CLINICAL COUNSELLING AT THE CARING PLACE IN REGINA: A FIELD PRACTICUM REPORT

Submitted to the Faculty of Social Work
In Partial Fulfillment of the Requirements
For the Degree of

Master of Social Work
Faculty of Social Work, University of Regina

By

Irene A. Forcheh
Regina, Saskatchewan
June 6, 2022

Copyright 2022: Irene A. Forcheh
All Rights Reserved
Abstract

This report documents the learning and insights I gained from my clinical field practicum at The Caring Place (TCP). In this report, I emphasize how I achieved my learning objectives, the ways in which I integrated theory and practice while engaging on the activities to achieve my objectives. My overarching goal was to gain graduate level clinical social work skills and knowledge in counseling, specifically on Cognitive Behavioral Therapy, Narrative Therapy, and Trauma Informed Care. I show examples from my counselling sessions that demonstrated how I implemented the tenets and principles of these therapeutic modalities. This report starts with the discussion of my rationale of doing a clinical social work practicum, which has led me to The Caring Place. This is followed by literature review related to the counselling modalities mentioned as well as discussion of my theoretical framework. I also incorporated a section where I discuss the challenges I encountered during the practicum. I concluded by reflecting on my vision for future clinical social work practice.
Acknowledgements

The journey to complete my Master of Social Work degree has been challenging but yet a very rewarding experience for me. Achieving this milestone has been possible because of the relentless support and encouragement from many people. First, I want to thank my children, Fualefac, Rostand, Nkemazem, and Azoacha, for encouraging me every step of the way and believing in me. I want to thank my mom Christina for encouraging me to follow my dreams.

I want to thank all the clients at The Caring Place (TCP) who trusted me enough to let me be part of their healing journey. I would like to thank the staff at TCP for being welcoming, encouraging, and supportive throughout my field practicum. Thank you to Graham and Ramona for the encouragement. Thank you, Ramona, for supporting me throughout my field practicum. Graham, I appreciate the relentless guidance on the techniques and skills development, directions on accessing resources that addressed my specific learning needs, and most of all, for believing in me.

I want to thank my professional associate Dr. Sam Berg who was very supportive and encouraging throughout my practicum. It was remarkable and motivating to watch you implement Narrative Therapy effortlessly. Thank you for supervising my field practicum and empowering me with the knowledge that enabled me to achieve my field practicum goals.

Thank you to my academic supervisor, Dr. Fritz Pino for guiding me throughout my field practicum and the practicum report writing process. I appreciate your input, encouragement, and relentless support during this process. Thank you to my committee members Dr. Douglas Durst and Dr. Gabriela Novotna for all the support and encouragement.
Dedication

This report is dedicated to my mother who is my biggest supporter and believes that I can do anything that I put my mind to it. Thank you, mom, for the love and support and for always believing and encouraging me. You are my rock.
# Table of Contents

Abstract .......................................................................................................................... i  
Acknowledgements ........................................................................................................ ii  
Dedication.......................................................................................................................... iii  

**Chapter One: Introduction** ......................................................................................... 1  
1.1 Rationale For A Field Practicum ............................................................................ 1  
1.2 Overview of The Caring Place (TCP) ..................................................................... 2  
1.3 Practicum Objectives ............................................................................................... 5  
1.4 Skills Gained ............................................................................................................. 7  

**Chapter Two: Therapeutic Approaches** .................................................................... 9  
2.1 Cognitive Behavioral Therapy (CBT) ..................................................................... 9  
2.2 Narrative Therapy (NT) .......................................................................................... 12  
2.3 Trauma-Informed Perspective .................................................................................. 15  

**Chapter Three: Theoretical Framework** ................................................................ 20  
3.1 Origins of Social Constructivism Theory ............................................................... 20  
3.2 Social Constructivism and Social Work Practice ................................................. 22  
3.3 Anti-Oppressive Practice ......................................................................................... 25  
3.3.1 Why Anti-oppressive Practice ......................................................................... 26  

**Chapter Four: Achieving Practicum Learning Objectives** ..................................... 29  
4.1 Learning Objective One .......................................................................................... 29  
4.1.1. Activity One: The Population Accessing TCP Services and Programs .......... 29  
4.1.2. Analysis Of Issues From A Social Work Lens .............................................. 31  
4.1.3. Team And Supervisory Meetings and Training ............................................. 32
Chapter One: Introduction

1.1 Rationale For A Field Practicum

As a social worker, I have worked on the frontline for more than 10 years providing services to women and men, youth and older adults, families, and individuals dealing with challenges such as disability, domestic violence, trauma, divorce, addiction, mental health, poverty, and homelessness. After completing my first master’s degree in clinical Social Work (MSW) at the University of Botswana in 2005, I worked as a counselor at The Kagisano Society Women’s Shelter Project in Botswana. As a counselor, I worked with clients who were impacted by domestic violence, divorce, addiction, abuse and trauma, and homelessness. During my time at the shelter, I established the difference between counseling clients and providing them with resources and just providing resources without counseling. I realized that clients who received counseling and resources had better coping skills than those who just wanted a safe shelter and support programs (cleaning, art, cooking skills). These experiences at the Kagisano Society Women’s Shelter Project motivated me to complete a Master’s degree in Gerontology at the University of Regina in 2012 and this Master’s degree in Social Work at the University of Regina.

I am an African Canadian and after completing my first degree in Cameroon, I moved to Botswana. I have worked in human service field as a social worker for over 12 years. I have completed a BA degree in English and Literature Studies from the University of Yaoundé in Cameroon, a Post Graduate Diploma in Tertiary Education (PGDE) from the University of South Africa, a Master’s degree in Social Work (MSW) from the University of Botswana, and an MA degree in Gerontology from the University Regina. I’m currently completing this Master’s degree in Social Work (MSW) at the University of Regina. The second reason why I opted for a
field practicum was because CASW recommended it so I could have a Canadian MSW equivalence.

The next step was to identify an agency or organization that would help improve my skills and knowledge in clinical social work. I wanted to learn more about Cognitive Behavioral Therapy (CBT), narrative therapy, and trauma-informed Care. So, the focus of my search was on agencies that use these three approaches. Considering that many organizations were not accepting practicum students due to COVID-19, I applied for a practicum placement opportunity in Regina, Saskatoon, and Prince Albert but decided that The Caring Place in Regina was the best fit for me. The Caring Place was very appealing to me because it has highly qualified, diverse, experienced, and world class therapists. I had the privilege to work with two of the best and most experienced narrative therapists at TCP who helped me achieve my practicum goals.

1.2 Overview Of The Caring Place (TCP)

This clinical field practicum was completed from September 2021 to December 2021 at The Caring Place in Regina. The Caring Place was established in 1991 as a non-profit, professional, faith-based Christian Counselling Center. The Caring Place (TCP) offers counseling services to individuals, couples, and families in Regina and surrounding communities (Friedrich & Board of Directors, 2019). According to Friedrich & Board of Directors (2019), the goal of The Caring Place is to provide a place of safety and trust where people of all ages from young children to seniors, and where people can find a caring professional to help them deal successfully with personal problems. The Caring Place provides counseling services to persons from a wide variety of backgrounds, ethnicities, religions, cultures, and sexual orientations.

Further, TCP provides counseling services to those dealing with challenges that include but not limited to depression, grief and crisis, couple and family problems, abuse and trauma,
anxiety, conflict resolution, pre-marital counseling, sexual harassment, and childhood abuse. TCP offers online counseling via Zoom platform, telephone, and in-person counseling services to the clients. Although TCP already had the online and telephone counseling options in place, these methods of communication became instrumental in reaching many clients during COVID-19.

TCP provides counseling services to everyone who seek their services regardless of their religious affiliation while recognizing the importance of Christian faith and modeling the highest principles of care and empowerment. The Caring Place partners with organizations such as REMA, all churches of Regina, Employee Assistance Programs (EAP), schools offering marriage and family therapy programs, schools of Social Work and schools offering clinical psychology programs (Friedrich & Board of Directors, 2019).

TCP has a team of skillful and experienced counselors who are compassionate, dedicated, and very knowledgeable, and provides the highest level of care and tools to support the progress of their clients. The Caring Place offers counseling services to clients on a sliding financial scale to give everyone the opportunity to access quality counselling services at a reasonable rate regardless of their socio-economic and employment status (Friedrich & Board of Directors, 2019). Therefore, individuals who do not have insurance coverage or may be unemployed but can afford the minimum counseling session fee, also have access quality professional therapy at The Caring Place. The Caring Place will balance the number of pro-bono or low paying client visits with donations given to The Caring Place, and this number will be reviewed on a semi-annual basis. Pro-Bono and Low Paying is any client who pays $30.00 or less per hour for TCP services (Friedrich & Board of Directors, 2019).
As a client-centered organization, The Caring Place counselors are accessible to clients outside of the usual office hours of 9:00 am to 4:00 pm to ensure that the needs of clients with busy work and family schedules are met. To accommodate the needs of all clients, TCP counselors offer flexible service hours on weekdays and weekends as follows:

- Mondays, Wednesdays, and Fridays, services are available from 9:00 am to 4:00 pm
- On Tuesdays, services are available from 9:00 am to 7:00 pm
- On Thursdays, services are available from 9:00 am to 9:00 pm
- Mondays, Depression and Anxiety group meetings from 7:00 pm to 8:30 pm
- Saturdays:
  - An Adoptee Support Group
  - Sexual Assault support group meetings from 10:00 am to 12:00 pm every second Saturday
  - Individual counseling sessions from 9:00 am to 2:00 pm upon request

Friedrich & Board of Directors (2019) states that the staff of The Caring Place are bound by the Code of Ethics of the Professional Association of Canadian Christian Counsellors (PACCC) and are expected to treat all clients with respect and dignity. The Caring Place code of conduct stipulates that staff are expected to dress businesslike, be ethical, and have a lawful conduct all the time. This includes proper use of authority and appropriate decorum when filling their roles as representatives of The Caring Place regardless of the setting. The Caring Place expect staff members who are social workers to follow the Social Work Professional Code of Ethics in their practice at the agency.
1.3 Practicum Objectives

I completed a full-time clinical practicum at The Caring Place consisting of 450 hours from September to December 2021. My practicum was completed in three significant parts. In the first part of my practicum, I read The Caring Place contractor and staff handbook, *The Primal Wound: Understanding the adopted child* by Nancy Newton (2017), made a cultural awareness presentation, and completed over 21 counseling session observations. I participated in weekly staff meetings and was privileged to participate in bi-weekly clinicians’ supervisory meetings. I took an online course on narrative therapy, completed a literature review, and watched online videos on the process and techniques of CBT, narrative therapy, and trauma-informed approaches.

