Counselling at Family Service Regina: A Field Practicum Report

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Abstract

This report outlines my practicum experience at Family Service Regina in the Counselling Unit. I chose to focus on two counselling approaches: cognitive behavioral therapy with individuals and emotionally focused therapy with couples.

Themes that have emerged in the practicum setting include mindfulness, anti-oppressive social work practice, bearing witness to client healing, and empathy and compassion in professional practice. I will also include a discussion of boundaries and vulnerability as effective tools for self-care and growth both personally and professionally.

Implications for future social work practice, implications for Family Service Regina as an agency and my learning as an emerging counselling practitioner are highlighted and woven into the experience of working with clients and family systems on an interpersonal level.
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Dedication

This practicum report is dedicated to the memory of the incomparable Dorothy Deringer, a woman who taught me how to love and serve others with ferocity and selfless compassion. Her strength, wisdom and sparkling laughter will not be forgotten.
# Table of Contents

Abstract ............................................................................................................................... ii  
Acknowledgements ............................................................................................................... iii  
Dedication ............................................................................................................................. iv  
Table of Contents .................................................................................................................. v  
List of Appendices ................................................................................................................ vii  

**Chapter 1: Introduction** ........................................................................................................ 1  
1.1 Family Service Regina Agency ..................................................................................... 1  
1.2 Practicum Proposal ......................................................................................................... 2  
1.3 Writer’s Relationship to the Agency ............................................................................. 4  
1.4 Report Outline ................................................................................................................ 5  

**Chapter 2: Theory** .................................................................................................................. 7  
2.1 Cognitive Behavioral Therapy ....................................................................................... 7  
2.2 Online Cognitive Behavioral Therapy ........................................................................... 10  
2.3 Emotionally Focused Therapy ....................................................................................... 13  
2.4 Solution Focused Therapy ............................................................................................. 16  
2.5 Attachment Theory ....................................................................................................... 17  

**Chapter 3: Ideology and Values** .............................................................................................. 20  
3.1 Values of Family Service Regina .................................................................................... 20  
3.2 Personal Ideology and Values ....................................................................................... 22  
3.3 People are Not Their Problems ..................................................................................... 25  
3.4 Anti-Oppressive Practice ............................................................................................... 27  

**Chapter 4: Achieving Proposal Objectives and Skills Assessment** .................................... 31  
4.1 Goal One .......................................................................................................................... 31  
   4.1.1 Activity One ............................................................................................................... 31  
   4.1.2 Activity Two ............................................................................................................. 32  
   4.1.3 Activity Three ........................................................................................................... 33  
   4.1.4 Activity Four ........................................................................................................... 34  
   4.1.5 Activity Five ........................................................................................................... 36  
   4.1.6 Activity Six ............................................................................................................. 37  
4.2 Goal Two .......................................................................................................................... 41  
   4.2.1 Activity One ............................................................................................................... 41  
   4.2.2 Activity Two ............................................................................................................... 41  
   4.2.3 Activity Three ........................................................................................................... 43  
   4.2.4 Activity Four ........................................................................................................... 44  
      4.2.4.a. Independent Assessments ................................................................................. 45  
4.3 Summary ........................................................................................................................ 48  

**Chapter 5: Integrating Theory into Practice** ........................................................................ 50  
5.1 Therapeutic Alliance ...................................................................................................... 50  
5.2 Generalist Practice ......................................................................................................... 52  
5.3 Holistic Model of Care ................................................................................................... 54  

**Chapter 6: Emerging Themes** .............................................................................................. 56  
6.1 Mindfulness ....................................................................................................................... 56  
   6.1.1 Mindfulness and CBT ............................................................................................. 57  
   6.1.2 Mindfulness and EFT ............................................................................................. 58  
   6.1.3 Integrating Mindfulness into Anti-Oppressive Practice ........................................... 59
List of Appendices

**Appendix A**  Client Consent Form ...........................................................................................................84
Chapter One: Introduction

1.1 Family Service Regina Agency

I chose to complete my field practicum in the Master of Social Work program with Family Service Regina in their Counselling Unit. I have been an employee of Family Service Regina for four years, and completed my Bachelor of Social Work major practicum in the Domestic Violence Unit at Family Service Regina. Being that Family Service Regina has different units to serve the diverse needs of the community, I was successfully able to complete my Master’s field practicum experience in the Counselling Unit. Since 1913, Family Service Regina’s (FSR) mandate has been “Healthy families and strong communities” (Family Service Regina, 2016), a proclamation that resonates deeply with me as a social work practitioner.

From its early beginnings FSR, has successfully reflected the social concerns of the communities that it services within Regina (Family Service Regina, 2016). Family Service Regina is a dynamic agency that works hard to anticipate the needs of an ever changing Regina community and strives to provide services at the micro, macro and mezzo levels through a variety of programs.

Family Service Regina as an agency is broken down into several sections. The Counselling Unit, which includes an Employee and Family Assistance Program (EFAP), Domestic Violence Unit (DVU), Teen Parent Program (TPP) and Older Adult Response Service (OARS). The Counselling Unit, where I chose to complete my practicum, has a staffing complement of five full time counsellors and a number of contract counsellors. Each counsellor has a diverse background and set of skills to bring client centered services to the population the agency serves. Regardless of the focus of each unit within the Agency, the mandate remains the same and Family Service Regina is dedicated to “offering support, hope and opportunities to help people realize their possibilities and find their strength” (Family Service Regina, 2016).
As noted above, the Counselling Unit at FSR currently has five full time counsellors on staff and seven contract counsellors working to provide EAP services to the Employee and Family Assistance Program contracts that FSR currently holds. The majority of referrals for the full time counsellors are referrals from the community and the Ministry of Social Services. The Counselling Unit also offers walk-in counselling every Thursday, which provides brief, solution focused counselling to community members and makes referrals for follow up services as deemed necessary. The counsellors employed with FSR also provide a great deal of education and community awareness including workplace wellness presentations, *Lunch and Learns* and mediation services.

Family Service Regina has recently adopted a solution focused model as the theory and approach of choice across program mandates and believes strongly in meeting the needs of individuals and families from a strength based and solution focused approach. The solution focused approach will be discussed in greater detail throughout the rest of the report.

**1.2 Practicum Proposal**

My counselling practicum at Family Service Regina consisted of 450 hours on a part time basis, over two semesters, beginning January 5, 2016 and ending June 2, 2016. I had two objectives outlined in my practicum proposal with several goals identified to achieve each objective. The first objective that I set out to accomplish was to learn the foundations of cognitive behavioral therapy (CBT) with individuals and emotionally focused therapy (EFT) with couples. I aimed to achieve this objective in relation to counselling experience by observing counselling sessions led by my professional associate, by carrying a small caseload of my own clients, and by observing and participating in drop-in counselling on a weekly basis as offered by the Agency. I also completed a literature review to understand the solution focused therapeutic
approach, CBT and EFT. I was also involved in professional development opportunities to enhance my practice as a counselling professional. On a personal level, the goals I set to achieve included allowing time for personal reflection, self care, completing research on both CBT and EFT as therapeutic approaches, and partaking in professional development opportunities to enhance my practice as a counsellor.

The second objective identified in my practicum proposal was to learn administrative counselling skills including intake requirements and processes, clinical note taking, assessments and intervention. I aimed to achieve this objective through learning the intake process in the counselling unit of Family Service Regina and spending time with the intake counsellor to learn the process and observe her work with clients. Second, I set out to learn the process of clinical recording and making administrative notes on counselling files and practicing these skills. I also attended administrative meetings within the Counselling Unit to learn best practice standards for the Agency. Finally, my goal was to also learn intervention and assessment skills by observing counselling staff conduct interviews for assessment and intervention purposes and to conduct 5 independent assessments on my own by the end of the practicum.

During my practicum, I worked specifically with clients from the community and with clients that were referred for services by the Ministry of Social Services. Family Service Regina has a large Employee and Family Assistance Program (EFAP) enterprise but as a practicum student I did not work with EFAP clients due to the specific accreditation standards as outlined by the National FSEAP network (FSEAP, 2010). However, I did get the opportunity to sit in on several EFAP counselling sessions conducted by my professional associate and I also facilitated two separate Lunch and Learn presentations on managing multiple life demands for two of Family Service Regina’s EFAP contracts.
Along with the *Lunch and Learn* presentations which focused on managing multiple life demands, I also had the opportunity to deliver a presentation to the counsellors in a peer support meeting, which focused on internet cognitive behavioral therapy (ICBT) and the Wellbeing Program offered through the University of Regina. I had the opportunity to take a clinical course on ICBT and then continued on with the Wellbeing Program as a volunteer upon completion of the course. Presenting information on ICBT to the Counselling Unit was a positive learning experience, providing me the opportunity to incorporate my classroom and volunteer learning into the practicum setting.

I also attended a mindfulness counselling workshop in Regina put on by the Crisis and Trauma Resource Institute, and a solution focused therapy and motivational interviewing workshop organized through Family Service Regina. Having the ability to engage in professional development opportunities outside Family Service Regina assisted in enriching my practicum experience and the skills and tools I was able to utilize with clients.

Due to my previous relationship with the Agency as a Domestic Violence Outreach Worker, I came into this practicum placement with a great deal of awareness of the groups that are offered to clients through FSR and I co-facilitate the Domestic Violence Drop-In Group offered every Wednesday night. This awareness, and my previous experience with these programs, gave me an advantage in the ability to refer clients to these services with the confidence that they would benefit from any of the group counselling support options recommended in complement to counselling.

1.3 *Writer’s Relationship to the Agency*

The placement at Family Service Regina presented a unique challenge as I was now positioned as a practicum student, taking on a new role as a student counsellor while at the same
time working as an employee in the Domestic Violence Unit. I was faced with resuming the
same role in the Domestic Violence Unit, while also developing a new role as a student
counsellor and aligning myself with a different program within the Agency. Establishing
boundaries between the different roles in the Agency became a top priority in order to maintain a
work/practicum balance. I did not realize how quickly my roles could blur and become
enmeshed if I was not firm in my boundaries throughout the entire course of my practicum.
Maintaining a balance between my work and practicum has been a challenge throughout my
practicum experience. Learning mindfulness in my practice of boundary maintenance has been a
main theme within my practicum and called me to the highest level of ethical practice not only as
a student and employee of Family Service Regina, but also as a registered social worker through
the Saskatchewan Association of Social Workers (2012a).

1.4 Report Outline

This paper is a reflection of my experience as a counselling practicum student with
Family Service Regina. I have chosen to focus on two theories to inform my approach to
counselling. These two theories of focus are cognitive behavioral therapy (CBT) with individuals
and emotionally focused therapy (EFT) with couples. This paper will review each of these
therapeutic approaches and highlight their theoretical basis specifically through discussion of my
counselling work. This report will also include a discussion of online cognitive behavioral
therapy verses in-person CBT, attachment theory, and solution focused therapy that is utilized as
the Agency’s model of choice for working with individuals across program mandates; more
specifically in walk-in counselling.

This paper will also discuss several themes that have emerged that I have chosen to
highlight through discussion of my practicum experience, and examination of my personal and
professional values and how those have impacted my practicum experience. This report is written from a client centred perspective with cognitive behavioral therapy and emotionally focused therapy as cornerstones to practice. Anti-oppressive social work practice and mindfulness will be highlighted as over-arching themes discovered in positioning myself as a clinical social work practitioner and student counsellor.

Finally, this paper will discuss implications and recommendations for future social work practice within Family Service Regina and where I see myself in future clinical practice.
Chapter Two: Theory

I chose to focus on two theoretical approaches in this practicum: cognitive behavioral therapy (CBT) and emotionally focused therapy (EFT). Chapter two describes each of these theories, and discusses how they serve to meet the needs of clients both individually and in couple’s sessions. This chapter will also discuss cognitive behavioral therapy through the use of online delivery as opposed to in-person forms of talk therapy. It will also include a discussion of solution focused therapy an approach adopted by FSR across its program mandates. Finally, this chapter will provide an overview of attachment theory as it is at the heart of EFT and understanding principles of CBT. It is also important in understanding relationships between individuals, families, couples and the therapist.

