigating the triggers that arouse our harsh inner critic, defusion techniques were helpful when supporting clients who identified that their inner critic was always harsh. Hayes et al. (2013) and Davies (2021a) relate that defusion is a good weapon against self-defeating thoughts. Defusion guides individuals to separate from their thoughts and inner voices to stop them from dictating actions, moods, feelings, and perceptions. Acceptance and commitment therapy and cognitive behavioural therapy believe that rather than fight against your inner critic, sit with it and hear what it has to say. Ask your inner critic why it says all those things, what evidence it has for these thoughts, and allow yourself to feel what you are feeling regardless of how unpleasant it is.

This chapter discussed a few presenting issues that clients brought forward. It summarized a few skills and techniques that I used from acceptance and commitment therapy, cognitive behavioural therapy, and other therapeutic frameworks to support clients. The next
chapter will provide a comprehensive summary of the learning and training opportunities I was able to take part in during my practicum at Ehrlo Counselling Services.
Chapter Five: Learning and Training Opportunities

While engaged in this practicum, I had the honour of having numerous opportunities to learn from, and with, the Ehrlo Counselling Services (ECS) team. Some of the opportunities included: an Indigenous Naming Ceremony; a presentation on secondary trauma and compassion fatigue to frontline workers; participation in a Truth and Reconciliation book club; a training session on vicarious trauma and compassion fatigue in counselling; observation of a presentation by one of the counsellors at ECS on working with clients’ grief and loss; a presentation by a fellow student on the place for gentle teaching principles in counselling; acceptance and commitment therapy for beginners training; a training session focused on the Attachment, Self-Regulation, and Competency (ARC) treatment framework; and finally I attended a training session on Trauma and Violence Informed Relationships with Children and Families. This chapter will briefly discuss a few of the training opportunities I attended during my practicum. It will also discuss the presentation I facilitated to the ECS team which focused on grief during the dementia journey.

Indigenous Naming Ceremony

On my second day at Ehrlo Counselling Services (ECS), we participated in a naming ceremony conducted by Cree Elder Sam from Ochapowace First Nation, and Saulteaux Elder Alvin from Sakimay First Nation. The ECS building and the counsellors and practicum students who attended were given Indigenous spirit names and colours. The Elders advised that finding ways to honour your spirit name is important. This can be done through feasts and ceremonies (Elder Alvin, personal communication, January 6, 2022). They advised that when you feast your name, you are also honouring your colours. Every name has a meaning and power. A spirit name expands your identity, and the name you are given suits who you are, and offers guidance,
healing, and protection. Your colours represent your powers; they provide guidance and help you focus your gifts and responsibilities to your community and to the Creator (personal communication, January 6, 2022). Receiving an Indigenous spirit name felt like an acceptance into the community and an establishment of kinship. I particularly found it interesting that my spirit name and ethnic (surname) had similar meanings. I am honoured to have had the privilege of getting my Indigenous name. Participation in this naming ceremony was Ehrlo Counselling Services’ action towards fulfilling its commitment to Truth and Reconciliation. It was an action towards creating kinship by understanding and taking part in the Indigenous traditions and ways of knowing.

**Truth and Reconciliation Book Club on The Highway of Tears**

The Ehrlo Counselling Services book club is an initiative the agency takes in its action towards truth and reconciliation. The book club strives to educate staff members on the history and stories of Indigenous peoples. Discussions encompass reflections, lessons from the novels, and inspirations taken from the stories. The books and documentaries provide insight into the trauma that Indigenous people and communities are experiencing. As a trauma-informed agency, ECS strives to broaden its knowledge of the different ways that Indigenous identities have intersected with systems and how these intersections have resulted in deleterious consequences for many generations.

The Highway of Tears is a non-fiction novel by Jessica McDiarmid (2019). This book is a snapshot of many stories of racism and systemic indifference experienced by Indigenous people in Canada. This book provides a harrowing, eye-opening, and heart-penetrating account of the stories of some of the missing and murdered Indigenous women and girls in the Northern part of British Columbia. It depicts the deep-seated racism that lurks within Canada’s flawed
justice systems. It opens our eyes to see the impact of society’s indifference towards the lives of the missing and murdered Indigenous women and girls, and the effect that this indifference has had on families, friends, and communities. Through this novel, we are given a raw narrative of the tension-heavy ache that comes from not knowing what has happened to family members who have gone missing, and the wrenching pains of finding the remains of one’s dearly loved family member.