During the second part of my practicum, I completed two counseling sessions that were observed by an experienced clinician who provided very helpful feedbacks after each session. I also had one-on-one supervisory meetings with clinicians who continued to guide me on the techniques of implementing CBT, narrative therapy, and trauma-informed perspectives during counseling. The one-on-one meetings with an experienced CBT therapist improved my skills in identifying and exploring core beliefs and automatic thoughts during CBT sessions, and how to support clients with suicidal ideation, self-harm, and suicide attempts. I also had a couple of one-on-one supervisory meetings with an experienced narrative therapist who guided me on the use of narrative metaphors in helping clients achieve their goals, on helping clients on externalizing problems, mapping the effects of the problem, identifying unique outcomes or exceptions to the problem, reframing the story, and focusing on restoring or alternative stories that infuse more optimism, hope, and confidence into their stories.
During the third part of my practicum, I conducted in-person counseling sessions with individuals and couples without the clinician’s observation. I incorporated all the skills and knowledge gained from previous activities into my therapy sessions. After completing counseling sessions, I debriefed with my professional associate and two senior counselors who gave me constructive feedback. I also presented some of the cases at the clinicians’ supervisory meetings where I got positive feedback from clinicians with experience in CBT, narrative therapy, and trauma-informed therapeutic approaches.

Completing these activities during my practicum greatly improved my knowledge on issues that brought clients of all ages, gender, race, and faith to TCP for counseling. Some of these issues include addiction, depression, anxiety, codependency, loss and grief, self-esteem, and marital issues. Participating in these activities also improved my counseling skills and confidence as I became better in building therapeutic relationships with clients, helping clients set therapeutic goals, and exploring issues deeper by asking open-ended questions and sometimes role play with clients. Further, I learned to infuse TCP values, the clients’ values, and Canadian Association of Social Workers (CASW) professional ethical values into my counseling sessions.
1.4 Skills Gained

The activities completed were vitally important in improving my counseling skills and confidence in effectively implementing narrative therapy, trauma-informed, and CBT. The activities also improved my ability in combining these approaches with other social work approaches and theories during sessions when necessary.

The learning objectives outlined in my practicum proposal were achieved by completing activities discussed in the report. My first learning objective was to gain an understanding of the population that access counselling at The Caring Place and the support programs offered. This objective was achieved by identifying the social location of the population and their issues, analyzing the issues from a social work lens, and by participating in staff meetings, case consultations, trainings to enhance my clinical social work knowledge and skills.

The second learning objective of my practicum was to acquire graduate level skills and knowledge in Cognitive Behavioural Therapy (CBT) in a clinical social work setting. This objective was achieved by completing a literature review on CBT, observe 2-4 counselling sessions that demonstrate CBT, watching online videos that demonstrate CBT, developing a critical reflection on CBT, managing a caseload of 5-8 clients under clinical supervision, demonstrating an understanding of the applicability of the CBT approach, and by writing a personal journal of learning experiences of CBT.

My third learning objective was to gain graduate level skills in narrative therapy. I achieved this objective by completing a literature review on narrative therapy, observing 2-4 counselling sessions that demonstrate the narrative therapy approach, watching online videos that demonstrate narrative therapy counselling technique, managing a caseload of 5-8 clients, and by demonstrating an understanding of the applicability of the therapeutic model.
The fourth objective was to gain an understanding of the trauma-informed perspective and apply such critical understanding to counselling skills used during the practicum. The objective was achieved by completing a literature review on the trauma-informed perspective, by understanding and documenting the theoretical and historical foundations and how they have been used in practice, by outlining the critiques and limitations of the perspective, and by applying the trauma-informed perspective in the analysis and reflection of the various client engagements done at the agency. I gained skills in completing counseling sessions with clients who have been traumatized without re-traumatizing them by always carefully framing questionings. These learning activities are discussed in detail subsequently.
Chapter Two: Therapeutic Approaches

The three main therapeutic approaches that I used during my practicum were the cognitive behavioural therapy (CBT), narrative therapy, and the trauma-informed perspective. This section discusses each of the models by reviewing the literature that examines the use of the models in clinical social work practice. By completing a literature review on these approaches at the start of my practicum, I gained an understanding of the theoretical foundations and the applicability of these models in practice.

2.1 Cognitive Behavioural Therapy (CBT)

I chose the cognitive behavioural therapy (CBT) because of its efficiency, versatility, and popularity, and the fact that it can easily be understood, adopted, and used by clients as proven by research. Hofmann and Asmundson (2017) support this by arguing that CBT was developed based on behavioral, cognitive, and social learning principles, understanding more about how specific techniques in CBT utilize aspects of various learning theories may shed light on potential areas for improvement and augmentation. Cognitive strategies within CBT utilize principles from theories of constructivism, attribution theory, and metacognition to aid clients in learning how thoughts impact feelings and how CBT therapists can maximize their clients’ learning (Hofmann & Asmundson, 2017).

Dr. Aaron Beck, an American psychiatrist, developed the cognitive behavioural therapy (CBT) approach by conducting many experiments on his patients on the psychoanalytic concept of depression (Beck, 1979). The cognitive behavioural therapy model assists with normalizing and managing experiences, feelings, and reactions (Knight, 2015). Palazzolo (2015) posits that CBT is a brief, structured psychotherapy that focuses on the key roles that cognitions and behaviours have in the onset and maintenance of mental illness. CBT is a commonsense
approach that is based on the fact that our cognition has a controlling influence on our emotions, behaviour, and how we behave can strongly affect our thoughts process and emotions (Wright et al., 2006). CBT is the gold-standard of psychological treatment or the best standard in the field because CBT is the most researched form of psychotherapy, no other form of psychotherapy has been shown to be systematically superior to CBT and the CBT theoretical models or mechanisms of change have been the most researched and are in line with the current mainstream paradigms of human mind and behavior (David et al., 2018). According to Nathan and Webber (2010), CBT was formulated in response to the rising requirement for evidence-based approaches because it is an empirical form of talk therapy that responds efficiently to numerous clinical diagnoses in addition to several psychosocial factors.

There has been extensive research that supports the notion that CBT is an effective approach to help people dealing with mental health disorders and has also been proven to decreased chances of relapse (Collimore & Rector, 2014). In CBT, you learn to identify, question, and change the thoughts, attitudes, beliefs, and assumptions related to your problematic emotional and behavioural reactions to certain kinds of situations (Rector, 2010). CBT is a form of therapy that examines the connection between thoughts, behaviours, and emotions (Albin & Bailey, 2014). CBT recognizes and examines dysfunctional thinking and behavioural patterns and replaces them, as this allows clients to better manage their current problems and improve their mental health (Chawathey & Ford, 2016). Chawathey and Ford (2016) posit that the goal of CBT is to address unhelpful thinking patterns and behaviors to help clients reduce their overall stress. According to Fenn and Byrne (2013), the aim of cognitive behavioural therapy is to help individuals become their own therapists by learning how to monitor their own thoughts and
behaviours and successfully apply coping skills that can be adapted within different areas of their life.

Consciousness, automatic thoughts, and schemas are the main principles of CBT. Consciousness is a sense of awareness in which decisions are made on a rational basis. Conscious attention allows people to monitor and assess interactions with the environment, link memories with present experiences and to control and plan future actions (Sternberg, 1996). Automatic thoughts are cognitions that stream rapidly through our minds when we are in the mist of situations or events (Wright et al., 2006). They further state that these thoughts are not subject to careful rational analysis. Automatic thoughts can also be logically sound and can be an accurate reflection of the reality of the situation. Incoming information is channeled through these automatic thoughts and evaluated according to underlying assumptions which are link to personal schema (e.g., I am unlovable) to further reinforce negative personal belief (Wright et al., 2006). Schemas are core beliefs that act as templates or underlying rules for information processing (Wright et al., 2006). Schemas allow people to screen, filter, code, and assign meaning to information from the environment (Wright et al., 2006). Schemas are enduring principles of thinking that start to take shape in early childhood and are influence by life experiences such as parental teachings and modeling, formal and informal educational activities, peer experiences, trauma, and success (Wright et al., 2006). They also posit that CBT is versatile and can be used to treat many clinical conditions and that other clinical approaches such as Dialectic Behaviour Therapy (DBT) and Cognitive Analytic Therapy (CAT) have been developed from CBT.

Cognitive Behavioural Therapy has been a proven tool to effectively challenge thoughts, feelings and behaviors with widespread application encompassing the simplest cognitive
distortions to known diagnosable mental health disorders (Beck, 2011). CBT is used to understand the perceived occurrences in our lives and to help us deal with these occurrences with emotional and behavioural strength (Briers, 2015). When people get stuck in negative thinking patterns, they can slip into unhelpful thoughts, emotions, and behaviours which can create a circle of negativity (Briers, 2015).

The CBT model recognizes that there are complex interactions among biological processes (such as genetics, neurotransmitter functioning, brain structuring and neuroendocrine systems), environmental and interpersonal influences, and cognitive behavioural elements in the genesis and treatment of psychiatric disorders (Wright, 2004). Cognitive assessment is done at the level of automatic thoughts that come spontaneously, appear valid and are associated to problematic behaviour and are often distorted (Leahy, 2003). Leahy (2003) states that these thoughts may appear as mind reading, labeling, personalizing, fortune telling, and all or nothing thinking. The CBT model assumes that cognitive and behavioural changes are modulated through biological processes and that psychotropic medication and other biological treatments influence cognitions. Therefore, an integrated and detailed formulation treatment plan that include biological, social, cognitive-behavioural, and interpersonal consideration is recommended (Wright et al., 2006).

2.2 Narrative Therapy (NT)

Narrative therapy is a postmodern “story changing” method that draws from the social constructivist work of French writer and philosopher Michel Foucault (Besley, 2002). The purpose of narrative therapy is to help people understand the power of dominant stories that influence their interpretation, perception, and experience of the world (Koop Harder, 2017).
Freedman and Combs (1996) posit that the narrative therapy approach is built on the foundation of two organizing metaphors known as personal narrative and social constructivism.