2.1 Cognitive Behavioral Therapy

I chose to use cognitive behavioral therapy (CBT) as a framework for my practicum learning as it is a widely accepted and utilized approach in a variety of therapeutic settings. Cognitive behavioral therapy is one of the most researched forms of treatment for depression and anxiety in the field of medicine (Sudak, 2012). It is also seen as effective for a variety of other psychiatric issues and has been found to be applicable to a variety of individuals regardless of their education level, socio economic status, culture or age (Beck, 2011). Cognitive behavioral therapy has become one the most frequently used psychotherapeutic approaches amongst social work professionals (González-Prendes & Brisebois, 2012). CBT is based on the cognitive model which proposes that people’s behaviors, emotions and physiology are influenced by their perception of events (Beck, 2011). It is not a situation in and of itself that determines how people feel, but rather how they perceive a situation (Beck, 2011).
Cognitive behavioral therapy (CBT) proposes that dysfunctional thinking, which leads to changes in mood and behaviour is at the root of all psychological disturbances (Beck, 2011). “Cognitive behavior therapy has become the treatment of choice for many disorders, not only because it reduces people’s suffering quickly and moves them towards remission, but also because it helps them stay well” (Beck, 2011, pg. 8). Developed in the 1960’s by Aaron Beck, cognitive therapy, now known as CBT, was originally a short term, structured form of therapy used solely for the treatment of depression (Beck, 2011).

I also chose to use CBT as a counselling approach as it has been proven to be highly successful for the treatment of anxiety and depression; two issues that present themselves often in a counselling setting. CBT also has long term success rates and is easily able to be integrated into a holistic approach to therapy that includes not only aspects of cognitive work, but awareness of the entire body and its innate ability to heal itself. “Even in situations that are inherently painful, negative thinking can generate additional, unnecessary suffering” (Edelman, 2007, pg.13). The integration of mindfulness practice into CBT teaches how to relate to pain in a different way, thus alleviating suffering and making the pain a bit more manageable (Cayoun, 2015).

Important components of cognitive behavioral therapy include a focus on helping clients solve problems; making efforts to become behaviorally activated and having the client identify and evaluate their negative thinking patterns about themselves, their world and their future (Beck, 2011). The focus of CBT is to help develop realistic thoughts in order to minimize the experience of upsetting emotions (Edelman, 2007). I utilized several CBT techniques in sessions with clients including; thought challenging, psychoeducation around cognitive distortions, using
One of the basic principles of CBT is that it emphasizes collaboration and active participation (Beck, 2011). I have found this principle to be useful for both in person and online forms of therapy. I have been encouraged multiple times through the course of my practicum to pay attention to ensure that, as a therapist, I am not working harder than my client. I have found it freeing in practice to be able to allow myself to bear witness to the changes that clients are making and walk in a way of collaboration rather than in a way of authority and expertise. CBT as a therapy fits well with my personal values and approach to working with individuals because it recognizes the strengths and abilities that people have to find healing within themselves. Collaboration and the development of a strong therapeutic alliance allows freedom on both sides of the therapeutic relationship to engage in the healing process at the client’s pace. I view CBT as a foundational approach that allows therapists to build upon and incorporate other therapeutic approaches to best serve the needs of the client. The ability to bring alongside other tools and approaches in complement to CBT allows for the creation of a holistic way of working, where the client and their needs are at the heart of the therapeutic relationship. CBT is client centred in its approach, and it includes collaboration with the client and allows that collaboration to be a critical aspect of building a therapeutic alliance (Beck, 2011). CBT’s client centered perspective generates a more egalitarian focus for the therapeutic alliance because it is collaborative between the therapist and the client and supports client collaboration and self-determination (Gonzalez-Prendes & Brisebois, 2012).

Being aware of negative thoughts and beliefs is an important first step in beginning to develop healthy cognitions (Edelman, 2007). Through beginning to recognize negative and
distorted automatic thoughts, individuals are able to recognize symptoms and behaviors that are a result of their negative thinking patterns. Cognitive therapists engage clients in identifying automatic, negative thoughts that lead to depressive or anxious states (Leahy, 2003). Responding to automatic thoughts and using a worksheet called the “Daily mood log” developed by David Burns (1999) has been helpful in my counselling practicum and something I have regularly drawn on to give individuals an opportunity to notice distorted thinking patterns they may be struggling with and begin reframing or challenging them. I found this was particularly helpful when working with a few clients who were struggling deeply with anxiety or with accepting a medical diagnosis such as chronic fatigue and chronic pain.

I found that the CBT practice of structuring the therapeutic process through expectation and goal setting complemented nicely with the first session expectations as outlined by Family Service Regina. Counsellors in the Agency complete an assessment in the first session with a client in order to understand client history, presenting problems and the client’s goals for therapy. Effective CBT requires an evaluation, so you can accurately formulate the case, conceptualize what is going on for the individual you are working with and plan treatment (Beck, 2011).

When I first started my practicum, I had a difficult time connecting theory to practice and recognizing all of the ways I was using CBT in my counselling sessions. As mentioned above, I had been previously trained in using CBT in an online form of service delivery, thus a transition into in-person CBT was required when I began my practicum at FSR. In-person CBT often takes a more subtle approach in thought challenging than the structured form of CBT that is offered through the Online Therapy Unit at the University of Regina.

2.2 Internet Cognitive Behavioral Therapy
During the course of my practicum, I had the experience of volunteering with the Online Therapy Unit at the University of Regina and worked as an online therapist in the eight week Wellbeing Course offered through the Online Therapy Unit. It was timely for me to work as an online therapist while doing my counselling practicum as I was able to experience the differences between practicing CBT in-person, versus the online delivery of CBT through the Wellbeing Course. There are several differences between online delivery of CBT and in-person CBT due to the nature of the service delivery of each approach. ICBT presents patients with the same psychoeducation and CBT strategies as traditional face-to-face CBT, but the information is presented through structured modules over the internet (Hadjistravroploulos, Alberts, Nugent & Marchildon, 2014). The modality of delivery is structured to act as a safe guard for clients to engage in online service delivery in a safe way that promotes health and growth.

Internet cognitive behavioral therapy (ICBT) is seen as an effective way to disseminate CBT services especially for those living in remote or rural areas of Saskatchewan with no access to in-person therapy. Depression and anxiety are prevalent amongst Canadians, but many individuals report that these conditions go untreated (Sunderland & Finlay, 2013). ICBT also serves to address other barriers to treatment such as limited access to mental health providers, unwillingness to disclose mental health concerns, and challenges in seeking care such as limited time, remote residence, and/or mobility issues (Hadjistravroploulos et al., 2014). The structure of the Wellbeing Course has been well researched and documented as best practice for online therapy services and all the ICBT courses offered through the University of Regina have been licensed from the Swinburne University of Technology in Melbourne, Australia (Hadjistravroploulos et al., 2014). The way that therapists work to engage clients online versus
in-person are different, however, establishing a therapeutic alliance still remains the foundation of therapist assisted online therapy as it is for in-person counselling.

ICBT has similarities to CBT in that it incorporates the same core principles and approaches to therapy, however it is not done face-to-face and thus requires a reliance on the internet and written communication to provide services to clients. ICBT can be conducted as an independent learning experience for clients, or it can be a therapist assisted form of internet based learning. However, studies show that having a therapist strengthens compliance with ICBT material and reduces drop-out rates in the courses (Hadjistravroploulos, Thompson, Klein & Austin, 2012). Similar to CBT, ICBT also involves teaching a client to be their own therapist through psycho-education and active participation (Andersson, 2015).

When comparing therapist assisted ICBT to face-to-face CBT for depression and anxiety disorders, studies report similar treatment outcomes (Hadjistravroploulos et al., 2014). However, the Wellbeing Program provides telephone screening for participants prior to them starting the course to ensure their appropriateness for internet delivered service. The criteria for clients engaging in ICBT treatment include being over the age of 18 years old, a resident of Saskatchewan, reporting symptoms of panic, generalized anxiety or depression and having access to the internet and a computer (Hadjistravroploulos, 2014). Clients who are deemed more suitable for in-person treatment include those beginning a new psychiatric medication for anxiety or depression within the last month, current substance use or dependence, diagnosis of a psychiatric disorder such as bi-polar and high risk for suicidality (Hadjistravroploulos, 2014). CBT as an in-person approach has been seen to be effective in working with couples; however, ICBT through the Wellbeing Program has a focus on individuals experiencing depression, anxiety and panic and is not currently utilized for working with couples. However, the Wellbeing
Program has extended services to being effective to working with chronic pain and post-partum depression (Pugh, Hadjistravroploulos & Dirkse, 2016).

While CBT has been seen as effective in working with couples, I chose to focus on emotionally focused therapy as an approach with couples because of the experiential nature of EFT as a therapy and its focus on the role emotion in therapeutic change.

2.3 Emotionally Focused Therapy

Emotionally focused therapy (EFT) can be defined as the practice of therapy informed by an understanding of the role of emotion in psychotherapeutic change (Greenberg, 2011). EFT is an experiential therapy and focuses on how people experience their relationship, how they put together their emotional experience, and how they express those emotions (Johnson, 2004). The focus of EFT leads the clients and the therapist towards creating strategies that promote self-awareness, acceptance, expression, regulation and transformation of emotion as well as corrective emotional experiences (Greenberg, 2011). The goals of therapy in this approach are to strengthen oneself, regulate affect and create new meaning (Greenberg, 2011). Accessibility, responsiveness and engagement are the three main components in EFT to draw people into emotional connection and conversation that can begin to create safe bonds (Johnson, 2008).

The process of EFT involves three stages and nine steps (Johnson, 2004) and can normally be conducted in between eight and twenty sessions (Johnson, 2008). I chose EFT as an approach to working with couples because EFT has substantial empirical evidence including sixteen outcome studies on the process of change with couples and how it occurs (Johnson, 2004). EFT is an example of significant development within couple’s therapy in that it provides a model that helps to understand the dynamics of the relationship between couples (Crawley & Grant, 2005). EFT has been utilized with couples with depression issues, couples that have faced
trauma, and couples with chronically ill children; and it has proven to be an effective form of therapy for these and a variety of concerns (Johnson, 2004).

The goal of EFT is to create a more secure emotional bond, creating satisfaction, intimacy and trust that can come from feeling more secure with your partner. EFT serves to look at the whole relationship, and patterns within that relationship, and how couples can get stuck in very negative patterns (Johnson, 2008). “Emotion not only governs our view of self and others but also strongly influences interactions between people” (Greenberg, 2011, pg.8). Thus, EFT holds the view that interpersonal conflict can be resolved through changing what people express, and how they express it (Greenberg & Johnson, 1988).

To feel is to want to act in relation to the world and to be organized to do so (Greenberg and Johnson, 1988). Emotions provide essential information about our reactions to situations, which can be either attended to or ignored (Greenberg and Johnson, 1988).

The EFT therapist is always trying to create safety within the counselling setting, but this is not always possible with a power differentiation between the couple in the relationship (Greenberg, 2011). It can be difficult to create safety with couples if an individual is feeling threatened by way of emotional harm, or even physical harm or retaliation. Through the advice of my academic supervisor, I made the decision early on in my practicum to see individuals separately before bringing them together in couples counselling if there were safety concerns, to effectively assess the level of comfort and commitment to engaging in couples work. It is common in couple’s work as part of the initial assessment process for the EFT therapist to conduct individual sessions with each partner (Johnston, 2004). This can be useful to not only bolster the therapeutic alliance with each individual, but also to seek information about the commitment level, risks and previous attachment traumas that impact the current relationship.
(Johnson, 2004). I had several couples on my caseload that wanted couples counselling, however after speaking to them individually, it became clear that there were safety risks that presented too great a challenge to bring them together for a couple’s counselling session.

Primary emotions often underlie the stable interactional positions occupied by distressed partners; these feelings can be a rich source of information and can be used in therapy to create new perceptions, responses and interactional patterns (Greenberg & Johnson, 1988). Exploring and discerning whether or not an emotional response is a primary or secondary emotion can be important for the therapist to begin addressing patterns and facilitating change in how the couple relates. Insight itself is not sufficient for change, but rather individuals must have emotionally meaningful experiences in order to evoke changes in themselves to develop new interactions within their relationship (Greenberg & Johnson, 1988). The therapist thus has the privilege to explore alongside the clients the underlying emotional conversation happening between them in the counselling setting. The couple can then begin to reframe and create new meaning and understanding in their emotional responses to one another.