McDiarmid (2019) describes the highway of tears to be “a lonesome road that runs across a lonesome land” (p. 1). She refers to it as a dark slab of asphalt that stretches across numerous communities infesting what were once peaceful and healthy homes. This highway has connected numerous Indigenous girls and women to deadly perpetrators who, with destructive intents, have left many families with deep voids as their Indigenous women and girls are taken; some of them have been found dead, while others are still waiting to be found.

**Vicarious Trauma and Compassion Fatigue in Counselling Presentation**

This presentation was about vicarious trauma, secondary traumatic stress, and compassion fatigue in counselling professions. The presenter stated that vicarious trauma is possible when helping or listening professionals or individuals experience a change in their worldview due to exposure to others’ traumatic situations (M. Abbott, personal communication, February 17, 2022). Watt (2018) states that compassion fatigue is the deadly repercussion experienced when giving is no longer living. She explains that compassion fatigue is the cost of caring for everyone- it is the cost of being human.

The presenter spoke about the typical signs and ignored signs of vicarious trauma, secondary traumatic stress, and compassion fatigue, which are very common in helping professions (M. Abbott, personal communication, February 17, 2022). Some physical signs
include exhaustion (constantly drained, tired after what would ideally be a good sleep), sleep difficulties, headaches, increased susceptibility to illness, and psychosomatic complaints (emotional stress symptoms that manifest in the form of physiological distress - tense muscles, gastrointestinal discomfort) (M. Abbott, personal communication, February 17, 2022).

Behavioural signs include anger, irritability, change in eating patterns, an exaggerated sense of responsibility, impaired decision-making that may be in the form of impulsiveness or indecisiveness, forgetfulness or poor concentration and retention, and avoidance of clients. Psychological signs include emotional exhaustion, cynicism, feelings of dread when certain clients are scheduled, diminished sense of enjoyment from one’s work, disrupted or changed worldview (loss of faith or trust in humanity), heightened anxiety, intrusive involuntary and unwanted imagery or thoughts of clients’ stories, difficulty separating work and home life, and resentment (M. Abbott, personal communication, February 17, 2022). Cunningham (2016) talks about self-entitlement as one of the signs of compassion fatigue. She describes it as the defence that human service workers use to validate the dysfunctional behaviours they engage in under the guise of the positive things they do in their lines of work. For example, I am irritable and snappy today because I stayed up all night at the hospital with a client. The presenter discussed the importance of self-care to cope with and address vicarious trauma and compassion fatigue.

**Working with Clients’ Grief and Loss Presentation**

I have always been passionate about grief work, so being able to observe a counsellor present on this topic was a wonderful experience. I believe that regardless of how much we read, practice, and train, there is always more to learn about grief and any other topic. Some insights I got from this presentation are highlighted below.
Grief is an emotion felt during or after the experience of loss (Humphrey, 2009). Grief is a reactionary response to losses that are not conclusive to death only. Grief is the internal experience of a loss (Worden, 2018), and mourning is the intentional process of adapting to the loss (Worden, 2018). Wolfet (2006) relates that people who experience a significant loss will feel grief, but not all of them will experience mourning. Clinicians need to be comfortable speaking to clients about death and grief.

The presenter stated that counsellors tend to be apprehensive about speaking to the clients about their deceased, their grief, and the complex nature of coping with losses, and they tend to hide under the guise that clients are not or may not be ready to talk about it (D. Wiebe, personal communication, April 7, 2022). The presenter encouraged counsellors to reflect on whether discomfort about talking to clients is related to the client not being ready to talk or if, in fact, it is that we are not ready or comfortable speaking to the client (D. Wiebe, personal communication, April 7, 2022).

The presenter discussed mediators of grief, such as: the relationship with the person who died or who was lost, the nature of the attachment to the person, the individual’s history of losses, their personality, their social variables, and other concurrent stressors existing at the time of the loss (Worden, 2018). There was discussion about happiness during grief and encouraging clients to embrace happy moments amidst grief and mourning. Clients may encounter happy events or milestones, reminisce about happy moments, but then feel bad about experiencing joy amidst grief and mourning. Clinicians need to validate these feelings of ambivalence and remorse.

One of the many topics presented was Dr. Alan Wolfet’s (2006) Tenets of Companioning the Bereaved. Wolfet (2006) states that clinicians should aspire to be companions to their clients.
Companions have open hearts and offer safe spaces, affirmation/validation, and hope. According to Wolfet (2006), companioning is being present to the client’s pain rather than trying to take it away; it is honouring the client’s spirit instead of focusing on their intellect; it is listening with your heart rather than analyzing with your head; it is about walking alongside the client rather than leading them; it is about valuing silence rather than trying to fill it up with words; and it is about having compassionate curiosity rather than assuming expertise.