Narrative therapy was developed by Australian social workers Michael White and David Epston in the 1980’s (Nicholas, 2014). Their work with Indigenous communities in Australia inspired them to ground individual stories in cultural and historical context (Murdock, 2009). White (1999) defines narrative therapy as a storied account of a person’s experience in a particular context or situation, told through the unique biographical lens of the client. Narrative therapy is a form of psychotherapy that leverages therapeutic approaches designed to support the client’s values, skills, and the knowledge they use to live their lives, tell stories about their lives, and solve problems that are part of their lived story or experiences (Madigan, 2019). Morgan (2000) defines narrative therapy as a respectful, non-blaming approach to counselling and community work, that considers people as the experts in their own lives. Narrative therapy reflects the idea that the experiences we have are mapped into stories that we construct as our reality and these stories become problem-saturated dominant stories (Merscham, 2000).

A narrative “is the mental structuring process through which we define our existential relationship to the movement of our earth and the planets, stars, and galaxies, …and to our sense of moving from past to future, through retrospection and anticipation, with the present as a continuing interaction point with both” (Payne 2006, p. 19). Payne (2006) argues that a person’s self-story is a first-person narrative through which he defines who he is, based on his memories of his history, his present life, his role in social and personal settings, and his relationships. Fleming (2003) posits that a narrative, in contrast to events described randomly, offers a way of making sense of our experiences by ordering them temporally according to a theme. Fleming further argues that many narratives might be constructed from experiences and the account
chosen reflects decisions made concerning the significance of events and what themes provide a coherent storyline. Payne suggests that the narrative can mean an account of an event or events, or story telling or giving an account of any occurrence. He also states that a narrative is a schema in which human beings give meaning to their experience of temporality and personal actions and provides a framework for understanding past events of one’s life and for planning future actions.

Freedman and Combs (1996) posit that the narrative therapy approach is built on the foundation of social constructivism. White and Epston (1990) were influenced by the philosophy of social constructivism. Social constructivists believe that the problems people experienced are socially constructed through interactions (Payne 2006). Social constructivists argue that there is no objective social reality and that our identities are socially constructed through the stories we narrate to others (Murdock, 2009). Murdock further argues that the way we view ourselves, others, and the society is through the interactions we have with others. Social constructionist psychologists focus not on theories of deficit, inner damage, or pathology, but on the social and cultural processes through which we gain our views of the world, and how those views in turn influence our actions and relationships (Payne, 2006). Narrative therapists endorse the constructionist view that although socio-cultural factors are the most powerful influence on thoughts and behaviors, these influences can be identified, examined, and discarded (White, 2004). Narrative therapy is popular and has provided an attractive means of supporting people from diverse backgrounds and has been used to help people deal with a range of problems, from depression, asthma, anorexia, bulimia, anxiety, relationship problems and other psychiatric illnesses to trauma (Murdock, 2009).
Narrative theory gives us an ontological framework for deconstructing an individual’s experience and then re-storying that experience such that the individual is equipped with a more empowered sense of their reality and thus, better able to respond with improved coping strategies as it relates to the psychological impact of traumatic events (Gilkey, 2021). Narrative therapy seeks to empower groups and individuals, providing them with the resources and skills needed for positively improving their own well-being and coping with a wide range of life challenges (Hutto & Gallagher, 2017).

2.3 Trauma-Informed Perspective

Trauma-Informed perspective and Trauma-Informed Care (TIC) will be used interchangeably in this report. Trauma-Informed care is an organization-wide framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Guarino et al., 2014). A trauma-informed approach seeks to resist re-traumatization of the clients as well as staff (SAMHSA, 2014).

Trauma has been perceived and defined in different ways over the years, contingent on the development of knowledge and the understanding of the impact of traumatic experiences on the individual, family, society, and community (van der Kolk, 2014). Trauma is defined as an experience that is too overwhelming to cope with (Greaves & Poole, 2012) and trauma-informed perspective views trauma-related symptoms and behaviors as an individual's best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma. Trauma theorists argue that individuals are unique in the way they respond to traumatic events and a lot of research has been done on resilience, protective factors, and the disparity in the severity and
duration of individual responses to the same traumatic event (Baskin, 2016). Trauma theory posits that the individual and the environment are interconnected when it comes to health outcomes and overall well-being (Bloom, 2016). Trauma is a widespread, harmful, and costly public health problem and occurs because of violence, abuse, neglect, loss, disasters, war, and other emotional harmful experiences (SAMHSA, 2014). Burke-Harris (2018) also states that trauma is a public health problem that we can connect back to the costly individual and social problems that confront all areas of health care. Trauma is an almost universal experience of people with mental health and substance use disorders that affects people regardless of age, gender, socioeconomic status, ethnicity, race, sexual orientation, or geography (SAMHSA, 2014).

When a person experiences a traumatic event, it can have a lifelong devastating effect on the person’s sense of self, safety, attachment, relationships, ability to regulate emotions, and physical or mental health (Burke-Harris, 2018). Many of the inequities we see when it comes to populations experiencing chronic health issues, child maltreatment, school failures, crime, family conflict, and breakdown, mental illness, substance use, homelessness, interpersonal violence, community violence, and job performance issues are all correlated with experiences of childhood adversity and trauma (Burke-Harris, 2018). Research indicates that there is a relationship between exposure to traumatic events, impaired neurodevelopmental and immune system responses and subsequent health risk behaviours resulting in chronic physical and behavioural disorders (SAMHSA, 2014). According to Covington (2008), with appropriate support and intervention, people can overcome the effects of traumatic experiences. However, unaddressed trauma greatly increases the risk of mental and substance use disorders and chronic physical diseases (Anda et al., 2008).
The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery and requires a multi-agency public health approach that includes public education and awareness, prevention, and early identification and effective trauma-specific assessment and treatment (SAMHSA, 2014). Further, public institutions and service systems that are intended to provide services and support to individuals are often a source of trauma for some service users (SAMHSA, 2014). SAMHSA further states that these institutions include but not limited to coercive practice (seclusion and restraints), use of invasive procedures in the medical system, the abrupt removal of the child from an abusing family in the child welfare system, harsh disciplinary practices in educational systems, and intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma.

The pervasive and harmful impact of traumatic events on individuals, families, and communities and the unintended but widespread re-traumatizing of individuals within our public institutions and service systems, makes it vital to rethink doing business as usual (SAMHSA, 2014). However, some of these public institutions and service systems are focusing on the impact of trauma and how service systems may help to resolve trauma-related problems or re-traumatizing of individuals. Trauma-Informed Care (TIC) incorporates an understanding of the frequency and effects of early adversity on psychosocial functioning across the lifespan (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014). TIC is different from Trauma-focused therapy as its primary goal is not to directly address past trauma, but to view presenting problems in the context of a client’s traumatic experiences (Brown et al., 2012). Trauma-focused cognitive behavioural interventions help the client to discuss painful memories and reduce anxiety to a more tolerable level, and to increase their ability to modulate
emotions and behavior (Cohen & Barron, 2021). Trauma-Informed social workers rely on their knowledge about trauma to respond to clients in ways that convey respect and comparison, honour self-determination, and enable the client rebuilding of healthy interpersonal skills and coping strategies (Leveson, 2017).

Leveson (2017) further argues that Trauma-Informed Practice is consistent with promoting social justice for the oppressed and vulnerable populations which is the ethical core value and mission of social work. TIC focuses on creating a safe environment for clients that facilitates trust, collaboration, choice, and empowerment so that the client can experience healthy relationships with others (Leveson, 2017). TIC delivers services in a way that recognizes the emotional vulnerability to trauma survivors, and the worker also avoids inadvertently repeating the dynamics of abusive interactions in the helping process (Knight, 2015). Trauma-specific interventions are aimed at reducing symptoms resulting from negative sequelae of trauma in the life an individual while TIC service delivery reflect the needs of survivors to connect with others to be respected, and become hopeful regarding their own recovery (SAMHSA, 2013). A Trauma-Informed approach regards presenting problems as maladaptive coping and regards trauma as a framework for understanding experiences that can define and deeply affect a person’s identity (SAMHSA, 2014).

By understanding how early adversity shapes the client’s beliefs about the world, the social worker then helps the client to create new ways to organize feelings, coping skills, behaviours, and relationships (Knight, 2015). This perspective is shared by CBT and narrative therapy approaches. By viewing the collective experiences of the individual holistically, client’s behaviours that seem irrational, self-destructive, or abusive, are reconceptualized as surviving skills that once helped the client respond to threatening events, but which now impede their
ability to tolerate distress and set boundaries (Leveson, 2014). Leveson also argue that Trauma-Informed workers can help clients change problematic behavior and manage crises better.

The CBT, narrative therapy, and the trauma-informed practice are versatile and can be used as a single approach or in combination with other therapeutic approaches during counseling. Using these approaches during my practicum greatly improved my ability to use more than one therapeutic approach in a session. I used the solution-focused and strength-based approaches with CBT and narrative therapy during my practicum. The trauma-informed perspective was a key guiding principle in all my counseling sessions during the practicum as I worked collaboratively with the client as the expert of their problems. Understanding and implementing these approaches improved my ability to ask questions that helped the client to understand the influence of their past lived experiences on their current problems and to identify and adopt better coping skills to solve their problems.
Chapter Three: Theoretical Framework

This chapter discusses social constructivism theory and anti-oppressive theory as the underlying theoretical frameworks that guided my practicum.

3.1 Origins of Social Constructivism Theory

The social constructivism theory is a social learning theory developed by a Russian psychologist Lev Vygotsky who argues that individuals are active participants in the creation of their own knowledge (Schreiber & Valle, 2013). The social constructivism theory guided the implementation of the counselling approaches used during my practicum. The origins of social constructivism and social work practice are discussed in this chapter. Social constructivism is an epistemological perspective based on the assertion that humans actively create the realities to which they respond (Lee & Greene, 1999). Constructivism is an epistemological perspective that argues that there is not an objective reality independent of the observer (Greene et al., 2005). Proponents of constructivism argue that the human mind plays an active role in organizing and creating meaning rather than discovering reality (Lee & Greene, 1999).

The basic concepts of social constructivism can be traced back to philosophical developments that flourished several hundred years ago (Carpenter & Brownlee, 2017). According to Teater (2019), philosophers such as Giambattista Vico, Hans Vaihinger, Immanuel Kant, Friedrich Nietzsche and Karl Marx, and psychologists Lev Vygotsky, Jean Piaget, and George Kelly were instrumental in initiating thought around knowledge development and the influence of psychological, cognitive or sociological factors in this process. Carpenter and Brownlee (2017) have also acknowledged modern day theoreticians such as Paul Watzlawick, Ernst von Glaser-Feld and Heinz von Foerster as contributing to the development of social
constructivist ideas particularly through their examination of realness or reality as observer-dependent.