“Failure to develop a satisfying intimate relationship with one’s partner has been reported to be the single most frequently presented problem in therapy” (Greenberg and Johnson, 1988, pg.7). The experience and expression of emotion is considered central to the way couples structure their relationships and central in the process of changing such relationships (Greenberg & Johnson, 1988). The key moments of change in EFT occur when secure bonding takes place (Johnson, 2008). A secure attachment bond ensures that each member of the couple feels secure, understood and calm enough to explore and communicate their needs (Johnson, 2008). Thus, working with couples as a therapist requires a heightened sensitivity to the emotional conversation that occurs between two people.
2.4 Solution Focused Therapy

Family Service Regina has recently included solution focused therapy as a standard practice across its programs. I used solution focused therapy in conjunction with other therapeutic models in counselling sessions with clients; however solution focused therapy is the model of choice in the Domestic Violence Unit and in the walk-in counselling setting.

Solution focused therapy is a short term goal focused therapeutic approach which helps facilitate change with clients in the construction of solutions rather than dwelling on problems (Walsh, 2010). In a session, it then becomes the therapist’s role to highlight the strengths within the client and assist them in realizing that they have the capacity to be agents of change rather than victims of circumstance (Walsh, 2010).

I found solution focused therapy particularly empowering in that the therapist collaborates with clients to find solutions to their problems and it focuses on strength and moving forward in solutions rather than focusing solely on the problem the client is experiencing in the immediate sense. When looking at walk-in counselling specifically, focusing on solutions and collaboration are vital to achieving the goals the client may have, especially since this approach to practice is so brief in nature. A solution focused perspective is based on the belief that significant therapeutic change can occur rapidly (Walsh, 2010). The solution focused model holds the belief that rapid change is possible and thus single session therapy results can be just as beneficial as those achieved using longer term therapeutic approaches (Nelson, 2005).

Solution focused therapy sets a positive tone for the exchange between client and counsellor, and can be particularly helpful in maintaining motivation and engagement in therapy sessions as clients are encouraged to view themselves as the experts in their own lives (Nelson,
The therapist and the client are seen as being on a journey together to help find solutions rather than problem solve with the therapist as the expert (DeJong & Berg, 1998).

Using the solution focused technique of incorporating scaling questions has been particularly helpful in a variety of counselling settings. Scaling questions provide a client an opportunity to rate themselves and can be used to assess the client’s perception about anything, including self-esteem, pre-session change, self-confidence, investment in change, prioritization of problems to be solved, hopefulness, and it can also be used as a progress evaluation tool (DeJong & Berg, 1998). Using solution focused therapy to highlight success for clients rather than focusing solely on the presenting problems can often draw out strength in the individual to realize they have the ability to influence their situation by focusing on their own healing and well-being. Sometimes, the counsellor is the first person to accept the client unconditionally. As such, the therapeutic relationship can often supersede other dysfunctional attachments in a person’s life and forge a new, healthy way of relating to others that is built on trust, mutual respect, and clear, consistent boundaries (Muller, 2011). When the counsellor focuses on strengths, this also has the ability to boost a person’s self-worth, optimism and create a sense of empowerment.

2.5 Attachment Theory

It became very clear to me through my readings that both CBT and EFT, as theories and as therapeutic approaches, rely heavily on attachment theory as a foundation to practice. Attachment theory recognizes the human need to feel safe and connect to another person (Johnson, 2013). Emotionally focused therapy in particular draws heavily on the work of Bowlby and attachment theory, which he originally developed as a therapeutic approach (Johnson & Bradley, 2010). Bowlby’s (1988) work considered the tendency to form attachment relationships
as representing survival value in humans. He talked about the attachment behavioral system as a biologically based system oriented toward seeking protection and maintaining proximity to the attachment figure in response to real or perceived threat (Muller, 2011). Throughout our lives we develop different attachment styles and EFT uses attachment theory as a foundation and becomes focused on strengthening a couple’s bonds through increased emotional accessibility and responsiveness (Johnson & Bradley, 2010). The goal of successful couples therapy from an EFT perspective is thus to restructure attachment and create safe emotional connection (Johnson & Bradley, 2010). Attachment theory is clear that dealing with key emotional needs in ways that lead to more secure bonds promote each partners individual growth and healing (Johnson & Bradley, 2010).

Emotionally focused therapy uses attachment theory to explain many principles in the emotional bonding and love shared between couples. Johnson describes understanding attachment amongst partners during her development of EFT as a theory (2013). Different patterns of adult attachment are presumed to follow from the models of attachment that were developed in childhood and adolescence (Muller, 2011). Isolation and the potential loss of a loving connection are coded by the human brain into a primal panic response (Johnson, 2008). Thus, when emotional connections seem lost, partners go into fight or flight mode (Johnson, 2008). Attachment theory speaks to the importance of connection and emphasizes that without secure attachment to others, individuals are susceptible to difficulties with regulating their emotions (Makinan & Johnson, 2006).

While cognitive behavioral therapy looks specifically at how an individual’s thoughts influence their emotions and behaviors, it also provides an understanding of how core beliefs, or schema’s about the self and others are formed (Leahy, 2003). Examples of schema’s, or core
beliefs that are often underneath distorted thought patterns, can include vulnerability to harm, themes of dependence, incompetence, shame, fear of abandonment, defectiveness and undesirability (Leahy, 2003). Attachment theory can serve to assist in looking at the development of some of these core beliefs as recognized by CBT. Looking at the development of a schema such as abandonment for example has its roots embedded in Bowlby’s attachment theory in recognizing that an absence of secure attachment in childhood has a direct impact on the core cognitive beliefs that individual carries into adulthood (Young, Klosko & Weishaar, 2003).

Regardless of the type of psychotherapy an individual is engaged in, Bowlby argues that a large number of patients display symptoms of disorganized or insecure attachment (Bowlby, 1988). Thus, therapists can serve as a secure base from which the patient explores the world and begins to reframe their internal dialogue and the way they relate to others in their world (Young et al., 2003). Part of my value base personally, as a social worker and student counsellor, is to be mindful of creating an atmosphere of security, empowerment and support to the clients I am working with.
Chapter Three: Ideology and Values

This chapter will shift from theory to focusing on the personal values and ideology that I bring into my practice as a social worker and counselling student both personally and professionally. It will also include a discussion of the values and ideology of Family Service Regina as per their vision and mission statement. I will also be highlighting a strength based and anti-oppressive approach to social work practice and counselling as integral to both my personal and professional values. Finally, this chapter will discuss how my personal values coincide with the Agency values and the values of the Canadian Association of Social Workers Code of Ethics (2005a) and the Saskatchewan Association of Social Workers Standards of Practice for Registered Social Workers in Saskatchewan (2012b).

3.1 Values of Family Service Regina

According to formal Agency statements, Family Service Regina is committed to the belief that healthy and strong individuals will in turn build healthy communities. The mission statement of FSR is to “strengthen individuals, families and communities through responsive leadership and innovative programs” (FSR, 2016). Based on my practicum experience as a student counsellor, and working within the Agency as a Domestic Violence Outreach Worker, I have observed the staff and management of FSR to take a client centred and non-discriminatory approach to practice that adheres to the mission statement of the Agency.

“Family Service Regina envisions a safe, inclusive and vibrant community in which all people are resilient, confident and filled with hope” (Englot, 2015, p.4). Thus, the ideology and mission of FSR as an agency is to assist in strengthening individuals, families and communities through leadership, innovative programs and services (Englot, 2015). Values including collaboration, respect and dignity of all individuals, and empowerment are the foundation of the
ideology that Family Service Regina as an agency practices. Interestingly, these values are also reflected in the Canadian Association of Social Workers (CASW) Code of Ethics (2005a) and by the Saskatchewan Association of Social Workers Standards of Practice for Registered Social Workers in Saskatchewan (2012b). The SASW (2012b) also highlights strengthening individuals, families and communities in their values. The CASW Code of Ethics (2005a), states that the profession of social work must uphold the service of others consistent with social justice as an objective of professional practice. FSR, is continually working to find balance in serving the ever-changing needs of the community that they serve.

The Performance and Quality Improvement (PQI) Committee at Family Service Regina outlines that the ideology and focus of FSR as an agency is to “deliver high quality services that have a meaningful impact on the lives of individuals and families” (Englot, 2015, pg.3). The quality of care that people receive from the Agency, and the ability to connect with individuals to assist them in being their best in all areas of life, is the theme that resonates within Family Service Regina’s ideology regarding their overall goals for service (Englot, 2015).

While Family Service Regina has not made any formal statements regarding the inclusion of anti-oppressive practice as an Agency, FSR does provide policy identifying a commitment to equality regardless of ethnicity, language, race, age, ability, gender, sexual orientation, income, political or religious affiliation (FSR, 2014, G.GO.4). The policy and procedures manual of the Agency also highlights the benefits of diversity and the changing population which they serve (FSR, 2014).

Finally, Family Service Regina as an agency strongly believes in having clients at the centre of their practice and formally acknowledges the systemic barriers that can make it challenging for individuals and families to engage in services. The Agency also recognizes that
the barriers and challenges that people face do not always occur in isolation. “Programs seek to eliminate systemic barriers to full participation and promote positive relationship and attitudinal change towards discriminated groups” (FSR, 2014, G.GO.4). Gil (2013) states that people’s personal issues are often deeply entwined within political structures which seek to “fix” the individual and not examine and change the deeply rooted ideologies and policies that fuel and sustain inequalities in society. As a social worker, I strongly identify with the values of anti-oppressive social work practice, thus I identify with FSR’s commitment to the equality of all individuals.

3.2 Personal Ideology and Values

There are several ideologies that I adhere to in my personal and professional life. As a practitioner I strongly believe in an anti-oppressive and client centered/strength based approach to care. I also believe strongly in, and adhere to, the Saskatchewan Association of Social Workers Standards of Practice for Registered Social Workers in Saskatchewan (2012) and the Canadian Association of Social Workers’ Code of Ethics (2005).

As a Domestic Violence Outreach Worker at Family Service Regina, and a registered social worker, many of my personal beliefs were developed through a combination of social work values and principles, but also justice based ideologies that have stemmed from my work and passion for Victim Services. Value two in the CASW Code of Ethics (2005) states that social workers have an obligation to the pursuit of social justice; more specifically, “Social workers believe in the obligation of people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity and to afford them protection from harm” (CASW, 2005a, pg.9). Victim services providers advocate, collaborate and work with individuals to provide support and keep them safe from re-victimization through the criminal justice system.
It was not until I began my counselling practicum with FSR that I realized how strong the Victim Services lens was which I applied in working with individuals, couples and families. The obligation to benefit humanity and afford individuals protection from harm was something that I had to keep in check throughout the course of my practicum. While the pursuit of social justice is a strength and can be applied to my anti-oppressive practice values, it could also be a disservice to my clients in that I found it a challenge to put the domestic violence lens aside when domestic violence issues presented in a counselling setting, specifically when working with couples. The domestic violence lens that I adopted perceived domestic violence situations in a black and white way that did not take into account the gray area of the underlying issues that can often surface through counselling. Identifying as an anti-oppressive, strengths based social work practitioner, the domestic violence lens that I often brought into counselling sessions with me was challenged in that anti-oppressive social work practice looks at broader systemic structures and oppression that plays a role in the lives of individuals and in social issues such as domestic violence.

CBT and EFT, as counselling approaches, appeared to be good matches for my personal ideology as each theory believes in a client centred approach to practice and allows the client to be the expert in their own life. “Anti-oppressive practice is about ensuring the people are never silenced” (Dalrymple & Burke, 2006, pg.162). The CBT and EFT theoretical frameworks that perceive people as experts in their own lives enhance my personal ideology that is based on a foundation of anti-oppressive social work and strength based approach to social work practice.

Both in a personal and professional capacity, I also strongly identify and align myself with the Canadian Association of Social Workers Code of Ethics (2005). I believe strongly in the “inherent dignity and respect of all individuals” (CASWa, 2005) and strive to practice from a
position that believes that individuals possess within them the capacity for change, resilience and healing.