**Student Presentation to Ehrlo Counselling Services**

One of the learning activities in my practicum proposal was to present to the Ehrlo Counselling Services team on a topic of my choice. My presentation was about grief in the dementia journey. I talked about what dementia is, the different types of dementia, some warning signs of dementia, and the impacts that dementia has on the person living with the disease, their families, and friends. I talked about some types of grief experienced during the disease progression, such as anticipatory grief, ambiguous loss, complicated grief, cumulative grief, and disenfranchised grief. These types of grief are often experienced before death loss. Finally, I spoke about some insights that acceptance and commitment therapy and cognitive behavioural therapy have on supporting clients as they work through dementia-related grief.

Acceptance and commitment therapy (ACT) uses mindfulness to help people process grief and accept loss. ACT helps people learn to accept negative emotions and situations and then helps them develop healthy patterns to live well amidst the journey of loss (Harris, 2019). ACT helps people accept their feelings as they experience losses instead of trying to run away from them, feel guilty about them, or avoid them altogether. ACT encourages people to make some room for their feelings, and stresses that it is important to accept that there will be times
when things will be overwhelming. It encourages people to learn skills to anchor them when the waves of emotion hit (Harris, 2019).

Cognitive behavioural therapy helps people become aware of their negative thought patterns that contribute to behaviors that make it difficult to process grief (Davies, 2021b). This can be done through cognitive reframing or restructuring. Here you challenge irrational or harmful thinking patterns and replace them with adaptive and helpful thoughts (Davies, 2021b). Refocusing or using distractions can be helpful for people struggling with anticipatory grief and anxiety which cause them to catastrophize or magnify situations. This technique involves catching oneself in a stream of distressing thoughts and intentionally redirecting one’s attention to think about or do something else (Davies, 2021b). Targeting behaviours involves addressing unhelpful or harmful behaviors or habits and replacing them with helpful ones (Davies, 2021b).

**Attachment, Regulation and Competency (ARC) Model Presentation**

The Attachment, Regulation and Competency (ARC) model recognizes attachment, regulation, and competency as central to trauma work. The ARC model was designed to treat children and youth who have experienced complex traumas. It recognizes the effects of trauma exposure on an individual’s attachment, self-regulation, and developmental competencies (M. Blaustein, personal communication, April 13, 2022). The ARC model emphasizes the importance of cultivating the child’s awareness and skills in identifying, understanding, tolerating, and managing their internal experiences (M. Blaustein, personal communication, April 13, 2022). This is done by helping them understand feelings, body states and sensations, and the connection between thoughts, feelings, and behaviour. The facilitator emphasized that practitioners need to uphold collaborative work from a trauma-informed approach which means they are working towards encouraging the youth to do ‘more good’ (focusing on strengths and
talents) rather than focusing on telling the youth to do ‘less bad’ (responsive and reactive
behaviours a child or youth may have). The facilitator stated that we should try to understand the
purpose of the defensive, reactive and responsive behaviours to better serve our clients.

The ARC model focuses on strengthening the caregiving system by enhancing
knowledge and skills and encouraging caregivers and practitioners to recognize, understand,
accept, and manage their own emotional and physiological responses to children and youth’s
behaviour (M. Blaustein, personal communication, April 13, 2022). The facilitator advised that
practitioners will experience times in their practice when they feel dysregulated and strained. She
encouraged us not to carry the misconception that we are above being emotionally taxed while
we are working with people’s emotions, trauma, and stress. Instead, we should make time to
regulate ourselves, take care of ourselves, and ask our peers and supervisors for what we need.
The facilitator referred to this as a regulated provider system. She stated that a caregiving system
cannot be effective if the caregivers (counsellors in this case) are not taking proper care of the
content they absorb in sessions (M. Blaustein, personal communication, April 13, 2022).

The facilitator advised clinicians to welcome all their emotions, acknowledge them, stay
aware of their limits/boundaries, and build a toolbox for self-care and coping/regulating
strategies. She cautioned that there are some emotions or feelings that we will always welcome
more than others. However, she urged practitioners to accept all emotions that come up during
their practice (frustration, dislike, anger, annoyance). The facilitator emphasized that we should
be aware of things that push us out of our comfort zones because they lead us to feel more
annoyed, irritable, or resentful. In addition to being aware of their limits inside the counselling
room, practitioners should know what they bring to the room. That is, their work history,
caseload, push buttons (triggers), experiences with trauma, coping skills, and their comfort with vulnerability (M. Blaustein, personal communication, April 13, 2022).