Bruner (1990) and Piaget (1972) are prominent theorists among the cognitive constructivists and due to Vygotsky (1934) contributions, he became the principal and most influential theorist among social constructivists (Marshall, 2017). Elements of social constructivism have been incorporated into theories used in social work for years in strengths perspective, solution-focused practice, person-centred approach, and narrative therapy, but was only recently formally recognized within social work (Carpenter & Brownlee, 2017).

Teater (2010) argues that social constructivism permeated other social science disciplines outside of philosophy and psychology following the publication of *the social construction of reality* by Berger and Luckman in 1966. She also states that Berger and Luckman expanded the social constructivism stance by establishing that social constructivism is mainly concerned with explicating the processes by which individuals come to describe, explain, or account for the world in which they live. Teater (2010) further states that Berger and Luckman (1966) explored how individuals create knowledge, make sense of the world around them, and construct reality and that reality is how people view and understand the world around them and how they make sense of what they see, feel, and believe to be real.

Anderson (1990) argues that the shift towards a social constructivism approach to thinking acknowledges that the objectivist worldview that previously dominated modern social sciences era, characterized by giving people in the absolute and permanent rightness of certain beliefs and values, was collapsing. The emergence of social constructivism in place of objectivism asserts that all stories, human creations truths, knowledge, and values are situated
within both individual experiences as well as within a universe that remains beyond us, and always mysterious, where there are no singular truths, perceptions, or realities (Anderson, 1992).

3.2 Social Constructivism And Social Work Practice

Constructivism as a conceptual framework is relatively new for social work practice (Carpenter & Brownlee, 2017). Carpenter and Brownlee (2017) argue that while various practice perspectives and treatment approaches in social work have historically reflected constructivist concepts and principles, only recently have they been recognized as such. However, constructivist ideas have a long history in human thought, having found expression in such diverse fields as art, literal criticism, mathematics, philosophy, the social and behavioural sciences, and related helping professions (Carpenter & Brownlee, 2017). Teater (2010) posits that the social constructivist theoretical lens is used to explain social problems. In adopting a social constructivism theoretical approach to social work practice, social work professionals value each client’s unique life experience and recognize that all individuals can experience situations very differently, particularly when influenced by a variety of social, cultural, and personal values against a backdrop of shared understandings, practices, and languages (Cooper, 2001).

Carpenter and Brownlee (2017) state that social constructivism is a postmodern relativist theory that can be deployed as a meta-theory for attaining a deeper understanding of the nature of modern or realist theories. While general practice guidelines can be inferred from constructivist concepts and principles, specific and detailed practice guidelines reflecting constructivism as a conceptual framework can be found in practice approaches such as narrative and solution-focused therapies (Carpenter & Brownlee, 2017). Constructivism evolved relatively recently as an attractive more pliable alternative that can accommodate different ways of viewing the world
and different interpretations of reality (Martinez-Brawley, 2020). Martinez-Brawley (2020) argues that constructivism offers a framework that is more receptive to the post-colonial cultural and identity challenges that social work practice encounters. Therefore, social work practitioners can apply the social constructivism framework in practice by using the six skills identified by Teater (2010) as a guide in implementing therapeutic approaches.

During my practicum, I used the six skills of the social constructivism framework as the foundation on which I implemented narrative therapy, CBT, and trauma-informed approaches. The six social constructivism framework skills that I used during my practicum are described below. According to Teater (2010), the six skills that enable social workers to apply the basic premises of social constructivism to practice are as follows:

The first skill is to develop collaborative relationships with clients. This involves the client and the social worker sharing power as they work together. Teater (2010) argues that taking a collaborative approach requires that the social worker acknowledge clients as the experts in their own reality and the social worker should attempt to understand the clients’ realities rather than attempt to have clients conform to the reality of the social worker. Greene and Lee (2002) support Teater’s idea by arguing that the social worker and the client should maintain an egalitarian relationship rather than a relationship where the social worker is viewed as the expert who is there to help the client by applying learned theoretical knowledge to the client’s situation.

Focus on and work towards client-defined goals is the second skill that social constructivism theory emphasizes. This involves clients specifying and defining the problem from their own reality and setting goals that are personally meaningful. Clients are less likely to be motivated to work towards goals that are externally imposed on them versus working towards
goals which they find relevant to their needs and situation (Lee & Greene, 2009). By allowing clients to define their challenges and identify potential solutions for their problems from their own perspective, they are more likely to be motivated to make preferred changes in their lives.

Taking a position of curiosity is the third skill. When assuming a social constructivism framework, social workers take a position of curiosity by attempting to discover the reality of the client. This is achieved by genuinely perusing an understanding of the way in which the client views their life, their problems and their strengths, and their resources. When social workers take the curiosity stance, it shows that they truly value and are interested in the client (Lee & Greene, 2002).

The fourth skill is taking a not-knowing, non-expert position. The social worker should acknowledge that the client is the expert in his or her own life when using the social constructionist framework. The social worker should take the not-knowing, non-expert stance and allow clients to express their realities through their own words instead of the social worker making assumptions about clients’ situations. This enables the social worker to work collaboratively with the clients in attempting to understand their reality and acknowledge that the clients can teach the social worker about their competencies, strengths, resources problems, and solutions (Lee & Greene, 2009). The social worker should use empathy and to see things through the viewpoints of the client. However, the social worker should not be passive when the client asks a question or seek their opinion, but they should give an honest response.

Learn and use the client’s language is the fifth skill required by the social worker. To continuously validate the client as the expert in their own situation, the social worker should attempt to learn and use the client’s language and the meanings that the client attaches to concepts. Teater (2010) further explains that it is vital for social workers to learn and understand
the client’s use of language as language is the root of historical, cultural, and personal experiences and values. According to Anderson (1997), a social constructionist approach to clinical practice places more emphasis on language use and dialogue with the client and to skillfully use language to maintain the therapeutic dialogue until the problem is addressed.

The sixth skill is reality is co-constructed through dialogue. Dialogues are conversations and special relationships in which change, growth, and new understanding are cultivated (Gergen, 1999). Social workers are in the business of facilitating change and when clients have a view of reality that is disempowering, stigmatizing or harmful to them, the social worker should have a dialogue with the client to co-construct a new reality that is more positively accepted by the client. Greene and Lee (2002) posit that a social constructivist approach allows clients to express their reality and experiences to help them view their reality as influenced by the dominant culture and encourages clients to look at alternative interpretations of their stories. The social worker works with the client to help them move from a problem narrative to a positive narrative. The narrative approach involves the social worker and the client working collaboratively to explore and revise the client’s story (Dean, 1993). This means the social worker and the client work together to develop a more fulfilling reality for the client.

3.3 Anti-Oppressive Practice

The anti-oppressive approach is a second theoretical framework that I used during my practicum as I continued to explore alternative approaches to help clients better. This section discusses the importance of Anti Oppressive Practice. Oppression is not always overt and social workers must be knowledgeable and have insight into how social structures operate as well as how to visualize and work against such injustices that exist within these structures (Young, 1990).
Anti-oppressive practice is a social justice-oriented practice model embraced by a wide swath of social workers in clinical, community, and policy settings which is taught in schools or departments of social work around the world (Cocker & Hafford-Latchfield, 2014). Anti-oppressive practice (AOP) recognizes the structural origins of oppression and promotes social transformation by using critical theories such Marxist, feminist, Indigenous, postmodernist, poststructuralist, anti-colonial, and anti-racist theories, among others (Baines, 2011). According to Sakamoto and Pitner (2005), anti-oppressive practice works to eradicate oppression and challenge power structures through collective institutional and societal changes. Critical consciousness is the process of continuously reflecting and examining how our biases, assumptions, and cultural worldviews affect the way we perceive difference and power dynamics (Sakamoto & Pitner, 2005). While The Caring Place does not have an explicit policy regarding anti-oppressive practice, TCP has a policy that identifies a commitment to equality of services regardless of ethnicity, race, ability, gender, sexual orientation, and religious affiliation (Friedrich & Board of Directors, 2019).

3.3.1 Why Anti-oppressive Practice

Anti-oppressive social work addresses social divisions and structural inequalities in the work done with clients and workers (Amadasun & Omorogiuwa, 2020). Anti-oppressive social work should attempt to build safe and respectful environments for marginalized groups (Karabanow, 2004). Anti-oppressive practice reconciles and provides a path to link social work theories and values with practice by utilizing self-reflection, assessment of service users’ experiences of oppression, empowering service users, working in partnership, and minimal intervention in practice principles (Healy, 2014).
Self-reflection in practice is one of the most important principles of anti-oppressive practice in social work. Healy (2014) posits that self-reflection in practice by social workers is crucial to avoid recreating oppressive social relations as social workers occupy a position of power and privilege via their access to resources and hierarchical structure of the social service sector. During my practicum, self-reflection was an important routine that I learned and performed daily which enabled me to always be aware of the power dynamics between the client and myself. Therefore, I treated clients with respect, dignity, and ensured that my personal beliefs and cultural values were not imposed on the client. Being conscious of and using anti-oppressive principle of self-reflection became the foundation of my interactions with clients.

According to Healy (2014), another vital principle of anti-oppressive practice is assessing service users’ experiences of oppression in practice as personal, cultural, and structural processes that each shape individuals’ problems and access to solutions. The assessment helps social workers to understand how social work discourse and language use in framing of problems can contribute to sustain oppressive power structures (Healy, 2014). As a frontline social worker, I am always conscious of the language I use when interacting with clients especially because clients often seek services when they are at a vulnerable stage. I have made a conscious decision to avoid using words and phrases such as “reject” or asking about client’s sexual orientation as this may be triggering to some clients who have experienced rejection and/or have been discriminated against because of their ethnicity and/or sexual orientation. I practice this in all my interactions with clients during my practicum.