Personally, I also identify as a spiritual person and practice a Christian faith especially in my self-care practices of prayer and meditation which are very important to me. As social workers, having awareness of personal values is important for understanding implications for practice. Clinician self-awareness is considered a benefit for both the therapist and the therapeutic process (Norcross, 2000). While I am aware of potential value conflicts that stem out of my spiritual practices, I am also aware of the benefit of having a spiritual practice for my personal well-being. Taking a holistic approach to self-care is considered crucial to the ability to maintain personal and professional well-being (Harrison & Westwood, 2009).

I am also passionate about the pursuit of social justice as highlighted in the CASW Code of Ethics (2005a) and believe that people have rights and deserve basic freedom and liberties regardless of race, gender, age or socio-economic status. The SASW Standards of Practice for Registered Social Workers in Saskatchewan (2012b) states that “a social worker shall not impose any stereotypes on a client based on behavior, values or roles related to race, ethnicity, religion, marital status, gender, sexual orientation, age, socioeconomic status, income source or amount, political affiliation, disability or diagnosis, language or national origin, that would interfere with the provision of professional services to the client” (pg.15).

As a practitioner, client centred and holistic counselling that has a focus on the autonomy of individuals is of utmost importance to me. I believe that each individual has the tools within themselves to facilitate change and healing and that my role as a counselling practitioner is to bear witness to the process in which my clients discover their capacity for change, growth and healing. The work of Carl Rogers (1942) and a client centered approach to services has also been
influential for me in identifying with the role of a therapist being someone who walks alongside clients to find answers rather than being seen as the expert in the room. Rogers argued that humans are positively motivated with a natural internal drive towards growth, health and adjustment. “They can be trusted to make choices that enable them to shape, direct and take responsibility for their own existence and the way they live their lives” (Casemore, 2006, pg.5).

Given that my value base has a strong foundation in strength based, client centered practice, I recognized very quickly that my initial proposal outlining my desire to use pure CBT and EFT as counselling approaches were quickly challenged by the presenting needs of my clients and the desire to use an eclectic approach to best meet their needs, rather than attempt to fit the client into a specific model or approach to therapy.

3.3 People are Not Their Problems

As noted above, Family Service Regina as an agency practices from a non-discriminatory, inclusive perspective with the incorporation of elements from a strength based and anti-oppressive approach to service provision. Family Service Regina believes that people are not their problems and regardless of the agency program, or therapeutic approach the staff use, there is a common value that is upheld that is that individuals are the experts in their lives and they possess within them the inherent strength to overcome the challenges that they face.

I also learned in the Counselling Unit the idea that the body has the innate ability to heal itself and that issues people face are complex and require an acknowledgement of not only individual roots, but also the role that systemic oppression has played in their lives. As a Domestic Violence Outreach Worker, I am able to clearly see the role that systemic oppression plays in the lives of individuals, and also have a strong desire to advocate for and “fix” the barriers that my clients are experiencing. I placed a lot of pressure on myself when I first started
my practicum to solve the problems that the clients I was working with were experiencing. However, believing that people are the experts in their own lives and that they possess all the tools within themselves to find healing is a freeing stance to take as a practitioner as it removes the pressure to need to fix every client that comes through the door.

I also had to be aware of my values as a Victim Services worker, which meant not to impose them onto the clients that I was working with in a counselling capacity and recognize that while I still believe that there are systemic causes to some barriers that individuals experience, not every client that I work with will identify the roots of their problems in the same way. When social workers automatically frame client’s problems in terms of oppression (e.g. racism, sexism, heterosexism, ageism, classism, ableism), they may inadvertently do so to the detriment of the needs of the client. In fact, clients may not define their problems in these same terms (Sakamoto & Pitner, 2005). FSR as an agency, and myself as a social worker, can hold the belief that people are not their problems; however, taking a client centered approach to practice allows the client to define and speak to the source of their problems and identify their goals for treatment based on their personal needs and values.

Family Service Regina also utilizes a number of formal assessment tools to help identify the severity and impact of presenting problems. Assessment tools that are used frequently include a Session Rating Scale (Miller, Duncan & Johnson, 2002) and an Outcome Rating Scale (Miller, Duncan & Johnson, 2000). These validated scales are designed to provide outcome information and can be used in a counselling session to both gain and provide feedback from clients on the counselling process and how they view the counselling process as helping. I find that the use of the scales is helpful for the clients to rate how they perceive themselves as doing in relationships with others and their general sense of wellbeing.
The OQ45 is an assessment tool developed by a software company titled Quality Measures. The questionnaire includes forty-five questions, which are generally completed by an individual at their first and fourth counselling sessions. The information from this tool is generated into a program that provides results on outcome measurements using software to compare a client’s progress with their expected improvement rate (OQ Analyst, 2006). Another measurement tool called the OQ30 is used for youth and/or Ministry of Social Services referrals and works similar to the OQ45. Session Rating Scales are also useful in having clients identify what is going well for them in counselling and what areas they would see as needing improvement on and would like to focus on. Some counsellors may make the mistake of identifying assessment as a means to an end, such as providing a label or diagnosis to a client. However, assessments have the ability to move beyond diagnosis and administrative purposes and can serve to enhance client collaboration (Balkin & Juhnke, 2014). Tools for outcome measures are known to cause controversy amongst anti-oppressive practitioners, as some would argue that implementing formal tools to measure mental health and well-being results in labelling of individuals. However, when clients are active participants in the assessment process, they have the opportunity to learn something about themselves, including personal strengths, challenges, and interests that can promote growth and wellness (Balkin & Juhnke, 2014). These tools can give an opportunity for client collaboration and are client centered in that they allow a client to have a voice in their goals for treatment.

3.4 Anti-Oppressive Practice

Social workers believe in the obligation of people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity and to afford them protection from harm (CASWa 2005). Family Service Regina aims to be an agency that is
inclusive of all individuals regardless of age, sex, race, gender or religious affiliation. Although anti-oppressive practice is not defined specifically in the Agency policy, I have observed across programs that the staff of Family Service Regina takes a strengths based approach to client services.

The idea that social work promotes the liberation of people in a social justice context resonates deeply with the idea of anti-oppressive practice (Rush & Keenan, 2014). The incorporation of mindfulness into anti-oppressive social work practice can assist a practitioner in being aware of the impact of oppression at an individual level and how that in turn can present as problems in the therapeutic setting. When I first started my practicum, I had a difficult time connecting anti-oppressive practice into micro level practice in a counselling setting. Being mindful of the role that oppression has played in individual’s lives however is important awareness for a counselling professional to have. This is also important awareness for the client in order to make connections regarding the role that oppression has played in their life.

“The ultimate goal of anti-oppressive initiatives is the creation of non-oppressive relations rooted in equality” (Dominelli & Campling, 2002, pg.13). Working in a therapeutic environment with individuals and families from an anti-oppressive perspective requires awareness at all times to avoid reproducing oppressive patterns while working with people. Dominelli (2011), talks about being aware of the “culture of professionalism” that exists, especially when working in a clinical setting with individuals. Creating a comfortable environment, adhering to professional values and using language and the therapeutic alliance to dissipate power imbalance and the differentiation between “professional” and “client” and create more of a working relationship with individuals is vital (Mullaly, 2010).
The literature on anti-oppressive practice in a clinical counselling setting highlights three themes to be kept in mind when working as an anti-oppressive clinician on a micro level; first, the oppressed persons must be agents of their own change, whether it is individual, social, or cultural change (Mullaly, 2010). The belief that people are capable of change, and often rapid change, is a cornerstone of solution focused therapy and a belief of Family Service Regina as an agency. “Lack of control over one’s destiny and the unpredictability of one’s world contribute to a general insecurity, anxiety, fear and restlessness” (Mullaly, 2010, pg.81).

The second theme to keep in mind is to manage power in a way that promotes empowerment (Dominelli, 2011). Through challenging personal values and assumptions and looking honestly at how one’s values and assumptions in a counselling setting may perpetuate oppression, a practitioner can become more open to the vulnerability of acknowledging the position of power that is innate in the role of a social worker as a professional. Through awareness, space can be created to walk in humility and operate from a place of empowerment with the clients the therapist has the privilege of serving.

Finally, ensuring one’s practice is critically reflective is vital in practicing anti-oppressive practice in a therapeutic setting (Mullaly, 2010). Critical reflection helps us understand how our identities have been largely influenced by dominant ideology, both personally and professionally. When we are able to come to a place of acknowledging and reflecting on the role that oppression plays in society and how it impacts our role as helping professionals, it creates space for greater empathy and sensitivity to issues of social injustice and oppression. It is an important practice to look at the source of our social beliefs, how we assert our power in our professional role and the impact these beliefs and ideologies have both personally and with the individuals we serve.
In talking with other counsellors at the Agency and learning the way they approach counselling, I recognized that working with people is not about fitting them into theoretical boxes, but rather utilizing a variety of skills from different theoretical models to adequately meet the needs of the individual. Rather than focusing specifically on CBT or EFT, the incorporation of other approaches such as mindfulness, and somatic experiencing served to complement my initial theoretical choices while providing a holistic focus. It has been important for me as a practitioner to not only focus on the whole person in a counselling session, but also to use mindfulness to reflect critically on the role that my personal ideology and values play in the counselling setting and serve to complement or clash with the values and goals of the client.
Chapter Four: Achieving Proposal Objectives and Skills Assessment

This chapter will discuss my original practicum proposal objectives and outline how each objective was achieved by identifying and discussing the specific activities associated with each goal. The two main objectives of my proposal included: 1) developing foundational skills in cognitive behavioral therapy with individuals and emotionally focused therapy with couples and, 2) learning administrative skills including intake, clinical note taking, assessments and intervention. I will also highlight specific independent assessments conducted with clients and how the process of critical reflection served to highlight several themes in my experience as a student counsellor.

4.1 Goal One

Developing foundational skills in CBT with individuals and EFT with couples was achieved in several different ways in order to gain proficiency not only in the theoretical underpinnings of CBT and EFT, but also in gaining an understanding about their application within a counselling setting when working with both individuals and couples.

4.1.1 Activity One

My first activity was to complete a literature review of both CBT and EFT as therapeutic approaches. I began my literature review in November 2015, two months before I started my practicum placement. I conducted a variety of searches through academic journals, books from experts in both cognitive behavioral therapy and emotionally focused therapy and conducted searches through web-based search engines and electronic journals through the University of Regina library. As noted above, I also made the decision early on in my practicum to also conduct a review of the literature pertaining to solution focused therapy and attachment theory as it related to CBT and EFT. Having some knowledge of what the literature said about CBT and
EFT as approaches before I began my practicum was helpful in beginning to reflect on the skills and tools I was able to bring into each counselling session.

4.1.2 Activity Two

My second activity was to observe counselling sessions facilitated by my professional associate and by other counsellors employed at Family Service Regina in the Counselling Unit. I had the privilege of sitting in on several counselling sessions with my professional associate throughout the duration of the entire practicum placement, and had the ability to see her use a variety of approaches and skills with her counselling clients. My professional associate incorporated techniques from CBT and brought in elements of mindfulness and somatic experiencing into her counselling sessions. I found that clients responded favorably to the holistic, client centred approach utilized by my professional associate. Along with observing the sessions, I also had the opportunity to debrief the session with my professional associate afterwards and make suggestions for therapeutic approaches and assist in developing a case plan for the client she was working with. Having the opportunity to not only sit in on sessions but collaborate about strategies and ask questions about the sessions was very beneficial for my growth and learning.

I also had the opportunity to act as a co-therapist with another counsellor in the Agency for a number of counselling sessions with a specific family on an ongoing basis. Having the opportunity to work alongside a senior therapist for family counselling sessions was a powerful learning experience in understanding how to work in complement with another counsellor to positively affect and meet the goals of the clients we worked with. “Co-therapy is a commitment to a relationship with a peer in which significant therapeutic gains are possible for the patient and
considerable collegial support and learning are possible for the therapist” (Nelson & Roller, 1991, pg.3).