This chapter discussed a few of the learning and training opportunities that enriched my practicum experience. The next chapter will discuss reflections on my practicum experience, de-colonization in counselling, insights on self-care, and some ethical dilemmas and considerations.
Chapter Six: Reflections and Ethical Considerations

This chapter will articulate reflections and lessons I learnt from my practicum experience. It will portray some of the ways that I utilized self-awareness, integrity, and self-reflection within clinical practice, and it will entail discussions on de-colonization of counselling, self-care, and ethical dilemmas and considerations.

Pandemic Experience

My practicum took place during the tail-end of the pandemic public health restrictions, and this made for a unique experience for myself (personally and professionally) and Ehrlo Counselling Services and their service users. At the beginning of my placement, counsellors had the leeway to work from home or in the office. At that time, clients were, for the most part, being seen virtually through Microsoft Teams, which is an online platform. Two weeks into my practicum, I tested positive for COVID-19 and had the misfortune of having all the painful and uncomfortable symptoms. This led to me staying home for about a week and a half. ECS was well equipped to support me in working from home with ease, and I am grateful that they supported me selflessly throughout this very inconveniencing virus.

At the beginning of my placement, I was worried that I would miss out on the in-person experience, but the restrictions were lifted, and then my worry was about having to tell clients that even though restrictions were lifted, masks were still preferred. Additionally, clients were encouraged to stay home, reschedule, or change their appointment to a virtual or telephone format if they were sick. Having had COVID-19, and having lost over a week of my practicum hours, I felt slightly selfish each time I had to be directive about clients’ well-being. I also did not want to get sick, and I took all the necessary measures to be healthy. I interpreted my actions as selfish because I was trying to maintain good health so that sickness did not to impact my
practicum again. On the other hand, it is important for people to be physically healthy while working on being emotionally and psychologically healthy. My consolation was that the ECS team remained diligent in keeping themselves and their clients at home if they were sick.

**Using Different Communication Methods for Counselling**

Because my practicum took place two years into the pandemic, I came to Ehrlo Counselling Services and found well-established alternatives to in-person counselling: virtual counselling through Microsoft Teams and telephone counselling. I used all three counselling methods at different points during my practicum. In January, all sessions were hosted on Microsoft Teams except for clients with safety concerns. In February, there was a blend of in-person, virtual, and telephone counselling, and I observed the ECS counsellors using all three counselling methods. I started seeing my clients in February, and our sessions were held in person while following distancing rules, sanitation, and mask use. In March, restrictions were lifted. However, ECS maintained a sanitation and mask usage policy which helped me feel more comfortable as I continued to see my clients in person. With the exception of one client, I continued to see most of my clients in-person until the end of April. There were a few sessions that were switched to virtual or telephone because of weather conditions and health needs.

In-person sessions have numerous benefits, such as the opportunity to meet in a neutral location that is safe from the client’s day-to-day life, the ability to observe non-verbal language and the client’s emotional and physiological reactions to topics, the ability to do activities with the client, and a better opportunity to support a client through emotional dysregulation (McGee, 2022). I found it easier to create crisis plans for clients who were suicidal during in-person sessions compared to online because I could observe their non-verbal responses to the task. Typically, a safety plan should include someone that the client can call when they are in a state
of distress; it should include coping strategies and emergency numbers. I faced a situation where the client did not wish to include any family members as people to speak to, they did not have safe coping strategies, and were hesitant to call emergency services. The in-person option meant that I could go with her to the hospital if she were in crisis. The most significant disadvantage of in-person sessions that I observed for some of my clients was transportation. Most of my clients preferred to have face-to-face interactions but getting to the office was a challenge.

Virtual sessions were more convenient for some of my clients. They were also useful when there were weather-related travel advisories for clients who live outside Regina. There is also the visual element present in virtual sessions, so you can still observe non-verbal cues to an extent. Virtual counselling allows for anonymity (McGee, 2022), especially for those clients who would need to take time off work to attend a session, or those who would need support with transportation. Some disadvantages of virtual sessions are related to technology and trouble with internet connections (McGee, 2022), inability to do activities on paper with the client, a possible violation of privacy and confidentiality, possible safety risks, disruption of sessions by others in the house, and the level of support for emotional dysregulation is sometimes not sufficient.