One of the principles of anti-oppressive practice requires social workers to work in partnership with clients rather than as experts on the problems and life of clients. Service users must be included in the decision-making process on matters that affect their life, and this is
achieved via power sharing and providing clients with information necessary to make decisions that serve their best interest (Healy, 2014). As a social worker, I practice social work ethical values and principles by always treating clients with respect and dignity and walking alongside them to support them as they achieve their goals. I used this practice during my practicum by letting clients know at the start of the counseling session that they are the experts of their stories, have the right to determine what to focus on during therapy, to decline to answer questions that they were not comfortable answering, to terminate the session if they want at any time, and to request a different therapist if they feel that I am not the best fit for them.
Chapter Four: Achieving Practicum Learning Objectives

This chapter discusses the four practicum objectives and the various activities that I completed during my practicum to achieve the objectives. The four practicum objectives that I achieved during my practicum included gaining an understanding of the population that access counselling at The Caring Place and the support programs offered, acquiring graduate level skills and knowledge in Cognitive Behavioural Therapy (CBT) and narrative therapy within a clinical social work setting, and gaining a critical understanding of the trauma-informed perspective and applying such critical understanding to counselling. The activities completed to achieve these practicum objectives are discussed subsequently.

4.1 Learning Objective One: To Gain an Understanding of the Population that Access Counseling at TCP and the Support Programs Offered.

To achieve this objective, I identified the social location of the population and their issues, analyzed the issues from a social work lens, participated in team meetings, case consultations/supervisory meetings, and learned about the support programs at The Caring Place (TCP). Completing these learning activities gave me a better understanding of the agency and the population it serves.

4.1.1 Activity One: The Population Accessing TCP Services And Programs

As discussed earlier in the report, I learned from reading the staff handbook that TCP runs the Depression and Anxiety support group, the Sexual Assault support group, Adoptee support group, and finding the missing piece for adoptive and foster parents free of charge. I facilitated and co-facilitated the Depression and Anxiety support group and the Sexual Assault support group. I also read “The Primal Wound: Understanding the adopted child” by Nancy Newton Verrier (2017) at the start of my practicum. Some of the issues that brought clients to
The Caring Place for counseling or to the support groups included but were not limited to addictions, depression, anxiety, couple and relationship problems, self-esteem, grief and crisis, work and school stress, domestic violence, and sexual assault (Friedrich & Board of Directors, 2019).

Completing these activities at the start of my practicum gave me an understanding of TCP, its programs, mission, and the population it serves and better prepared me for my practicum. I learned the importance of support groups in reducing or managing depression especially during COVID-19 where people were mostly isolated. Many participants of the Depression and Anxiety group confessed that the COVID-19 isolation created by social distancing increased their anxiety and depression. But that attending the weekly group meetings and sharing with members of the group in a safe and caring environment was very helpful in managing their depression and was the only activity that they were involved in and looked forward to.

TCP does not only provide affordable and quality counseling services to clients, but TCP also provide free support programs to people. These programs provide a safe place for people dealing with depression to come together and support each other in a caring and non-judgmental manner. The program is offered free of charge to anyone who is interested. The program is offered in person or online via zoom. Participants may choose to attend the program from the comfort of their homes or attend in person at TCP office. I co-facilitated and facilitated this support group throughout my practicum and learned a lot on how to deal with group dynamics. Some of the issues that brought clients into The Caring Place for counseling or to the support programs included but were not limited to addictions, depression, anxiety, couple and
relationship problems, self-esteem, grief and crisis, marital issues and divorce, work and school stress, domestic violence, and sexual assault (Friedrich & Board of Directors, 2019).

4.1.2 Analysis of Issues From a Social Work Lens.

This analysis was guided by the social constructivist and anti-oppressive theories. Depression and anxiety were a common challenge among clients. As per some of the clients, past and current trauma are contributing factors to the depression and anxiety that many clients were dealing with. For instance, I worked with a client who was dealing with depression. For confidentiality purposes, I will not use any information that identifies the client. As a social worker, gathering background information on the problem provides a better understanding of the problem. The purpose of gathering background information on this client was also to establish a connection if any between past traumatic experiences and the client’s current situation. During the first session, the client narrated their story as I asked clarifying questions. Once the client finished narrating the story, I asked open-ended questions about their family (parents, siblings, spouse, kids, and friends) and the nature of their relationships. I also gathered information on previous and current health and mental health issues as well as on community involvement (school and work) and on the client’s personal life as a child and as an adult. With this information, I was able to work with the client to identify the client’s core beliefs and how this influenced his appraisal of situations as well as determined appropriate interventions and resources required to address the problem. From a social work lens, I analyzed and supported clients to deal with challenges by using the CASW core ethical values and principles.

Social work ethical values and principles are the foundation of social work practice and are used by all Canadian social workers to serve clients effectively. The six core values and principles of social work that all social workers must know, and practice are respect for inherent
dignity and worth of the person, pursuit of social justice, service to humanity, integrity of professional practice, confidentiality in professional practice, and competence in professional practice (CASW, 2005b).

Social workers need to promote the self-determination and autonomy of clients and encourage them to make informed decisions (CASW, 2005b). I implemented this value by providing clients with information and asking clients questions that helped clarify doubts that clients had on issues that brought them to counseling. As clients often look up to their therapists for guidance and direction, I provided information to clients to help them make informed decisions. I also promoted and encouraged self-determination as clients were informed that they may decline to answer any question during the session if they did not feel comfortable answering it and to request for a different clinician if they felt that I was not a good fit for them.

Confidentiality is important at The Caring Place as maintaining the confidentiality of the clients and their records is a significant component of the trusted relationships built with clients at The Caring Place (Friedrich & Board of Directors, 2019). As a social worker, I have always valued and practiced confidentiality and at the beginning of all my intake sessions at the Caring Place, confidentiality was explained to clients. I also informed clients that they can request for their record at TCP anytime but that their records may not be shared with anyone else except requested by a court of law.

4.1.3 Team and Supervisory Meetings and Trainings

The purpose of this activity was to help me know TCP staff members and vice versa and to build professional relationships with other clinicians as well as learn more about TCP activities and programs. The Caring Place staff meetings were held weekly and were attended by
all staff members. Attending these meetings made it easier for me to settle in quickly and to start working on achieving the goals of my practicum.

Staff members often presented on different topics at the staff meeting and the rest of the group will ask questions or comment on the presentation. I made a presentation on counseling and the Nweh culture (my culture), other cultures in Cameroon and related Bantu cultures in Africa at one of the staff meetings. The Nweh culture in Cameroon and many other Bantu cultures in Africa do not believe in counseling as it involves discussing family and personal issues with non-family members. Therefore, counseling is discouraged and shunned in these cultures. Discouraging counseling in these cultures is not because these cultures do not like counseling but because they believe that the counselor should be someone who understands the family dynamics, the culture, and traditions of the people, and have the best interest of the family at heart. This cultural example confirms the social constructivist argument that in the process of socially constructing reality, individuals interpret, assign meaning, and create assumptions about themselves, other people, and their environment that provide the foundation for their knowledge of the world (Lee & Greene, 1999). Lee and Greene (1999) also argued that people filter their interactions with the environment through existing beliefs, which then give shape to how individuals interpret, explain, and come to understand what their world means.

Supervisory meetings play a crucially important role in achieving the goals of my practicum as I learned a lot from the great feedback that I received each time I presented and when others presented. I learned how to deal with complex cases and use analogies to explain clients’ situations, personal, and social-economic dynamics effecting the clients. The supervisory meetings helped a great deal in developing my counseling skills and confidence in conducting couple counseling sessions. When I started conducting counseling sessions, I was worried about
making mistakes during sessions and so would sometimes not ask all the follow-up questions that I had in mind. But I learned from positive feedbacks from supervisory meetings that asking follow-up and clarifying questions helps the client tell their story and the therapist to get a complete picture of the story. I also learned that making mistakes was part of the learning process although not making them will be ideal.

4.2 Learning Objective Two: Acquire Graduate Level Skills and Knowledge in Cognitive Behavioral Therapy

I became well-versed with CBT by observing counseling sessions, watching online videos on CBT, and by implementing CBT during counseling sessions. One of the activities to achieve this objective was to role-play with a clinician if the opportunity became available. This was not done due to the busy schedule of the clinicians and the impact of COVID-19.

4.2.1 Observing CBT Counselling Sessions

In preparation to implement the CBT technique and with the clients’ permission, I observed and participated in counseling sessions with experienced clinicians. I observed and participated in five CBT counseling sessions that supported clients in learning coping skills to better deal with the challenges that brought them into counseling. With the supervision of an experienced clinician, I completed counseling intake forms with clients and asked follow-up questions during observation that helped clients to understand and analyze their issues differently. My ability to validate clients’ feelings during sessions and helped them to understand the connection between core beliefs, feelings, emotions, and their current situation improved considerably. This knowledge was helpful when I started conducting counseling sessions without the supervision.
4.2.2 Watched Videos Demonstrating the CBT Approach

I watched online videos that demonstrated the implementation of the CBT counseling technique. Identifying automatic thoughts and linking them to cognitive appraisal, emotions, and feeling is one of the key steps in the CBT counseling process. I watched an informative video by Cotterell (2019) on how to identify automatic thoughts. I was able to understand and master the technique of identifying distortions in automatic thoughts especially with clients who may not know that they have these thoughts. For instance, I used questions like “what do you feel when you shake your head?” Focusing on the client’s feelings and sensations to help them identify these thoughts are vital in CBT as these thoughts are directly linked to the client’s presenting problem.

The video improved my understanding and the ability to use feelings and sensation to help clients identify automatic thoughts and how these thoughts influence their worldview and behavior. The main goal of a therapist who uses the CBT counseling approach is to identify and subsequently help the client change their core beliefs. Another vital video, that I watched was by Gary Van Warmerdam (2017) on “how to change core beliefs”. It improved my ability to help clients during a CBT counseling session to start reframing negative core beliefs and replacing them with positive core beliefs.

4.2.3 Demonstrating CBT Application

Under the supervision of an experienced clinician, I conducted my first CBT intake session during the practicum. All the knowledge and skills gained from literature review, session observations, and watching videos, were put into practice. The first CBT meeting I had with a client was an intake session under the observation of a clinician. I started the session by welcoming the client and making him feel comfortable. I introduced myself, the agency, the
clinician observing the session, and explained confidentiality to the client. I also explained the role of the therapist and informed the client that as the expert of their story, they decide what is discussed in the session and have the right to request a different therapist at any time if they want. The client then completed the intake and consent forms and returned to me. The intake session was one of the most vital sessions for me as it is the start of building a good therapeutic relationship with the client, getting background information about the client and their situation, and for the client to get to know the therapist.