I did not get the opportunity to sit in on sessions and observe other counsellors in sessions with clients. There were a few reasons for this including clients not being comfortable with a student sitting in on their counselling session, or the counsellor not being comfortable with students sitting in on the sessions. I did however sit down with all of the counsellors in the Agency throughout the course of my practicum and discuss the way they approach their practice and how they integrate theory into practice with the client population they specifically work with. Interactions with the counsellors in the Agency through one on one conversation and through counselling unit meetings allowed for me to understand the diversity amongst counselling staff and gave me the confidence to have conversations with any of the staff if I had questions when carrying my own caseload of clients.

4.1.3 Activity Three

During my practicum, my original goal was to carry a small caseload of 6-10 clients with an average of 6-8 counselling sessions per week, and this decision was supported by my academic and professional committee. An average of 20 contract hours is considered best practice for a full time counsellor (Mair, 2016). As a part time student counsellor, cutting this number down to reflect the number of hours I spent in my practicum per week, plus the inclusion of walk-in counselling and personal reflection seemed to be the best balance. Within three months of my practicum I built a caseload of 20 clients, however only 15 of the clients on my caseload were actively working with me and attending sessions regularly. I did manage to average between 5-8 sessions a week throughout the practicum placement, not including walk-in counselling. When I first started my counselling practicum, I anticipated being
able to average 10 or more counselling sessions a week and supersede my original proposal. However, I found that the best balance between walk-in, administrative meetings and reflection to be no more than 6 counselling sessions per week as I underestimated the time required for critical self-reflection, learning and administrative processes. It is essential with brief therapeutic contracts that caseload management is carefully monitored throughout the academic timeframe to ensure counsellors are not exceeding these guidelines so they can successfully survive the work (Mair, 2016). I was fortunate to have a professional associate and academic committee to be accountable to during the course of my practicum and ensure I was maintaining balance between my caseload, administrative tasks, meetings and walk-in counselling throughout the course of my practicum.

4.1.4 Activity Four

The fourth activity that I identified in achieving my original proposal objective was participating in the Agency’s walk-in counselling service offered every Thursday. Walk-in counselling gave me a great deal of experience with a variety of presenting issues and diverse client needs. Most weeks during my practicum I was able to see two clients for walk-in sessions and there were times when I had the privilege of seeing the same client for a second walk-in session if there was a need while they were waiting for longer term services. Single session, walk-in counselling was something that made me nervous when I first began my practicum; however it quickly grew into one of the most memorable parts of my practicum.

Walk-in counselling at Family Service Regina is counselling that is designed with a brief, solution focused model of therapy in mind. Single session therapy is intended to be complete unto itself, meaning it can be a “total experience” for a client with a beginning, middle and end (Hoyt, 1994). The most frequently occurring number of sessions in all models of therapy is one,
and that first session is potentially the most therapeutic and often has the greatest influence on
the outcome of therapy, regardless of the total number of sessions accessed (Slive & Bobele,
2011).

The aim of a single session is something in between triage/assessment/referral and a
miracle cure. We are satisfied if we can provide customers with something they can point
to at the end of their single session. That “something” could be limited to a new way to
think about their issues or a new behaviour with which to experience (Slive, McElheran
& Lawson, 2008).

My experience with single session therapy was positive in that I was able to see a wide array of
clients with a variety of presenting issues and have the opportunity to set specific goals and work
towards solutions at the client’s suggestion in the session. Studies have reported significant
reduction of distress as well as improvements in client satisfaction after a single session (Bloom,
2001). Single session therapy holds the belief that rapid change is possible and this was
something that I had the privilege of witnessing while in session with clients. “Walk-in services
can act as a safety valve for the community” (Slive & Bobele, 2011). Waitlists for counselling
are typically lengthy and it can be an added pressure for agencies to not be able to meet the
ongoing needs of the community they are serving. Walk-in counselling services can be utilized
in a way that reduces waitlists and helps individuals to find immediate relief often with just one
session.

When I first started walk-in counselling, I placed a lot of pressure on myself to “fix”
every issue that the client presented in the single session. Single session was a good opportunity
for me to focus in on specific problems that the client was presenting and take the lead from the
client I was working with. One of the most important questions that I began asking in single
session therapy was “what would you like to see happen during our time together that would make you feel like you got the most out of this counselling session?” Taking the lead from the client ensured that the client was having their needs met and I appreciated giving the client the autonomy to have a voice in what they would like to see happen in counselling.

4.1.5 Activity Five

My fifth goal to achieving my first proposal objective was creating space in my week for personal reflection and journaling to enhance personal growth and clarity in counselling sessions and my new role in the agency. Family Service Regina’s Counselling Unit frequently has an extensive waitlist for counselling services as there is limited space and access to counsellors for community and Ministry of Social Services referrals. When I first began my practicum, FSR had a waitlist in their Counselling Unit of roughly four months for community referrals. “As budgets shrink, mental health services become less able to keep pace with an expanding population and a greater need for a variety of services” (Slive, MacLaurin, Oakander & Amundson, 1995). Being aware of the waitlist for counselling services, and creating space for self-reflection was a challenge for me in terms of balance and boundaries as I had to override my desire to push through the pressure I put on myself to see as many clients as possible. It is not uncommon for counselling agencies to have a waitlist for service and I was told several times by the counselling professionals around me, that reflection is a critical part of allowing the counselling process to unfold organically. Being honest, I had no idea what allowing the counselling process to unfold organically meant until I stepped back and allowed myself to begin scheduling time for critical thinking and purposeful reflection.

Reflecting on counselling sessions, how I identified as a student counsellor, and how I was connecting theory to practice was a vital practice for personal and professional growth. For
meaningful insights to arise, the practice of stopping, resting and reflecting is crucial (Hanh, 1998). Using critical reflection and mindfulness became a way for me to begin forming connections between theory and practice and develop a deeper understanding of who I am as a social work practitioner and novice counsellor. Critical reflection was not an area of comfort for me when I first started this graduate practicum placement; however, leaving my comfort zone to pursue personal and professional growth is where I began to connect to my learning and counselling practice in a deeper and more meaningful way. Being self-reflective builds clinical competence and can help prevent burnout and boundary violations; it is necessary for all levels of clinical practice (Urdang, 2010). The CASW Code of Ethics (2005b) states that social workers have an obligation to maintain and increase their professional knowledge and skill. Maintaining competence in professional practice is achieved through critical reflection and ongoing opportunities for learning and professional development, thus both are crucial for best practice.

4.1.6 Activity Six

My final activity for my first learning objective was to schedule training opportunities for professional development to enhance my growth and development as a student counsellor. I achieved this activity in multiple ways, including attending two days of training on solution focused counselling, participating in a mindfulness counselling workshop held in Regina in May, and taking advantage of several opportunities to experience various counselling techniques as the client. I also had the experience of facilitating EAP Lunch and Learn sessions with two companies in Regina that access services through Family Service Regina EFAP.

Being able to participate in professional development opportunities such as solution focused therapy training and mindfulness counselling strategies was a good opportunity for growth and reflection as a student counsellor. The CASW Code of Ethics states that social
workers have the “responsibility to maintain professional proficiency, to continually strive to increase their professional knowledge and skills and to apply new knowledge in practice commensurate with their level of professional education, skill and competency, seeking consultation and supervision as appropriate” (CASW, 2005b, pg. 8).

I also had the opportunity to facilitate two sessions on “Managing Multiple Life Demands” for two of Family Service Regina’s EFAP contracts. I found each session to be well received and a positive learning experience for me as a student counsellor. Also having the opportunity to attend a mediation session and presentation with another EAP counsellor in the Agency was a valuable learning experience for me to continue to build competency and skill in workshop facilitation.

Finally, I had several opportunities to experience a variety of counselling techniques with my professional associate such as eye movement integration (EMI), somatic experiencing (SE), and also utilizing a two chair technique in session. Each of these approaches to therapy are experiential and require trust in the therapist by the client.

EMI is a therapeutic treatment for distressing and traumatic memories (Beaulieu, 2003). It uses guided eye movements to access information in cognitive and emotional forms and assists a client in integrating them to reduce psychological impacts (Beaulieu, 2003). EMI temporarily holds a client in a traumatic experience in order to integrate the experience and create a reduction in suffering. I completed an initial EMI session as the client with my professional associate and it was decided that I would have a second EMI session within a week of the first to complete integration of distressing memories. Often, problems related to a single traumatic event can be resolved in one session, and the most complex cases are successfully treated with a total of only six or seven sessions (Beaulieu, 2003). Thus, it is not uncommon to have only one or two EMI
sessions for a particular memory or traumatic event. I found EMI to be a highly intensive experience and placed me in a position of vulnerability as the client. I was expected to have a deep level of trust in not only the therapist, but the technique itself to resolve painful memories.

Somatic experiencing (SE) as a therapeutic approach is different from EMI in that it does not expose an individual to trauma and have them re-live or experience it (Levine, 1997). Rather, it is a gentle approach that looks at restoring an individual’s capacity to cope that was overwhelmed during the initial traumatic experience (Levine, 1997). I enjoyed my opportunity to participate in SE sessions with my professional associate, both observing sessions as a student and participating in them as a client to learn how the approach is experienced by the participant.

The two-chair technique is one of the most powerful and widely used gestalt therapy techniques (Wagner-Moore, 2004). The two-chair technique can be defined as working with a client to dialogue between two aspects of the self (Clark & Greenberg, 1988). One aspect of the self is expressed while sitting in one chair and the other expressed while sitting in the other chair, switching as needed from one chair to the other. “The goal for two-chair work is to bring the experiencing self and the internal critical self into contact with each other, for the client to attend to both sides for change to result as the client increases self-acceptance and develops new cognitive schemas” (Greenberg, Rice & Elliot, 1993, pg. 191). The two-chair technique can also be used for problem solving internal conflict and providing a client some acceptance of the different aspects of self they are wrestling with. I had observed a session with my professional associate using two-chair work with a client and then had the ability to experience the technique as a client myself. Observing the two-chair technique as a student was different than experiencing it as a client. The client has to be willing to trust the process of experiencing
different aspects of self, and it requires extensive skill on the part of the therapist to track the progress of the client.

My final opportunity for professional development as a client was participating in a hypnotherapy session with an EAP counsellor at the Agency. Hypnosis as a therapeutic technique is used to create subconscious change (Lynn & Kirsch, 2006). Hypnosis is a process during which a therapist suggests that a client experience changes in sensations, perceptions, thoughts or behavior. Although there are many different hypnotic inductions, most generally they include suggestions for relaxation, calmness, and well-being (Lynn & Kirsch, 2006).

Hypnosis has been used for the treatment of pain, depression, anxiety, stress, habit disorders and many other psychological issues people face (Lynn & Kirsch, 2006). I was highly anxious when I attended the hypnotherapy session with my colleague as a client as I had never experienced or researched anything regarding hypnosis in a therapeutic setting. I did however have respect for, and trust in my colleague as a very skilled therapist. My colleague reminded me that her role is to guide me as the client through the process, but ultimately I am in control of the experience. I learned a great deal from the experience and found it to be relaxing on a different level than mindfulness and guided imagery and I was able to process suggestions for change on a deeper level. Hypnotherapy is an approach that I would recommend to clients struggling with a variety of issues and I also have had my colleague attend the Domestic Violence Drop-In Group that I facilitate in the Domestic Violence Unit as a guest speaker to talk about and guide participants through hypnosis exercises.

Having the ability to experience a variety of therapeutic techniques as a client was a powerful experience and challenged me to embrace vulnerability in a more meaningful way than I had previously. Each of these opportunities gave me exceptional room for growth and provided
me with a deeper understanding of the value of each therapeutic technique with clients. Participating in sessions not only as a therapist, but as a client was a powerful learning experience in the vulnerability that can be found on the other side of the chair. I found it to be a rich experience, not only in the therapeutic technique that was being used, but in the power and importance in the development of a strong therapeutic alliance. Each training experience was an opportunity for me to begin bridging the gap between theory and practice, and enhance my professional skills as a new clinician.

4.2 Goal Two

The second goal for my graduate counselling practicum placement was to learn administrative skills that included specific interventions, assessments and clinical note taking as they pertained to the counselling unit at Family Service Regina.