Telephone sessions were convenient; however, they bare similar challenges to virtual sessions. The advantage of virtual and telephone sessions is that there are fewer no-shows and fewer cancellations compared to in-person sessions. These two counselling methods also provide accessibility to work with clients outside your immediate geographic area (Regina). I observed sessions where the counsellor worked with clients who were several hours away from Regina and could not drive to the city for weekly sessions. One disadvantage of telephones is that there is no visual element, so counsellors must rely on the client’s voice to observe emotional responses.
Ethical Dilemmas

Ethical dilemmas present themselves in many ways and with different complexities. Social work practice is guided by the Social Work Code of Ethics (Canadian Association of Social Workers [CASW], 2005a). This document highlights values and principles that help social workers navigate ethical dilemmas in their practice. The core values in the Code of Ethics include respect for the inherent dignity and worth of persons, pursuit of social justice, service to humanity, the integrity of professional practice, confidentiality in professional practice, and competence in professional practice (CASW, 2005a).

One of the ethical dilemmas I experienced during my practicum was trying to prioritize the clients' best interest while also considering therapeutic interventions that would promote greater learning opportunities for me, as highlighted in my practicum goals. The first guideline in the Canadian Association of Social Workers’ [CASW] Guidelines for Ethical Practice (2005b) asserts that social workers should always prioritize the client’s best interest. This led me to learn about dialectical behavioural therapy and motivational interviewing in addition to acceptance and commitment therapy and cognitive behavioral therapy that were my primary focus.

Another dilemma arose when I considered clients to work with from the intake list. Some of the clients seemed compatible with areas of practice I wanted to focus on. However, Value Six of the Code of Ethics challenged me against taking these clients on because I did not have the competence to support them at a level that was in their best interests (CASW, 2005a). Competency is built through training, education, and practice. I believe that the person I am now is more competent than the person I was when I started my practicum, and I am confident that I can offer better support to clients now than I could provide back then.
Another dilemma I experienced during this practicum was when a client whose presenting issues included grief came up on the intake list. I am passionate about doing grief work and would have loved to work with her. However, I recently worked with her children in one of my employment roles. I felt that it was better not to pursue sessions with this client because her other presenting issue was coping with getting her children back into her care and the parental stress that came with it. In this case, it would have been easy for me to take this client on, given that grief is one of my areas of interest and because I have worked with her children. However, I was challenged by the CASW value of integrity which calls upon social workers to be impartial and cautions social workers to avoid relationships with clients where our integrity and impartiality could be compromised. This value also encourages social workers to avoid any conflicts of interest, and if there is a conflict, the social worker must disclose this conflict of interest to their supervisor and client (CASW, 2005a). In this case, conflict of interest was avoidable, so I did not take the client on.

**Ethical Considerations**

The Canadian Association of Social Workers’ [CASW] *Guidelines for Ethical Practice* (2005b) and the Saskatchewan Association of Social Workers [SASW] (2020) *Standards of Practice* documents were created to provide expectations of competent practice and to hold social workers accountable for their actions in practice. Social workers are expected to create ethical relationships with clients where boundaries minimize risks of harm to the client. I found it helpful to continuously reflect on my roles and responsibilities as a student counsellor to the individuals on my caseload and the organization.

From the beginning of my practicum, I tried to comprehend what services I could realistically provide to my clients within three months. As part of my aim to be transparent and
genuine with my clients, I informed them that our therapeutic relationship would be terminated at the end of April. This made me feel ambivalent about how much good I was doing for these clients. I wondered if there was any benefit to building rapport, opening up wounds, and starting healing work with clients only to terminate it at the peak of the collaboration. There were times I found myself preparing too much for a session, and upon reflection, I realized that my subconscious was trying to attack as many of the client’s goals as I could in the short amount of time I had with them. I was gratefully reminded that the best way to be efficient and competent is by doing what you can with the client and taking each session as it came. Preparation is great, but only when you focus on one thing at a time rather than flooding the client. With practice, it became more natural to accept the things that were not within my control and focus on the things that were. It is important to put the client’s needs before yours even though you have good intentions.

My responsibility to the organization was to follow their consent and confidentiality policies, utilize information and support from clinicians to ensure that I was performing best-practice standards, and upholding the Saskatchewan Association of Social Workers Standards of Practice and the Canadian Association of Social Workers Code of Ethics in every interaction I had with clients and clinicians. This came easy because of the supportive environment within ECS. Despite the differences in disciplines within the team, there was an admirable cohesion between all three departments at Ehrlo Counselling Services. There was a unanimous agreement on each clinician's standards of practice expectations, and these counselling practices are taught to all students and new team members.