I thanked the client for completing the forms and asked, “what can I do for you today?”. This permitted the client to tell their story or discuss their problem. I asked clarifying questions during the story telling to ensure that I understood the story and to help the client in narrating their story. Once they were done telling their story, I thanked them and validated their feelings. Through clarifications, reflections, and open-ended questions, such as “why were you sad when she did not greet you?” The client’s response was “because I am useless and not good enough for them.” It was deduced from the above statement that client’s core belief was that they are “useless” and “not good enough”. Through more questions in subsequent sessions, the client was able to identify and acknowledge their core beliefs and the impact of these distorted beliefs on their situation appraisal, thoughts, feelings, emotions, and behavior. Once the client understood their connection, the focus of the client in subsequent sessions was to develop positive coping skills to help them deal with the challenges they were facing. The client started by identifying positive core beliefs to replace the negative core beliefs. When I asked the client “What are positive words that you could replace “I’m useless” and “I’m not good enough” with? The client said, “I’m hardworking, handsome, caring, and intelligent.” The client also had to learn these new thoughts and beliefs by writing them in a place where he could see them daily until when
they get better at remembering them. The client was also aware that replacing the negative core beliefs with positive core beliefs was not going to happen overnight and that learning the new skills was a gradual process that required persistence.

4.2.4 A Personal Reflection on CBT Learning Experiences

CBT is a successful approach that can be adapted and used for personal development by therapists, clients, and anyone who understands the underpinning assumptions of this approach. CBT literature revealed that the concept and assumptions of CBT are easy to understand and versatile and, therefore, could be used in treating a variety of mental health problems. I noticed during my practicum that when I explained the link between core beliefs, situation appraisal, and the negative or positive feelings and emotions from the appraisal, all the clients could clearly see this link. Therefore, objectively appraising all situations and focusing on the positive outcome of the situation considerably reduced stress.

Learning more about CBT greatly improved my ability to effectively implement this approach in a counseling session and considerably changed the way I analyze or appraise personal situations and my outlook on life. Understanding the link between situation appraisal, core beliefs, and the negative feelings that arise from the appraisal has reduced my stress levels and helped me to better cope with stressful life events. I have developed a more positive outlook towards life as I started identifying and working on distorted automatic thoughts and core beliefs. Situation appraisal and the ability to focus on the positives of every situation rather than on the negative energy, worked great for me during my practicum by reducing practicum stress. Distorted core beliefs negatively impact our worldview, self-concept, and contribute to negative situation appraisal and may subsequently lead to mental health issues.
4.3 Learning Objective Three: Acquire Skills And Knowledge In Narrative Therapy

I watched videos demonstrating the narrative therapy technique, managed a caseload of five clients, demonstrated an understanding of the applicability of this approach, and wrote a summary of my learning experience with narrative therapy. Although I had read about narrative therapy approach in the past, I have never worked with the approach as a counselor or as a social worker. I decided to learn more about this approach when one of my friends, a retired as clinician, explained to me that narrative therapy is a great technique to deal with mental health issues such depression and anxiety and marital and relationship issues. When I started researching and mapping out the focus of my clinical field practicum, I decided to read and learn more about narrative therapy. The more I read and watched videos on narrative therapy, the more fascinated I became with this approach.

4.3.1 Observing Narrative Therapy Counselling Sessions

I observed more than ten narrative therapy counseling sessions and watched videos that demonstrated a narrative therapy approach as one of the learning activities. The videos and the observations were instrumental in my understanding and applicability of the narrative therapy approach. The first one-on-one meeting I had with one of the clinicians was about fifteen minutes long where he guided me on many counseling techniques that include but not limited to the importance of listening and observing, empathy, reflecting client’s feelings and paraphrasing for clarification. This clinician also explained the use of metaphors and showed me a dice block as one of the resources used to explain a narrative metaphor in a session and to always remember that the client is the expert of their story. During a second one-on-one discussion with the same clinician, he used one of the sessions that I just observed to guide me on how to ask follow-up questions and why he asked specific questions during the session. He guided me on note taking
during sessions, gathering necessary information that will help in understanding the problem, how to externalize the problem, identify exceptions to the problem, and how to start the re-storing process. These skills were further instilled in me as I started identifying the stage(s) of the approach used in sessions during debriefing.

The observation sessions and the debriefing meetings were informative, and I learned how to ask questions that helped clients to revisit and re-examine their stories. After every narrative therapy session that I observed with the client’s permission, I always debriefed with the clinician. This was always very helpful as the different techniques used during the sessions were analyzed to help me understand narrative therapy implementation. The clinicians invited me to ask questions during sessions and this boosted my listening abilities and confidence a great deal. I identified and explained the problem, the effects of the problem, what was said to externalize the problem, and what other theories or approaches were used in the session during debriefing.

4.3.2 Implementing Narrative Therapy In My Counselling Sessions

Gaining knowledge and skills on narrative therapy and applying them into practice was one of the major objectives of my clinical field practicum. I implemented the narrative therapy technique with individuals and couples during my practicum.

The first meeting I had with four of my clients were intakes as one of them was a transfer case. The first meeting was the most important because this is when the therapist starts building the foundation of a therapeutic relationship with the client. I started all my intake sessions by introducing myself and the mission of the agency to the client. This was followed with an explanation of the importance of confidentiality as per TCP and Social Work ethical expectations and values. The role of the therapist was explained, and the client made aware that they are the experts of their stories and have the right to request for the services of a different clinician if the
need arises. An intake form was completed with all new clients, and this was either completed by the client or the therapist as per the client’s determination. All sessions lasted 50 minutes, and all the clients were made aware of this in our first meeting. The intake session was a crucial initial stage of the therapeutic process as it gave me and the client the chance to know each other. It gave me the chance to learn about the client’s problems and their background (family relationships and personal life as a child and an adult) as it relates to their challenges. The stages of narrative therapy that I implemented during my practicum are discussed below.

In the first session, I invited clients to tell their story in a safe and uninterrupted setting as I actively listened and wrote down key words, phrases, and observed nonverbal cues, emotions and feelings displayed by the client. This information was subsequently used for clarification, to obtain more information about events, positive and negative relationships, feelings, and emotions expressed by the client as they shared their story. A problem-saturated description represents the person’s present dominant story, it is likely not the whole or only part of their life (Payne, 2006). Once the client was done describing their story, I thanked them and validated their feelings. I then asked clarifying questions and open-ended questions to understand the problem, identify the effects of the problem on the client, their family, and work life. For instance, “Tell me how this problem has affected your life”. The next step was to separate the client from the problem by externalizing the problem.

Externalizing the problem is one of the key techniques used in narrative therapy. Once I explored and understood the client’s story, the next step was to identify, name, and externalize the problem. Nicholas (2014) posits that instead of having a problem or being a problem, clients are encouraged to see themselves as struggling against their problems and that neither the patient nor the family is the problem; the problem is the problem. Problem externalization was one of
the tools that I used in my sessions to help clients to understand that they are not the problem and that the “problem is the problem.” One of the main narrative therapy tools for combating life-limiting stories is that of externalizing conversations that open options for people to redefine or revise their relationship with a problem (Murdoch, 2009). Denborough (2014) agrees by arguing that the person is not the problem; the problem is the problem. One of the main characteristics of the narrative therapy approach is externalization of the problem. According to Madigan (2011), the prevailing ways of describing clients were cultural-based constructs shaped by institutional places of knowledge such as social media, education, religion, science, law, medicine, and government. To change the way people view themselves and the world around them, narrative therapy convinces people to see themselves as people who are affected by their problems and not as the “problem.”

Problem externalization is a shift in attitude and orientation because it rejects the dominant cultural notions of pathology, diagnosis, or labelling through which people begin to themselves as being inherently flawed or dysfunctional (Morgan, 2000). I started externalizing the problem by inviting the client to give the problem a name. For instance, one of my clients described their problem as depression and described himself as weak, a dead bag, unattractive, and a failure. These descriptions were their imagination of what they thought people saw them as and not based on what the other person said to them. Through open-ended questions, the client referred to the habit of imagining what people think of them as “mindreading” and how this has contributed to the depression that invaded their life. With further questioning, the client called mindreading “self-sabotage.”

In our next meeting, I role-played with the client and self-sabotage (represented by a chair). In this report, I have changed the scenario to protect the client’s identity. The scenario
was that the client had a new choir member who did not laugh at their jokes, and this brought negative thoughts to the client’s mind. We each played the role of the new choir member and self-sabotage. I asked the client to say something funny. They did and we assumed that others laughed but the new choir member did not. We discussed what we thought self-sabotage was thinking, what the client was thinking, and what could have been the new member’s reasons for not laughing. This discussion was a great way to separate the client from the problem and to help him understand that they were not the problem, and that the problem was self-sabotage that has invaded their life.

Externalizing the problem contributes to mental health recovery and rehabilitation by challenging both the client’s negative thinking patterns and their fixed beliefs about themselves (Morgan, 2000). Through role playing with the client, they were able to see that mindreading and the negative self-concept were the dominant or thin stories that they tell themselves. Once the client was able to see how self-sabotage has invaded their life, we focused on identifying unique outcomes (exceptions) or when the problem is absent or less in their life.

Unique outcomes allow the therapist to help the client craft a story about their lived experience as it relates to past trauma experiences, in a way that tells the individual’s story from a positive lens (Gilkey, 2021). The client and the therapist identify those unique aspects of the client to create a stronger functioning identity that supports positive self-image, self-confidence, personal control, and authority over their lived experience, and develop a storyline that affirms the individual as valuable, worthy, and capable of creating a different lived experience for themselves (Gilkey, 2021). In the next session, the client focused on identifying unique outcomes to help him move away from thin and negative stories to positive stories. The client states that they were better than self-sabotage and that they are intelligent, has a great voice, cares about
people, loves sports, and is very good at it, hardworking, and dedicated. The client said they needed to start seeing themselves in a positive light as that will build his self-confidence and to trust that people are not always thinking negatively about them because many of the choir member like them. Identifying the unique outcomes is a great way to help the client to start re-storying the problem saturated story so that the focus of the story shifts from negativity to positivity and optimism. When the problem is externalized, the narrative therapist has many possibilities to explore clients’ relationships to the problem and to determine ways in which the client can be responsible for their own behaviours (White, 2007).