4.2.1 Activity One

The first activity I planned in order to achieve my second proposal objective was to spend time with the Intake Counselling Unit at Family Service Regina to learn the intake process. I spent several hours with the intake counsellor at FSR, learning administrative skills such as opening files, pulling files off the waitlist and taking referrals. I also had the opportunity to learn the SAP (substance abuse professional) process and how to administratively help clients obtain an assessment to move forward with treatment recommendations to get them back to work after a failed drug screen. When counsellors meet with clients to provide treatment recommendation, they will often provide literature and resources for the client’s education. I was able to complete a search for online resources and examine existing literature to assist the counsellors when making recommendations to clients for substance abuse treatment and provide to the clients for educational purposes.
4.2.2 Activity Two

The second activity to achieve my proposal objective was to learn the process of clinical recording that is utilized by the Counselling Unit. Being an employee of Family Service Regina in the Domestic Violence Unit, I had foundational knowledge in the general standards for clinical recording set out by the Agency and I also had a working knowledge of the computer system that is used for case management called “Caseworks”. However, being that the Domestic Violence Unit and Counselling Unit at FSR are separate programs with different mandates and administrative requirements, I found it a challenge to begin clinical recording in the Counselling Unit as the information gathered and highlighted in records looked very different than the writing required in the Domestic Violence Unit.

The biggest difference between the recordings in each unit are; in the Domestic Violence Unit documentation tends to be factual based information including court updates and information, whereas the Counselling Unit tends to record therapeutic processes and techniques used in the counselling session rather than factual content. It became a familiar and comfortable process by the end of my practicum to record notes according to the guidelines set out by the Counselling Unit and I found that I returned to my notes often to build upon sessions with clients and take note of the progress and growth between individual sessions. The achievement of this activity taught me the importance of accurate clinical recording as a vital part of the counselling process not only for Agency standards but as best practice as a social worker. The CASW Code of Ethics Guidelines for Ethical Practice (2005a) highlights diligence and transparency in professional practice. When in sessions with clients, if I was taking notes, I would always be sure that the client knew the purpose of the notes I was taking in order to have transparency and honesty be the foundation of the therapeutic relationship. The policy manual at FSR outlines best
practice for clinical recording and highlights diligence and transparency as cornerstones to best practice. The manual states that opportunity will be offered to the client to review his/her file on Agency premises, with an appropriate staff member if the need should arise (FSR, 2014). Clinical recording in accordance with Agency standards is also a practice of diligence in ensuring that the clinical notes and processes are timely and accurate. I was fortunate to not only learn the administrative processes in the Agency through practicing them personally in sessions with clients, but also in attending supervision and Unit meetings.

4.2.3 Activity Three

I attended weekly supervision meetings with my professional associate, attended counselling administrative meetings and weekly Peer Support meetings in the Counselling Unit. Attending these meetings ensured I was getting adequate direction and guidance from senior practitioners and learning the administration processes of the Counselling Unit.

The weekly supervision and direction that I received from my professional associate was invaluable to my personal reflection and overall learning experience. Having a set time every week to get together with my professional associate and reflect on my growth, ask questions about counselling sessions, therapeutic techniques, or administrative processes greatly impacted my overall learning experience. I appreciated that my professional associate normalized and empathized with the feelings of incompetence that can be a result of being a student counsellor. She created a comfortable atmosphere to share not only success, but feelings of vulnerability and incompetence when learning how to connect theory to practice in a meaningful way. The taboo associated with feelings of incompetence as a novice practitioner is greatly reduced when there is the opportunity to engage in an empathetic dialogue with colleagues and supervisors (Theriault, Gazzola & Richardson, 2009).
Part of my initial proposal for my counselling practicum was to video record counselling sessions to review them on my own and in supervision with my professional associate for further growth and learning. Video recording counselling sessions has been valued as one of the best ways to learn and improve oneself as a student therapist (Rogers, 1975). However, I did not have any clients who would consent to recording their sessions. Not having the ability to record counselling sessions required a deep reliance on verbal communication between myself and my professional associate and a deeper awareness on my part to be mindful of my body language and non-verbal communication within the counselling setting.

Finally, as a student counsellor, attending and participating in both the peer support meetings and the Counselling Unit administrative meetings was an important opportunity for growth within my practicum. Having the opportunity to interact with other counsellors in the Agency through peer support and obtain feedback through case consultation was vital to my personal growth as a student counsellor. Also, having the ability to attend administrative meetings was valuable to my growth as a student counsellor and understanding the administrative procedures of the Counselling Unit and Agency as a whole.

4.2.4 Activity Four

My final activity in achieving my second proposal objective was to complete five independent assessments within the course of my practicum. I did not realize prior to beginning my practicum that assessments are completed every time a client begins sessions with a counsellor. Assessments are completed during the first counselling session with a client in order to learn about the client’s history, have them identify the problem/problems they are facing and want to address and set goals for the counselling interactions (Beck, 2011). I was modest in my desire to complete five independent assessments by the end of my practicum and I was able to
successfully complete fifteen independent assessments for new clients coming to see me for counselling services. This next section will discuss an assessment of skills that I learned during my practicum experience of completing independent assessments that I conducted in one on one, couples sessions and walk-in counselling sessions.

4.2.4. a. Independent Assessments

I had the opportunity to conduct several independent sessions with new clients to the Agency; however I will be highlighting the work with two individuals and some couple’s work for the purpose of this report. Please note that all identifying information has been removed to protect the anonymity of the individuals I had the privilege of working with. I also obtained both verbal and written consent from the participants in order to discuss aspects of their counselling sessions and highlight the counselling process that was crucial to my learning as a clinician.

The first assessment that stood out was the opportunity to work with a woman and her partner that desired to process the grief of a chronic medical diagnosis. Adapting to a new way of life both personally and in relationship with her partner was a large piece of the work done in the sessions and beginning to bridge the gap between expectations of what life was like, to the reality of life now managing a chronic disease. I worked with the woman individually for several sessions and then had the opportunity to see her and her partner to do some couples counselling for multiple sessions as well.

I was nervous about working with couples because I recognized early in my practicum that the lens that I brought into counselling through the Domestic Violence Unit was strong, and I was unsure how to work with couples who were committed to one another. EFT was the main therapeutic approach I used in working with these clients to create space to facilitate meaningful conversation between the two of them about their feelings of vulnerability and inadequacy in the
face of the illness that they were combating as a couple. “An important part of couple’s therapy is helping both partners manage their vulnerabilities” (Germer & Siegal, 2012, pg.281). The illness that was present in this relationship was difficult for each partner to acknowledge, accept and balance. Thus, the work in counselling became creating a safe space for them to come together in this vulnerability to acknowledge the loss, feelings of inadequacy and failure.

Incorporating mindful compassion and EFT into the therapy session was helpful for these clients in beginning to relate to one another in their individual suffering. “Our aim is to help couples manage their vulnerabilities in such a way that they become a vehicle for cultivating compassion” (Germer & Siegal, 2012, pg.281).

The work that I was able to do with each member of the couple individually stemmed around the integration of mindfulness and CBT. One of the approaches that was recommended by the doctors of this client was pure CBT to begin challenging negative thoughts associated with her medical diagnosis. They held the belief that taking care of the negative thoughts would reduce the symptoms of the illness. In working in the therapy session alongside this client, we discovered that the incorporation of mindfulness and CBT techniques did in fact begin to change the way that she was able to relate to the pain of her illness. The client advised that when she was able to lean into the discomfort she was experiencing and give herself permission to self soothe and ask for what she needed, she saw a dramatic decrease in the suffering she had been experiencing.

The second assessment that I conducted was a woman who came to counselling as a self-referral and had been struggling for many years with issues of domestic violence and was also struggling with anxiety, panic attacks and depression. Part of my initial assessment with this woman was a suicide risk assessment as she reported in her initial session that she felt hopeless
and wanted to end her life. Hearing this client describe her feelings of hopelessness was
intimidating for me as I immediately wanted to enter a role of helping pull her out of those
feelings or help her “change her mind” about these feelings. Germer and Seigal (2012) describes
a suicidal person being someone trapped in a small room with no lights, doors or windows, and
the room is so painful that enduring it for a moment longer appears impossible.

The task of the therapist in this situation is to somehow find a way to get inside the room
with the person, see the world from that person’s point of view, and find that door to life
that the therapist knows is there. This view does not champion the idea of the therapist as
the only expert in the room. Both must look for the door together (Germer & Seigal,
2012, pg.206).

Through counselling with this individual I became very aware of how mindfulness is a safe
practice for both the therapist and the client as it reduced the risk of counter transference and the
ability to hear what the client was truly saying in her desire to end her life. In working with this
client, I became so aware of the body’s innate ability to heal itself and that my role as a therapist
was to truly bear witness to her healing journey and remind her of the tools she already
possessed and create capacity, safety and support for her to step into a more fulfilling
relationship with her mind and body. I integrated CBT practices and mindfulness self-
compassion into my work with this client and also incorporated elements of somatic
experiencing and ego state work. Ego state therapy aims to identify different roles that an
individual may have operating within themselves at one time and then integrate them into a
coherent self (Watkins, 1993). Ego-state therapists typical refer to a “family of selves” that
individuals can develop as adaptations to a variety of life circumstances (Watkins, 1993). Ego
state therapy works effectively in combination with CBT to begin to identify and integrate each
aspect of self. Through the recognition of negative thought patterns, this client was able to not only begin challenging her unhelpful thoughts, but with self-compassion, she was able to lean into her discomfort to begin reducing her feelings of suffering while experiencing anxiety and panic attacks. Therapists using mindfulness integrated CBT talk about suffering as being a part of the human experience, but that the act of suffering itself is not usually due to the situations that we find ourselves in, but rather our unfulfilled expectations (Cayoun, 2015). I was able to talk openly with this client about expectation versus reality for situations in her life that were causing suffering and through discussion she was able to identify that the space between expectation and reality created room for shame, guilty and anxiety.

Having the opportunity to observe my professional associate use somatic experiencing (SE) as an approach to working with clients, and also using the approach myself in complement with other therapeutic approaches, was helpful. The two clients I described above, both experienced SE as an effective tool in complement with CBT and EFT. “Somatic experiencing holds the attitude that the body and mind are designed to heal intense and extreme experiences, in contrast with common beliefs that the effects of trauma are permanent” (Taylor & Saint-Laurent, 2016). I found that incorporating somatic experiencing work into therapy sessions, especially with clients struggling with anxiety or who have a history of trauma to be a powerful and gentle approach to healing that could be used in combination with a variety of other therapeutic approaches such as CBT and EFT. I appreciate the gentle approach that SE offered to clients as you are not actually exposing the person to a trauma and having them re-live that experience. Rather, you're restoring the responses that were overwhelming, which is what led to the trauma in the first place (Levine, 1997).

4.3 Summary
Completing the objectives of my practicum proposal resulted in valuable growth and learning as a student counsellor. My professional associate recommended scaling the results of my learning objectives at the midterm and final point of my practicum to gain a sense of my personal growth and have an idea of areas that needed improvement. I found scaling to be very helpful in challenging my own learning goals and objectives. Critical reflection and professional development not only enhanced the development of my foundational counselling skills in CBT and EFT, it assisted in my growth both personally and professionally. Also, the integration of mindfulness into my practice as a student counsellor assisted in connecting theory and practice in a meaningful way to discover themes for best practice.
Chapter Five: Integrating Theory into Practice

The integration of theory into practice in a meaningful way was something that did not come easily to me in the beginning of my practicum experience. However, the practice of mindfulness became the bridge by which I connected theory to practice, and this will be discussed in greater detail in this and subsequent chapters. I identified three general aspects of counselling at Family Service Regina as important when looking at connecting the theory to practice as outlined in my practicum proposal. The aspects that I have chosen to highlight are the therapeutic alliance, generalist counselling practice and the application of a holistic lens to counselling.

5.1 Therapeutic Alliance

At the heart of any successful therapy lies the establishment of a therapeutic alliance (Muller, 2011). The therapeutic alliance can be a power vehicle for change and research suggests that the formation of a positive alliance between the client and the therapist is correlated with positive treatment outcomes (Raue & Goldfried, 1994). Connecting with clients in a meaningful and empathetic way built the foundation for establishing a therapeutic alliance and was an important element of the therapeutic process. Making collaborative decisions through setting goals and demonstrating a commitment to understanding and listening to a client with empathy can create a deep connection between the therapist and the client. It appeared that connection, compassion and empathy made the biggest difference in the lives of the people I was able to work with as a student counsellor in this practicum setting.