Social Location

Social location refers to a person’s position in society (Chandler, 2017). Social location
includes one’s ethnicity, gender, gender expression, pronouns, race, economic status, age, abilities, religion, sexual orientation, geographic location, social status, occupation, education, and other demographics (Chandler, 2017). Pena et al. (2015) state that one’s social location influences the approach they take when working with clients. Counsellors’ social locations impact how they express empathy, provide services, and approach community engagement and policymaking (Pena et al., 2015). Hays et al. (2007) relate that counsellors are sometimes unaware of their own social privilege and how it affects them and their clients. As a social worker, I recognize the damage that the profession once did to Indigenous communities in Canada and why many Indigenous people are apprehensive about social work. This history plays a big role in the profession’s social location and the lens through which people see our work. Trauma-informed techniques are a very helpful tool to use when working with clients who were previously hurt by the social work profession. In addition, it is important to keep in mind that many countries do not have a social welfare system, so immigrants may not understand the work that social workers do. The counsellor is responsible for explaining the purpose of the relationship following the Guidelines for Ethical Practice (Canadian Association of Social Workers [CASW], 2005b).

When I think of my social location, I know that several factors impact my life independently and collectively at different levels of severity in good and bad ways. As part of my journey through the student counselling experience, I made it a point to reflect on my social location as an individual and as an upcoming counsellor. Our social location shapes the lens through which we view the world, and as a result, it shapes our perspectives, our feedback, our interpretation of other people’s experiences, our willingness or unwillingness to interact with others, our boundaries, and our clinical practice. I found it helpful to take on a person-centered
approach because it helped me focus on the client. A person-centered approach recognizes human potential by offering clients empathy and unconditional genuine respect in order to facilitate change and goal achievement (Raskin et al., 2008).

There were many noticeable differences between myself and my clients’ social locations, starting with ethnicity, religion, upbringing, education, language, emotional expression, race, and socio-economic status, to mention a few. It was vital for me to consider these differences when working with my clients. One of the shortfalls I experienced was related to Canada's elementary and high school experience. I completed my high school and elementary education before I immigrated to Canada, so I do not have any experience in the Canadian pre-university school system. I found it hard to understand some of the challenges that my clients experienced. I could not relate to their experiences with class content, peer groups, extra-curricular activities, and the day school lifestyle. I went to boarding schools for my secondary education, so my experiences are very different, and while I did go to a day school in primary school, my experience was vastly different, starting with the school hours, dress code, learning styles, class content, and class set-up. Embracing a person-centered approach and using compassionate inquiry helped me to understand my client’s experiences better. I found it useful to ask clients to educate me on the layout, school culture, social hierarchies, and their experiences. I avoided assuming what they went through and instead always asked them to explain things to me.

I took time to reflect on Ehrlo Counselling Services’ social location and what that means for service users. ECS is a multi-disciplinary agency with staff from different educational backgrounds. Ninety percent of the ECS team have Caucasian roots, and each team member has their own individual lens that has been shaped by their social location. ECS serves the southern Saskatchewan community, so they see people from different walks of life. Therefore, it is
important for the staff to be aware of where they stand in relation to the clients they serve.

Counsellors must always take steps to educate themselves on the ways that their social location can harm or benefit clients.

**Decolonizing Counselling**

Decolonization is concerned with investigating the concepts of power and critically questioning the systems and institutions that perpetuate inequities (Hernández-Wolfe, 2011). Ratts et al. (2016) assert that counsellors should increase their understanding of the ways that counsellor and client worldviews, beliefs, biases, assumptions, attitudes, values, social group statuses, social identities, and experiences with power, privilege, and oppression influence the counselling relationship. In addition to this, Ratts et al. (2016) urge that learning about the history of Indigenous people, immigrants, and other minorities can lead counsellors to explore the wounds of internalized oppression that these communities have experienced and continue to experience. Finally, counsellors need to work alongside Indigenous healers to incorporate Indigenous approaches into counselling practice instead of seeing these healers as a separate specialized group (Singh et al., 2020).

Decolonizing counselling has to be a practice model, not just a theory. Decolonization is having knowledge of the impact that colonialism, neo-colonialism, cultural erosion, and cultural genocide have had on multiple generations. Decolonizing social work requires people to recognize that some of these impacts of colonialism still exist today (Fortier & Wong, 2019). Social work as a profession has a history of being an agent of colonialism in Canada (Fortier & Wong, 2019). These actions resulted in the breakdown of Indigenous families, communities, and they contributed to the current identity crisis that many Indigenous people are struggling with (Fortier & Wong, 2019).
Decolonization of social work requires recognition that the profession represents and reminds people of experiences that have been toxic in the past and, in some ways, in the present (Fortier & Wong, 2019). To integrate multiculturalism, decolonization, and social justice into counselling, we must conceptualize the role that power, privilege, and oppression have played historically, presently, and intergenerationally; and how these impact the counselling relationship (Singh et al., 2020). The counselling relationship itself will always have power differentials, and depending on the social location of the counsellor and client, the differential may be bigger or smaller. The counsellor’s responsibility is to ensure that they are upholding a person-centered, trauma-informed, anti-racist, anti-oppressive, and cultural humility approach. These practice models are important because they hold counsellors accountable for their actions and mitigate re-traumatization and oppression of clients (Fortier & Wong, 2019). In the same light, organizations are responsible for their minority staff who work with clients who may be racist. Organizations should have policies in place to support and protect their non-Caucasian staff.