With the use of role play, I worked with the client in subsequent sessions to start retelling their story in a positive light by using unique outcomes to build positive stories. With role play, the client was able to see that people think positively of them because they have a great voice, can sing well, is funny and caring, and hardworking. The re-storying technique supports clients by helping them to develop new alternative storylines that support new perfect identities (White, 2007). The therapist helps the client to tell their story in a way that is uninterrupted by others’ point of view and subsequently encourages the client to view their story with ownership (Beaudoin, 2015). The client is helped to identify what meaning they make of their life and discover a new meaning and re-storying of those experiences that have impacted them so greatly (White, 2011).

Re-membering is another technique used by narrative therapists to encourage clients to reflect on meaningful relationships. According to White (2007) re-membering permits clients to re-engage with significant figures from their past, present, or future that have had positive influences on their lives. Re-membering involves clients deliberately choosing to be more present as a member of their club of life and whose membership they would prefer to revise or
revoke (Morgan, 2000). During my practicum, a client said they were not good in school, and that their childhood friend was great in sports and school and would often brag of her athletic accomplishments. The client said they felt “not good enough” and inferior and this gradually consumed their life. This is one of the stories that the client had to re-tell from a positive light and to select close family members whom they identified (not listed for confidentiality reasons) as a support system.

4.3.3 A Personal Reflection Of Learning Experiences Of Narrative Therapy

Narrative therapy is a therapeutic approach that I did not know much about at the start of my practicum, so I had to read books and peer reviewed articles, watch videos, and took an online course with the Dulwich Centre to improve my skills and knowledge of narrative therapy. I completed an online course on “What is Narrative Therapy?” with the Dulwich Centre. I learned from this training that the stories we tell are usually not all our stories and often part of our story and not the whole story. White and Epston (1990) called these descriptions “thin stories.” Learning and implementing narrative therapy has helped me to grow personally and professionally as I look for the positive in most negative situations or events that I face in life rather than focus on the negative.

During one of the narrative therapy couple counseling sessions that I observed with my professional associate, I realized that focusing on identifying unique outcomes with the client does not only change the focus of the discussion from the negative to the positive aspects of the story, but also allows the client to see that their lived experiences have not just been “gloom and doom.” During this session, the couple mostly focused on the weaknesses of each other and how they argued a lot. But when I asked them, “Is there a time that the issues discussed are absent in your relationship?” They both responded yes and identify many instances that they were happy
and affectionate towards each other by going for walks, grocery shopping, and cooking together. One of the techniques of the narrative therapy approach that I used to help clients during my practicum was identifying the unique outcomes and using them as the foundation of the re-storying process.

4.4 Learning Objective Four: Trauma-Informed Perspective

Throughout my counseling sessions, I was careful not to retraumatize clients as many of the clients had been affected by trauma at some point in their lives. Therefore, I used the social work ethical core value of respect and professionalism as the foundation of my counseling sessions. According to Key (2018), work around trauma and its impact has its historical foundation in treatment approaches and that organizations came to understand trauma, its nature, its impact, and manifestations in attempts to find ways to mitigate its harmful effects through treatment. Key (2018) argues that the earliest and most extensive work on trauma was done in organizations serving children and youth. The lifelong impact of childhood trauma is well-understood across that field and treatment methods are in use, and continue to be developed, in behavioral health and other clinical health settings as well as in social services and human services organizations serving children and families (Key, 2018). Trauma has also been examined and treatment approaches tried with combat veterans who manifest post-traumatic stress disorder (PTSD) from the impact of wartime trauma. Research on trauma has recently extended beyond children, youth, members of the military, and veterans to include adults dealing with complex mental health issues, often rooted in earlier trauma such as trauma from experiencing chronic homelessness (Key, 2018).

A study by Felitti et al. (1998) established a closed link between childhood abuse, neglect, maltreatment and household dysfunction and adult health outcomes that encompass
physical, emotional, and social health. The study further established that adverse experiences in childhood are common that these experiences correlate to a range of negative health outcomes such as diabetes, cancer, teen pregnancy, criminal activities, and unemployment. Research in understanding and treating trauma realized that creating a climate where individuals felt safe and supported in tackling their trauma histories and working toward health required more than skilled clinicians (Key, 2018).

4.4.1 Theoretical And Historical Foundation And How It Has Been Used In Practice

Trauma theory refers to a set of physical, cognitive, and psychological responses to a particular horrifying, or traumatic event (Regehr & Bober, 2005). Trauma theorists argue that people are unique in their responses to traumatic events and a substantial amount of literature has been devoted to resilience, protective factors and the disparity in the severity and duration of individual response to the same traumatic event (Baskin, 2016; Burke-Harris, 2018; Harris & Fallot, 2001; Manitoba Trauma Information and Education Centre, 2013). The development of Contemporary Trauma-Theory (CTT) represents a paradigm shift in how social workers perceive and treat survivors of trauma (Goodman, 2017). The new trauma-based paradigm refrains from viewing survivors’ poor functioning as resulting from sickness, weakness, or deficiencies in moral character, and reframes viewing survivors as psychologically and physically injured, and instead, in need of healing and help (van der Kolk, 2014). According to Goodman (2017), CTT provides a theoretical framework for understanding the impact of trauma on a person’s functioning. Goodman argues that CTT provides a conceptual foundation for understanding the bio-psychosocial impact of trauma on children and adults. Goodman further discussed the central properties (dissociation, attachment, reenactment, long-term effect at adulthood, impairment in emotional capacities) of Contemporary Trauma-Theory (CTT).
Dissociation is the main defense mechanism used by a victim to negotiate and tolerate the horrific traumatic experience (van der Kolk, 2014). Attachment is another key property of CTT which states that childhood trauma (CT) impacts a person’s ability to develop healthy interpersonal relationships and to trust, and this limits their ability to form secured attachment with others and problems in personal relationships (Siegal, 2010). Re-enactment is an intense emotional state that releases tension or anxiety and provides the person with a sense of control and connectedness (van der Kolk, 2014). Long-term effect on later adulthood trauma experienced by a child inhibits appropriate development and predisposes the child to negative recurrence later in life, including comorbidity in physical and mental health problems (Goodman, 2017).

Impairment in emotional capacity is emotional numbing and the breakdown of the self-regulatory systems are direct impacts of trauma on the brain and on the adaptive functioning of the limbic system, the part of the brain that supports a variety of functions (van der Kolk, 2014). Traumatic events, and especially prolonged exposure to trauma, which is typical in childhood abuse or neglect, diminish the sense of baseline state of both emotional and physical calm or comfort, resulting in hyper-arousal symptoms that include hyper-vigilance, anxiety, agitation, night terror, and somatization (van der Kolk, 2014). CCT provides a conceptual foundation for understanding the bio-psychosocial impact of trauma on children and adults (Goodman, 2017).

4.4.2 Critiques And Limitations Of The Trauma-Informed Perspective

Although trauma-informed care has been recognized and adopted by behavioural health and other clinical health settings as well as in social services and human services organizations serving children and families (Key, 2018), critiques have been quick to identify the weaknesses or limitations of this approach. According to Ginwright (2018), the term, “trauma-informed
care”, did not encompass the totality of the client’s experience and focused only on the harm, injury, and trauma of the client. Ginwright argues that the term slipped into the murky water of deficit based, rather than asset driven strategies to support young people who have been harmed. Further, Trauma-informed care requires that we treat trauma in people but provides very little insight into how we might address the root causes of trauma in neighbourhoods, families, and schools (Ginwright, 2018).

If trauma is collectively experienced, treatment must consider the environmental context that caused the harm and by only treating the individual, only half of the problem is addressed, and the individual is left in the toxic systems, policies, and practices (Ginwright, 2018). Ginwright (2018) states that the term, “trauma-informed care”, runs the risk of focusing on the treatment of pathology (trauma), rather than fostering the possibility of well-being. He also argues that the absence of violence does not constitute peace, the reduction in pathology (anger, anxiety, fear, sadness, distrust, and triggers) does not constitute well-being (hope, happiness, aspiration, trust, imagination). Everyone wants to be happy, not just have less misery (Ginwright, 2018). He posits that without more careful consideration, trauma informed approaches sometimes slip into rigid medical models of care that are steeped in treating the symptoms, rather than strengthening the roots of well-being.

Despite the widespread support and growing adoption of trauma-informed care approach in schools across the globe, there are no studies to provide solid evidence to suggest that this approach is effective in achieving the stated goals (Maynard et al., 2019). While the premise of a trauma-informed school approach is a noble one, it is unclear as to whether the premise of this framework is delivering systemic and programmatic changes (Maynard et al., 2019). There is much confusion, overlap, and misuse of the various terminologies that refer to a trauma-
informed approach. The lack of consensus on the definition of trauma-informed care, makes efforts to both implement and study trauma-informed care challenging (Maynard et al., 2019). What is essential to a trauma-informed approach challenging has not always been operationalized, and the approaches and variations of the approach have been referred to in varying ways such as trauma-informed care, trauma-sensitive, trauma-informed system (Hanson & Lang, 2016).

4.4.3 How Trauma-Informed Care Supplemented Counseling Sessions

Trauma-Informed Care is an organisational model that everyone from staff to client has experienced trauma (Harris & Fallot, 2001). Trauma-informed care (TIC) involves understanding trauma survivors from the lens of what happened to you rather than what is wrong with you (Manitoba Trauma Information and Education Centre, 2013). Harris and Fallot (2001) developed a dimension model of TIC and it is one of the most discussed models in TIC research. According to the model, trauma-informed environments are characterised by guiding principles such as choice, trustworthiness, safety, empowerment, and collaboration (Harris & Fallot, 2001).

I have been guided by the assumption that people come to counseling or seek help because they are or have experienced traumatic situations. Therefore, throughout my practicum, I was conscious of the fact that the client could be re-traumatised by the therapist’s or social worker’s approach. Completing the above-mentioned learning activities during my practicum, greatly improved my knowledge of some of the challenges faced by the clients such as marital problems, additions, depression and anxiety, and childhood trauma. I also learned more about CBT, narrative therapy, and trauma-informed therapeutic approaches through literature review, observing experienced clinicians’ implementation of these approaches, watching online videos, and implementing these approaches with individuals and couples.
Chapter Five: Personal Ideologies, Values, And Ethical Considerations

I believe that personal ideologies and values of a counselor form the foundation of their overall professional philosophy. I have worked in human services as a social worker for over ten years and have been guided and continue to be guided by The Canadian Association of Social Workers (CASW) Code of Ethics (2005a) core values and principles. I used the client-centered approach throughout my practicum by meeting clients where they are at and by not imposing my values and belief system on the clients. The phenomenon of client-centered therapy comes to life when the counselor feels genuine acceptance and respect for the client and is willing to refrain from judging the client and to understand the client’s thoughts and feelings (Rogers, 1951).