The therapeutic relationship can become a nonverbal cognitive therapy instrument, which can heighten awareness between relationships that have previously caused trauma, and the relationship with the therapist (Germer & Siegel, 2012). “Whereas others have hurt, violated, or
rejected, the therapist actively supports, cares for and accepts” (Germer & Siegel, 2012, pg.270). The building of a therapeutic alliance is highlighted as demonstrating the most positive treatment outcomes in cognitive behavioral therapy (Beck, 2011). There is a lot of power in the therapist role and the therapist has the ability to project something different that may have never been experienced before by the client. Cognitive therapy involves directly challenging thoughts that influence emotions and behaviors, and also usually involves exposure (Germer & Siegel, 2012). A positive therapeutic relationship that is based on trust and transparency is an important foundation in beginning to undertake this work in therapy (Germer & Siegel, 2012).

The therapist can also become a secure base for the client and can promote safety in exploration, thus making it possible for the client to begin to experience healing (Sable, 2000). Building a safe relationship with the therapist can engage the client’s attachment system, which is sensitive to loving attention from important relational figures (Germer & Siegel, 2012). When working with couples, it becomes important to not only develop a positive therapeutic relationship with each individual, but it is also important for each member of the couple to see how the other interacts with the therapist in session (Johnston & Greenberg, 1989). Clients have to feel accepted and secure with the therapist to acknowledge aspects of themselves they do not normally acknowledge (Johnson & Greenberg, 1989). In order for a couple to begin the task of being vulnerable with one another, there needs to be an element of trust and safety with the therapist to begin creating a new emotional response to one another and begin exploring and recognizing what each partner longs for and fears in their relationship (Johnson & Greenberg, 1989). It becomes a delicate balance when working with couples and dealing with highly emotional content to attend to each person’s needs and establish trust, while ensuring their partner also feels safe and validated in their experience.
Seeking feedback from the client and recognizing that they are the expert in their own life is critical in beginning to balance the power differential between therapist and client and ensure autonomy for the client. There is an important distinction for clinicians to make between caring for a client and the desire or need to cure the client. Cure is what we try to do when we feel we have some ways to fix a problem. “Care is what we can still do when all efforts at curing have failed” (Germer, 2009, pg.33). I have learned that when we stop struggling to try and fix things, we often come to a place of openness to change with clients and a deepening of the therapeutic alliance. Looking at the therapeutic alliance from my personal value of anti-oppressive social work, I also have the view that establishing a therapeutic alliance with individuals is a sacred space that deserves to be protected. Using the therapeutic alliance to build empowerment and safety for the client rather than using the therapeutic relationship for personal gain requires a willingness to embrace critical reflection and to challenge the traditional power inequalities of client and therapist (Mullaly, 2010).

5.2 Generalist Practice

The counsellors at Family Service Regina all consider themselves generalist practitioners each with their own theoretical models that underpin their practice. However, each counsellor that I had the opportunity to meet with discussed that, in client centered work, connecting theory and practice is done at the pace of the client, and often times many theories are incorporated into a therapy session in order to meet the needs of that particular client. Generalist counsellors have a wide range of skills and therapeutic approaches to meet the needs of the individuals they work with. The utilization of an eclectic theoretical base allows for the practitioner to focus on individual well-being and on effectively assessing their needs within a variety of contexts (Meenaghan, Gibbons & McNutt, 2005). Generalist practice is also seen to emphasize the
connection between human problems, life situations and social conditions (Meenaghan et al.,
2005).

As a generalist practitioner being proficient in more than one therapeutic approach is
important in order to meet the complex needs of the client that you are working with. Also
having a genuine interest in the narrative and story that the client brings to the counselling setting
and the way in which they perceive the world will help guide the incorporation of theory into
practice (Saleeby, 2009). While I do believe it is important to have proficiency in specific
therapeutic approaches, looking at the elements of generalist practice was important learning for
me in recognizing that the therapeutic approach is determined by getting to know the client and
having the ability to adapt the therapeutic approach to meet the needs of the person you are
working with rather than having the expectation that the client must adapt to a specific
therapeutic approach.

Specific therapeutic approaches such as CBT and EFT are also shifting towards a more
generalist and eclectic approach to therapy. Recent literature has begun to look at using both
CBT and EFT in combination with mindfulness as a way to enhance emotional regulation and
promote cognitive change (Hayes & Feldman, 2004). There is the recognition that CBT or EFT
alone are not able to focus on all aspects of the complicated situations of each unique individual.
For example, CBT focuses specifically on how thoughts impact behaviors, and EFT focuses on
emotions. Rather than focusing in on specific aspects of the client, when using these techniques
in combination with mindfulness or another therapeutic approach it may serve to meet the needs
of the whole person.

The primary function of a generalist practitioner is to help clients recognize, marshal and
enhance their inherent strengths and abilities (Poulin, 2010). Focusing on generalist practice
from a strengths-based perspective in accordance with my personal values as a social worker, views the client as the expert and as having the ability to accomplish whatever change and growth is needed. Using a client-centered approach to generalist practice is something that FSR strives to practice across program mandates as the Agency recognizes that individuals and families are complex. Using a holistic approach in working with individuals allows the therapist to meet the specific needs of the person sitting in front of them. When therapists feel unprepared in therapy, we sometimes find ourselves turning to theory or using diagnostic labels to feel more confident in practice (Germer & Siegel, 2012). Instead of distancing when feelings of inadequacy rise up, it is important instead to come back to the present moment and focus instead on the relationship with the client and the role they play as the expert in their own life.

5.3 Holistic Model of Care

Mindfulness counselling strategies have been vital in beginning to apply the theories I have chosen to focus on during this practicum. Mindfulness has also assisted in beginning to see how the application of theory in a holistic way can promote a client centered approach to therapy. Moreover, the application of mindfulness to CBT and EFT has been able to assist in creating a holistic and client centred method of practice and can serve to complement and strengthen the aforementioned approaches.

Looking at the whole person as opposed to focusing on the pure applications of therapeutic approaches such as CBT and EFT became important practice for me in recognizing that individuals are complex and have individual needs. Being open to the needs of the client and taking the time to ask questions and hear the client’s goals for the counselling session created the ability for me to step out of the way as the counsellor and ensure client autonomy. I found that
bringing a holistic lens of care into counselling sessions was powerful and effective in order to address the whole person and recognize the complexity of the person I was working with.

Having the opportunity to sit in with my professional associate and observe several counselling sessions that she facilitated allowed me to see holistic practice unfold in a genuine and organic way in the therapeutic setting. My professional associate combines several approaches to therapy in order to meet the needs of the client in the room. Combining somatic experiencing practice with CBT, for example, was a powerful way to have the client not only begin to challenge the thought patterns contributing to behavior, but the somatic experiencing work allowed the client to become mindful of what was going on in the body while engaged in certain thinking patterns.

I have come to view generalist practice, the therapeutic alliance and counselling from a holistic lens to be the basic foundation for counselling at Family Service Regina and best practice as a student counsellor. I also view these aspects of counselling as a basis for integrating mindfulness into the counselling setting to begin connecting theory and practice.
Chapter Six: Emerging Themes

Mindfulness, vulnerability, bearing witness and empathy/compassion are four themes that have emerged from my practicum. In this chapter, I will discuss each of these themes to show how my work with clients and role as a counsellor has been shaped and influenced by my practicum experiences at Family Service Regina.

6.1 Mindfulness

Mindfulness quickly emerged as a major theme throughout the course of my practicum and in my learning experience. During my practicum, I intentionally chose to use mindfulness to bridge the gap between theory and practice. Mindfulness also emerged as a skill necessary to develop in order to enhance my personal boundaries. Through mindfulness I was able to fully attune to the people I had the opportunity to work with, and also attune to myself. When a clinician becomes the vehicle for client healing they must use mindfulness as a relational concept, where they model self-compassion through their own practice and behaviors (Dombo & Gray, 2013).

Mindfulness can be defined as knowing what you are experiencing while you’re experiencing it (Germer, 2009). However, mindfulness can also be defined simply as “awareness of present experience, with acceptance” (Germer, 2009, pg.38). I found it to be a challenging practice to have moment to moment awareness without structured boundaries and committing to being completely present in the moment. To broaden the definition, mindfulness can be viewed as having three distinct parts. The first part is looking at mindfulness as attentiveness or increased alertness and self-awareness; this can allow a person to be more attentive to daily activities and the impact of their behaviors (Enns, 2014). Second, mindfulness included aspects of creativity that can bring flexibility for healing and change from old patterns (Enns, 2014). The
The third element of mindfulness is contemplation and personal growth (Enns, 2014). Viewing mindfulness as an opportunity for growth begins to shift mindfulness from a state, to a trait; and creates capacity to hold and sustain the trait of mindfulness long term (Enns, 2014).

The concept of mindfulness was not something that I was familiar with when I began my practicum experience. I had heard the term discussed amongst the counsellors at Family Service Regina and always associated it with meditation and self-care practices. I did not realize that it would quickly become one of the foundations upon which I chose to centre my counselling work with clients. Not only has the practice of mindfulness been vital in learning to practice my counselling skills in an agency that I shared a dual role in, it also became vital to educate my counselling clients in the practice of mindfulness as a means to bring peace of mind to suffering.

“When we become more aware, more focused on the present moment, the past loses its power, and the future no longer scares us because the stories of our mind as seen as just that: stories” (Doyle, 2014, pg.29). Being rooted in the experience of being present with my clients allowed me to discover a deeper connection and cultivation of wisdom and self-healing in individuals, as opposed to attempting to fit clients into theoretical boxes. Mindfulness creates space to bridge theory and practice in a gentle way.

6.1.1 Mindfulness and CBT

I found the use of mindfulness particularly helpful in bridging the gap between theory and practice particularly when using CBT in working with individuals. I really found that CBT and mindfulness fit nicely together with the assumption that becoming more aware of automatic patterns, specifically negative thought patterns as identified by CBT can result in a shift towards a more mindful response.
Recent research indicates, however that the healing mechanisms behind successful therapy are not what we thought they were: it’s the process of establishing a new relationship with our thoughts and feelings, rather than directly challenging them, that makes the difference. The new relationship is less avoidant, less entangled more accepting, more compassionate, and more aware (Germer, 2009, pg.31).

Using mindfulness to approach these thought patterns with curiosity creates space to choose how we relate to our thoughts and feelings and I found clients very responsive to this practice. Mindful practice requires mental neutrality, which allows us to investigate our thoughts and feelings safely and with healthy curiosity (Cayoun, 2015). As human beings, we are prone to getting stuck in certain negative and distorted thought patterns. “We are evolved minds that are like Velcro for bad thoughts and Teflon for good ones” (Hanson, 2007, pg.4). I found that as clients were able to let go of judgement for their negative thoughts, they were able to cultivate curiosity and investigate these thought patterns and relate to them in a different way.

Leaning into our problems with open eyes and an open heart, with awareness and compassion, is the process by which we can often gain emotional relief (Germer, 2009). When clients began to explore their problems and meet them with curiosity rather than resistance, they began to experience a relief of the suffering associated with their problems. The problem itself did not disappear, but rather their relationship to the problem changed, reducing the overall suffering and pain associated with it.

6.1.2 Mindfulness and EFT

Mindfulness is also a useful approach to incorporate into emotionally focused therapy. Mindfulness provides a way to cultivate emotional balance and decrease habitual patterns that obscure perception and impair our judgement (Hayes & Feldman, 2004). Mindfulness is useful
to assist with emotional regulation and also address patterns of avoiding difficult emotions. We can often become preoccupied, or consumed by emotions or emotional experiences, mindfulness can help focus on the present and avoid either avoidance or over engagement with emotions (Hayes & Feldman, 2004). Recent evidence also suggests that mindfulness practice can in fact complement EFT in several areas of marital distress (Beckerman & Sarracco, 2011). Introducing mindfulness into therapy with couples proposes that openness and acceptance can create improved levels of relationship satisfaction, lower levels of stress, and better coping with marital strains (Beckerman & Sarracco, 2011). I observed that the non-judgemental stance that mindfulness takes can be helpful in lessening the negative views and opinions that couples may have of each. When practicing mindfulness, couples are more likely to stay in the moment and regulate their affective responses and less likely to respond to thoughts or feelings from their history or imagined future together (Beckerman & Sarracco, 2011). When combining mindfulness and EFT in counselling sessions with couples, I noticed that the couple was able to express their needs in the present moment and relate to one another with more vulnerability.