**Rainbows and Roadblocks in Counselling**

My practicum experience taught me to appreciate clients as if they were rainbows. Sometimes things will not go our way during therapy sessions. We should not see resistance as a roadblock; rather, we should appreciate the client for their individual experiences that have contributed to their responses. Instead of viewing resistance as roadblocks to your goals or work, appreciate the client’s uniqueness and give them time. As human beings, we non-judgmentally appreciate rainbows for what they are. We do not try to adjust them or complain about the amount of each colour, the size of the rainbow, or its clarity. Instead, we see the rainbow for what it is and take it as it is. This is the same attitude we should have with our clients. We should accept and appreciate them for who and what they are. We should not label them as bad,
difficult, or defensive, and we should not try to change them. We should also avoid critiquing them because they do not match our momentum during sessions. It may be frustrating, but that is part of accepting the things you cannot change (Harris, n.d.). It is easy to appreciate clients when they are engaged and cooperative during sessions, and it is hard to do so when conversations feel stalled and stuck. Harris (n.d.) encourages clinicians to appreciate clients the way we appreciate rainbows, maintain compassion, and embrace their uniqueness. There were several moments during my practicum when I had no rainbows, and it felt demoralizing to keep pushing. However, I found compassion, the use of silence, and motivational interviewing to be helpful in roadblock situations. Sometimes people do not need words; they just need silence, which can be seen as the calm before the storm.

**Self-Care: Embracing the Guilt of Not Being Okay**

Self-care refers to intentional acts people do to cope well with life’s stressors and maintain a healthy emotional, physical, and psychological well-being (Winters, 2019). Some days it was hard to transition from counsellor to regular human at the end of the day. After listening all day, the last thing I wanted to do was listen when I got home. It was a battle to stay present and be interested and interactive at my part-time job and at home. Everyone has their go-to activity for decompressing. Some people take the longer route home so that they have time to ‘change hats’, some people go to the gym to run some steam off, some people go grocery shopping, or they go to restaurants to buy dinner rather than ordering delivery, and others practice self-care when they got home by cooking or having a long shower. The biggest lesson I learnt about self-care from Ehrlo Counselling Services’ counsellors is that it becomes easier to practice self-care if you do it consistently on the good days and also during the not-so-good days.

Self-care is not just bubble baths, spas, and meditation. While it can include these things,
it is so much more. Self-care may include physical exercise, creative activities, music, structured routine, and spirituality (Lucock et al., 2011). Self-care is nutrition, debriefing, and finding ways to deal with the murky things. Self-care requires discipline. Practicing self-care activities is like the homework and experiential exercises (Harris, 2019), that we provide to our clients. Self-care activities require practice during the tame times so that when distress comes around, we can easily pull out our coping and regulation activities (Davies, 2021a; Harris, n.d.; Lucock et al., 2011).

Many times, we tell ourselves to keep going, be positive, focus on the good things, and be grateful. Other things we tend to tell ourselves as we cope with life’s challenges include: it could be worse, this too shall pass, and it is not the end of the world. We rarely tell ourselves that it is okay not to be okay. We rarely acknowledge that we have human experiences in a human world as human helpers. Counsellors tend to think of themselves as impervious to the stress they deal with during their sessions (M. Abbott, personal communication, February 17, 2022). I think of human service work as sponge duty. We spend our days absorbing everyone’s problems, and then we go home to fix the ‘booboos’, fill the bellies, wash the dishes, bathe the bodies, console our friends and celebrate our spouses. We put others first and take in their highs and lows all the time. At the end of the day, we are soaked and ready to be wrung out. However, we seldom wring out the absorbed stuff, but instead, we carry on with the rest of our week. Having walked this path these past few months, I discovered what all the self-care hype is all about. It is crying, laughing, yelling silently into a pillow, and screaming out loud in the shower. It is accepting that feelings are contagious, and I am not impenetrable just because I am a social worker. It is talking to someone about what triggered me during a session, and acknowledging that past demons resurface in the presence of empathy. It is embracing that I am a human being doing human
things, so, therefore, I will feel, act, think, say, and believe human things. Self-care is embracing the guilt of not being okay, because sometimes, I really am not okay, and that is totally okay.