For instance, I explained the importance of homework as it relates to achieving clients’ goals to clients and asked them if they were interested in doing homework when the need arose during therapy. Those who were comfortable and willing to do homework were given homework when necessary and those who were not interested never got homework. The reason I explained the importance of homework to clients and let them decide whether to do homework or not, was so they can make informed decisions, and can practice saying what they want or do not want.

As a social worker and a counselor, I believe in homework during therapy as it helps the client reflect more on the issues they are dealing with. However, because clients are the experts of their lived experiences, my role was to empower them with CBT basic skill of consciousness by letting them determine what they want to do rather than what I want for them. Conscious attention allows people to monitor and assess interactions with the environment, link memories with present experiences, and to control and plan future actions (Sternberg, 1996). The purpose of this was to recognize the client’s ability to use self-knowledge and self-determination to achieve personal goals and independence instead of imposing my values and belief system on them. Ryan and Deci (2000) support this by arguing that the client’s right to a self-directed
process motivates them towards improved self-differentiation, enhanced self-regulation, self-understanding, and acceptance.

Furthermore, during my practicum, I was guided by the Canadian Association of Social Workers (CASW, 2005b) code of ethics that articulates the importance of respecting the inherent dignity and worth of all individuals, while emphasizing the importance of upholding each person’s right to self-determination and ability to make informed decisions. I was raised with strong core values of kindness, compassion, and treating people with respect and dignity regardless of their religion, status in society, race, age, and gender. I practice these values in my professional and private life as I like to treat people the way I would want to be treated. I am a registered member of the Saskatchewan Association of Social Workers (SASW). As a social worker, I strongly believe that everyone deserves the right to be treated with respect and to be accepted for who they are. I accepted and believed in clients’ abilities during my practicum by focusing on their strengths and using this as the foundation of the skills they learned during therapy to enable them to achieve the change they are seeking for.

The Caring Place (TCP) prides itself with maintaining a high standard of client confidentiality and privacy. Maintaining the confidentiality of records is an important component of the trust relationships built at The Caring Place (Friedrich & Board of Directors, 2019). The commitment to safe spaces created by TCP by accepting all clients regardless of their gender, age, race, and protecting their information, aligns with the service to humanity, integrity of professional practice, confidentiality in professional practice values of CASW Code of Ethics. Confidentiality in professional practice is identified as one of the core values in the CASW Code Ethics. Social workers demonstrate respect for the trust placed on them by protecting the privacy of clients’ information and respecting the client’s right to control when or whether their
information will be shared with third parties (CASW, 2005a). I used this principle throughout my practicum as clients were made aware that their information can only be shared with a third party if they consented in writing or if it's subpoena by a court of law.
Chapter Six: Professional Challenges

Self-care and terminating the therapeutic relationships that I built with the clients during the practicum was challenging. This section focuses on these two themes. Although, I did not encounter significant dilemmas during my practicum placement, the core values, and principles of CASW are prominent in ensuring that social workers are ethical and professional by serving the interests of clients. The CASW Guidelines (2005b) online state that it is the responsibility of social workers to promote the self-determination and autonomy of clients and encourage them to make informed decisions on their own. This is because clients often expect therapists to provide directions on how they could solve the problem that brought them to therapy.

6.1 Self-care

Challenges and ethical considerations play a major role in social work practice and clinical counseling. As a fulltime MSW student and a single mother with little or no support system, self-care during my practicum was necessary and significant to prevent fatigue so that I could be an effective therapist and be fully present when dealing with clients. To build strong therapeutic relationships with clients, be respectful, and non-judgmental, self-care became a vital part of my practicum. The purpose of self-care is to have space to move through and cope with distress in the body and mind, and to create space for reflection on one’s own assumptions about clients and their own personal lives (Bressi & Vaden, 2017). I have never deliberately practiced self-care. At the beginning of my practicum, I started conscious self-care by going to the gym, debriefing after counseling sessions, eating well, and meditating. I realized that self-care helped me to relax and to better organize my thoughts and be focused during the counselling sessions.

Self-care is the purposeful process of implementing strategies that promote healthy functioning and enhance well-being (Dorociak et al., 2017). Lewis and King (2019) argue that
self-care for social workers is an integral part of professionalism and is intricately tied to our ability to be fully present with our clients. Considering the link between the high demands and stress of social workers to burnout and compassion fatigue (the ability to be an effective therapist), social workers must become more diligent in integrating self-care strategies into their personal practice. Burnout is exhaustion and results in reduced interest in activities or tasks (Gray-Stanley & Muramatsu, 2011). I took self-care seriously and started going to the gym and meditating to prevent stress, compassion fatigue, and burnout during my practicum. According to Straus (1999), to be an effective clinical therapist, one must maintain a positive sense of self and sustain an inner sense of connection with others. Going to the gym, meditating, and eating well helped me to maintain a positive sense of self which was vital in building and maintaining therapeutic relationships with clients. Self-care is a vital aspect of social work practice and clinical counseling that ensures ethical practice and prevent compassion fatigue and burnout, but enough emphasis has not been placed on self-care by the social work profession.

6.2 Terminating Therapeutic Process

At the start of my practicum, being a student was a barrier as some clients did not want services from a student, so it was difficult to create a caseload of 5-8 clients for me. This explains why I had a caseload of 4 clients instead of the 5-8 clients as anticipated in the practicum proposal. This was also a challenge during session observations as some clients did not feel comfortable having a student listen to their session. This was a bit of a dilemma but after discussing with my professional associate and my academic supervisor, it was decided that I should work with the four clients in my caseload as respecting the clients’ right to self-determination and autonomy took precedence over my goal of working with 5-8 clients during the practicum. This challenge at the start of my practicum motivated me to build a strong
therapeutic relationship with the clients in my caseload and to be professional during all my sessions as this was a great way to improve my self-confidence and gaining the trust of clients.

Terminating the therapeutic process with the clients was a challenge that I encountered towards the end of my practicum. Termination is a term typically used when referring to the ending of the psychotherapeutic relationship (Da Silva et al., 2021). During the first counseling session with clients, I introduced myself as a Master of Social Work (MSW) student on a practicum placement at TCP and informed them of the length of my practicum. As an experienced social worker, I know that ethically, it is the therapist’s responsibility to ensure that clients are aware of the length of therapy as this is an important component of the client’s goals.

Considering that I practice social work from a client-centered perspective, discussing termination of the therapeutic process in advance with clients was my responsibility and for the best interest of the client. The purpose of this discussion was to ensure that clients understood when, why, and how the therapy will end as well as discuss potential referral options so that services to the client are not interrupted. Building a good therapeutic relationship with clients is a gradual process that requires continuous improvement, but once built, terminating it can be difficult. Therefore, I started preparing the clients for the eventual end of the therapeutic process early on but in the last two sessions with the clients, we discussed the transfer process from my caseload to other caseloads in the agency. In the last session with the clients, we discussed the specialty of the clinicians at TCP as TCP has some of the best and experienced clinicians in Canada. The clients were also encouraged to discuss this further with the receptionist. Considering that practicum students only have so much time to spend with clients before their practicum placement ends, more emphasis should be placed on how to effectively terminate a therapeutic process as a social work trainee.
Chapter Seven: Visions For The Future Social Work Practice

This section discusses my vision for future social work practice after completing a field practicum.

7.1 Vision For Future Clinical Social Work Practice

I plan to bring the skills learned and the knowledge acquired during this practicum with me as I return to my role as a social worker with the Ministry of Social Services. To ensure that the skills learned from this practicum are intentionally inculcated into my practice as a social worker going forward, I will start implementing them when I resume work. The knowledge and skills that I learned from implementing various social work approaches such as CBT, narrative therapy, and trauma-informed perspectives have become some of my “go-to” therapeutic approaches that I plan to use in professional practice. These approaches are versatile and encourage the adoption and implementation of the client-centered perspective by all clinicians. My goal is to advocate for the adoption and use of a trauma-informed perspective by all social workers and human service organizations. I have a better understanding of the power of the strength-based approach as the foundation of client’s empowerment and skills development in a therapeutic process.

Self-reflection is one of the many skills that I learned during my practicum, and I will continue to use it in my social work practice and in my personal life as it gave me the space to appraise and evaluate my daily activities. Self-reflection is a powerful skill that enabled me to analyze my practicum activities daily to determine what I was doing well on and what needed more attention. Self-reflection is a skill that all social workers should adopt and practice as it helps the social worker to understand themselves better and how their belief system and how their own personal lived experiences may influence their approach to practice. As a social
worker I have always incorporated the social constructivism theory and the trauma-informed approach into the work I do with clients. My student experience at TCP has been an invaluable learning opportunity and has encouraged greater competence and confidence in me as a social worker. This experience has motivated me to continue to seek growth, knowledge, and future learning opportunities.
Chapter Eight: Conclusion

My field practicum experience deepened my knowledge of CBT and improved my skills in implementing CBT during therapy as an evidence-based approach that is an empirical way of talk therapy that deals could be used effectively in many clinical diagnosis and psychosocial challenges. Once I understood the basic principles of CBT, this enhanced my ability to support clients learn how to identify, question, and change thoughts, attitudes and beliefs that lead to problematic emotional and behavioral reactions. The practicum experience did not only lead to professional growth, but it also led to personal growth as I have adopted the CBT philosophy. It acknowledges and explores dysfunctional thinking, behaviors, and emotional patterns and replacing them with positive thoughts and behaviors to allow me to manage personal challenges better. Wright et al. (2006) further argue that if we can reorient our thoughts, emotions, and reorder our behavior, we can learn to cope with suffering more easily and prevent a great deal of suffering.

The practicum experience has ignited my vision to advocate for all social workers and social service institutions to incorporate the basic principles of trauma-informed perspective into their professional practice. This advocacy will ensure that clients who are already traumatized are not re-traumatized when they seek services by social workers. My vision is to promote and encourage all social workers to become trauma-informed by being aware trauma-informed care assumptions of realize, recognize, respond, and resist re-traumatizing. The approach enables social workers to provide services to clients in a respectful, compassionate fashion as well as promote client’s self-determination and help them to rebuild coping techniques.
References


van der Kolk, B.A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Group, LLC.