Ehrlo Counselling Services demonstrated a role model work environment in their emphasis on self-care. In addition to the stress dump conversations that I discussed earlier in this document, counsellors are also committed to checking in constantly and going for walks when they need to decompress. Lunchtime was reserved for connecting with others and talking about everything but work. People’s doors were open when you needed to chat about cheery topics to get your mind off work for five minutes before carrying on with your day. Counsellors also had supervision during which they talked about challenging subjects that came up, talked about self-care, and brainstormed ideas for ways to remain competent and expand their counselling skills.

My self-care suitcase throughout my practicum comprised of “sensory shut down days” where I would try to get as little sensory interaction as possible so that I could de-stress and get out of autopilot mode. I played scrabble games by myself because it was easier to zone into the game and not do any listening. The favourite activity was creative writing, where I would go into a different world, and create different stories and happy endings. When I was done writing, I was in a happier and lighter mood, and therefore I was able to reflect better on how the days went, how sessions were, and how to improve the following week.

This chapter comprised of reflections on my practicum at Ehrlo Counselling Services, ethical dilemmas and considerations that came up, and the ways I utilized self-awareness and self-reflections throughout my practicum placement. The next chapter articulates my final remarks and a summary of my growth amidst the rainbows and roadblocks in my counselling journey.
Chapter Seven: Conclusion

When I think back to the first month of my practicum, I cringe at how green I was, but I also feel proud of how far I have come. As cliché as it sounds, I am blessed to have had my professional associate and the Ehrlo Counselling Services team as guides and teachers throughout my student counselling journey. I was given space and support every step of the way as I prepared what I wanted to do during sessions, then debriefed on what I did during sessions, and then was provided with pointers on some things to do differently during the next sessions.

In the beginning, there was absolutely no way that I could sit in a room with a client by myself. Not because I did not know what to do, but because I was not confident in what to do. Over the last few months, I have been able to lead sessions independently and can practice on my own. This may be a simple achievement for some, but I have learnt that every achievement is a rainbow, so it should always be celebrated. I think back to the resistance from some clients, the unplanned terminations, the conversations that went off track and way after the allocated time, the deer in the headlights moments when clients dropped hot topics at the end of the session, and I am positive that if it were not for the roadblocks I faced during my journey, I would not have any rainbows.

One of the areas where I feel there has been specific growth and learning for me is in slowing down and making use of silence. At first, there was what felt like too much silence because I was inside my head, trying to formulate the right responses and trying to recall the information I had read in the client file and in the literature. Then there was an incessant need to fill any silence with all the information I had in my head. And finally, I embraced the motto of mollusks: “slow and steady”. McCartney (2004) states that it is vital for counsellors to be fully present during sessions. I found that when I used mindfulness to stay in the present moment, to
focus on what the client was saying and doing, I was able to respond a lot more appropriately and supportively. It was much easier to reflect, paraphrase, and validate, and I observed that this improved the therapeutic relationship.

I am truly grateful for the supportive learning environment I had at Ehrlo Counselling Services. I appreciate the selfless support the team gave to help me learn and achieve my goals. I am also grateful for their recommendations, encouragement, directions, and the training opportunities I was welcomed to join in. My greatest appreciation is for all the times I could walk into any office and ask if I could speak to someone for “two” minutes. My practicum goals were to acquire knowledge and understanding of acceptance and commitment therapy, cognitive behavioural therapy, and trauma-informed practice in a clinical setting. I hoped to develop experience, skills, and competence in these specific therapeutic approaches by using them as a guide for supporting individuals of various ages with diverse presenting issues. I aimed to understand how to provide clinical services during the pandemic by utilizing various communication mediums, such as telephones and video conferencing. Finally, I hoped to further cultivate the practice of self-awareness, integrity, and self-reflection within social work practice.

This report summarizes the wisdom- and experience-rich practicum I had at Ehrlo Counselling Services. I was able to achieve my goals and a lot more, and in doing so, I had some challenges and some celebrations. I had high-energy moments, and some stress-filled moments as well. There were deer in the headlights moments and superwoman moments. All in all, these experiences contributed to my professional and personal growth. My counselling and communication skills had a one hundred and eighty-degree turn towards a good direction where I am now more competent, trained, efficient, and able to practice independently.
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