6.1.3 Integrating Mindfulness into Anti-oppressive Practice

Finally, mindfulness techniques can be used to address oppressive ideologies and practice in the lives of individuals and thereby foster change not only on the intellectual level but also on levels of body, emotion and spirit, the levels where the most insidious and resistant formations of oppression can be lodged (Orr, 2002). The challenge of being a social work practitioner engaging in micro level clinical social work practice, is how do we take the work to a larger scale and context to begin promoting macro level, systemic change?

I would argue that not only can mindfulness serve as a bridge between theory and practice; it can also serve as a catalyst for broader social change. Mindfulness may provide a
window for observing and investigating events in our daily lives that can inform us, while also being structured by, larger social relations and structures (Hick & Furlotte, 2009). This requires unlearning the discourse of oppression (Orr, 2002). This too can create a sense of vulnerability for a practitioner in critically reflecting on the areas where oppression has been learned and internalized and how it in turn has affected the way in which we work with clients. Reflecting and becoming aware of my own fear of vulnerability and taking risks in a professional setting was a challenge. As mentioned earlier, I became aware of my own fear around being vulnerable and of seeing a counsellor myself to learn therapeutic approaches from the perspective of a client. I had internalized a feeling of shame associated with being vulnerable and allowing myself to engage in therapy as a client and not as the therapist. “When we attach judgement to receiving help, we knowingly or unknowingly attach judgement to giving help” (Brown, 2014, pg.54). This statement deeply challenged me in beginning to understand professionally that I need to work out in my personal life what I am requiring of the clients that I am working with.

“Anti-oppressive work is inevitably unsafe and uncomfortable because it challenges existing modes of thinking and working” (Wong, 2004, pg.4). Mindfulness does not serve to create a sense of safety in integrating anti-oppressive social work theory into practice, but rather it creates more of an openness to discomfort. In looking at my role as a novice counsellor and social work practitioner, mindfulness has assisted me in staying in touch with my own feelings of discomfort and vulnerability, to begin befriending the idea of discomfort in order to open up to a greater growth and learning.

6.2 Vulnerability

Vulnerability can be defined as opening up oneself to uncertainty, risk and emotional exposure (Brown, 2014). It is about exposing oneself to the possibility of attack and thus it is
courageous to walk into a place of vulnerability as both a client, and a therapist. Acting as a client made me more aware of the vulnerability that individuals experience when seeking counselling services. It was important for me as a student and a professional to reframe how I view vulnerability especially in relation to professionalism. It was a struggle for me at the beginning of my practicum to understand that there is room in counselling practice for both professionalism and vulnerability and that vulnerability was in fact critical for my professional development and growth.

Taking a risk to speak honestly and open up in a vulnerable way with another person requires trust and opens up the potential of attack, thus this idea can cause a lot of fear for people. “We have come to a point where, rather than respecting and appreciating the courage and daring behind vulnerability, we let our fear and discomfort become judgement and criticism” (Brown, 2014, pg.33). Engaging in empathy is vulnerable, as feeling understood and having one’s suffering acknowledged means being exposed (Muller, 2011). Being that empathy requires vulnerability, it becomes important to take risks to be vulnerable, not only as a client, but as a therapist to allow a genuine therapeutic relationship to be built on empathy and compassion to unfold.

As mentioned above, it was important growth both personally and professionally for me to learn to relate to the idea of vulnerability as evidence of courage not only for the clients I worked with, but for myself. Brene Brown, in her work and research on vulnerability, describes that we often view vulnerability as courage for other people and as an inadequacy in ourselves (Brown, 2014). Viewing myself as inadequate when put in positions where I felt vulnerable was not only a disservice to myself, but to the clients I was working with. When I became self-conscious of how I was perceived as a professional, it detracted my focus from the client I was
working with. Learning to relate to vulnerability creates freedom and wisdom to walk side by side with clients and bear witness to the growth and healing transformation taking place in the counselling session.

6.3 Bearing Witness

Bearing witness to the deep healing transformation, growth and learning of the clients I worked with was a privilege. Recognizing that my role as a counsellor was to bear witness and walk alongside individuals and families in their own healing process, and not focus on imparting my agenda on the client, was valuable learning. Working in the Domestic Violence Unit in an outreach role, I am often in a position where my interactions with clients are brief, solution-focused and contain a strong element of problem solving and advice giving. In the counselling setting, I learned that as a practitioner it is a privilege to have the opportunity to walk alongside someone and bear witness to their process of healing and growth.

As a student therapist, learning to not work harder than the client and instead to work at the pace of the client, was a valuable learning experience for me. Working at the pace of the client and allowing them to set their own goals in therapy requires a certain amount of faith in the client and their capacity for change. Without a belief in the client, clinicians can inadvertently impose their own goals on the clients they work with (Germer & Siegal, 2012). There were times during my practicum where I had to be mindful to not jump to offering advice to clients, and instead step back and trust in the client’s ability to change and grow while providing the content for the therapy session. Bearing witness to the transformation within the therapeutic process and looking at the therapeutic role as one of “servant” rather than “expert” creates powerful space for growth.

“Wisdom requires humility on the part of the therapist and a willingness to forgo the belief that he or she knows better what is good for a client” (Germer & Siegal, 2012, pg.28).
Wisdom on the part of the therapist to recognize that clients are the experts in their own lives is a powerful stance to take and recognize that clients possess the wisdom to create the change needed to achieve their goals.

6.4 Empathy and Compassion

The final theme that I will be highlighting and reflecting on from my practicum experience is the use of empathy and compassion in the counselling setting. The importance of therapist empathy and compassion cuts across forms of psychotherapy. Maintaining an empathetic point of view is crucial as it demonstrates an intimate understanding of the client’s perspective, as though they themselves were experiencing the client’s thoughts and feelings (Tuerk, McCart and Henggeler, 2012).

“Compassion comes from the Latin roots com (with) and pati (suffer), or to suffer with. When we offer genuine compassion we join a person in their suffering” (Germer, 2009). As a counsellor, walking in genuine compassion with individuals creates a deep and sustainable therapeutic alliance and dissolves any power imbalance present in the relationship. Our thoughts, feelings and actions are largely impacted by factors outside of our control: childhood history, culture, genetic and environmental conditions, as well as the demands and expectations others place on us (Neff, 2016). As a counsellor, recognizing the humanity and commonality of suffering can draw us to a place of wanting to care and help others ease their suffering. Compassion is informed by the understanding of our basic human condition (Germer & Siegel, 2012).

I observed the growth for clients when they were able to embrace the concept of self-compassion and “lean” into the idea of suffering without judgement. As a counsellor, I recognized that it was not my role to solve all their problems and take away the pain, but instead,
help them shift their thinking in a way that allowed them to relate differently to their pain. The common healing element in both mindfulness and self-compassion is a gradual shift towards befriending emotional pain (Germer, 2009). Compassion for one’s self and others allows for sympathy, forgiveness and love in the midst of pain.

The most compassionate thing a therapist can do is help assist a client to achieve his or her own goals for treatment (Germer & Siegel, 2012). I learned through the course of my practicum that meeting clients with empathy and compassion and trusting in their capacity for change, gave them the hope to also see that they could achieve their goals for treatment. Research shows that successful therapists focus on clients’ strengths and abilities and available supports from the very first therapy session (Bannink, 2014). When individuals are able to shift their thinking about the concept of suffering and begin to hold empathy and compassion for themselves, it begins to release tension and anxiety and free up mental space to problem solve and hold curiosity for a new way of thinking and relating to discomfort.

The themes that have emerged throughout my practicum experience have changed the way that I have worked as a social work professional and student counsellor. Engaging in vulnerability and mindfulness not only enhanced my ability to connect theory and practice, it heightened my awareness to the potential ethical dilemmas that can result in a therapeutic setting.
Chapter Seven: Challenges and Ethical Considerations

This chapter will provide a detailed discussion of the challenges and ethical considerations that I encountered as they arose during the course of my practicum. These ethical considerations served as powerful learning experiences for me as they challenged the nature of my practice and my relationship to my work both in the Domestic Violence Unit and as a student counsellor in the Agency. The challenges I will be discussing include; boundaries and how I navigated boundary setting between my role in the Domestic Violence Unit and the Counselling Unit, how the shifting of my roles during the regular work week challenged me ethically, finding balance between work, practicum and my personal life and ethical considerations associated with balancing the power differentiation between client and therapist. Finally, I will be focusing on vicarious traumatization as an ethical consideration and potential hazard of working as a helping professional.

7.1 Boundaries

Holding a dual role at the Agency during the course of my practicum presented unique challenges as well as opportunities for learning and growth. The use of boundaries became something that I not only viewed as important, but became vital in my practice both in my role as a domestic violence worker, but also in the practicum setting. I did not anticipate that my dual roles would create unique challenges that quickly escalated into ethical dilemmas as a practitioner. I had several clients on my caseload in the Domestic Violence Unit who requested that they start seeing me for counselling as well as remaining on my domestic violence caseload. This presented an ethical dilemma for me as a practitioner as I could see where it would benefit my clients to offer them counselling as a complement to domestic violence services as I already
knew their background and symptoms. However, maintaining clear boundaries between my role as a domestic violence worker and as a student counsellor had to become top priority.

In speaking with my academic committee, FSR and my professional associate it was decided before starting my practicum that I would not cross over services offered to existing clients and take them on as counselling clients in order to maintain professional boundaries in my existing domestic violence role, and offer best practice to these clients. The SASW Standards of Practice for Registered Social Workers in Saskatchewan practice states that “a social worker shall be aware of the circumstances that may lead to, or be perceived as, a conflict of interest and shall make reasonable effort to avoid such conflict” (SASW, 2012b, pg.6).

I also had clients from my domestic violence caseload drop into walk-in counselling to see me in a counselling capacity and had the opposite as well where counselling clients started coming to the Wednesday night drop-in group which I facilitate and then wanted to see me as a domestic violence outreach worker as a complement to the counselling services I was offering them. I also had to be mindful in setting boundaries around the knowledge I had regarding individual’s history with domestic violence when I was in the counselling setting and the potential for cross over between clients I had worked with in a domestic violence capacity that were now referred for counselling.

The practice of mindfulness in both my student counselling role and my role in the Domestic Violence Unit, as well as setting strict boundaries, became vital in ensuring I was offering best practice to both sets of clients I was working with. Being compassionate and caring within the therapeutic relationship includes the ability to create appropriate boundaries (Dombo & Gray, 2013). I struggled with boundary setting when I first started my practicum as I wanted to ensure that I was offering what I perceived as seamless services to the clients I was working
with. However, I realized that putting boundaries in place allowed me to maintain integrity in professional practice and also assisted me in maintaining a balance between not only my work and practicum, but also my work life and personal life.

Rather than feeling a sense of professional and personal guilt around setting boundaries with clients and my work place, I came to a place of understanding that generosity and helping others cannot exist without boundaries. Boundaries are the key to self-love and sustaining treating others with loving kindness (Brown, 2015). Boundaries have also assisted in the ability to shift roles between the Domestic Violence Unit and being a student counsellor in a seamless and transparent way.

7.2 Shifting Roles

Working in a student counsellor capacity with a strong foundation in domestic violence services proved to be a challenge in that I had to consciously take off the domestic violence lens that I had grown accustomed to when not in the Domestic Violence Unit. I also had to be aware of the relationships that I had already formed at the Agency and the impact that could have from an ethical point of view when working with clients in a different capacity aside from that of a domestic violence outreach worker.

In order to preserve the therapeutic alliance, I had to practice mindfulness and completely separate myself from my work in the Domestic Violence Unit on the days I was counselling by working in a separate office located at the other end of the Agency building in the counselling unit, by accessing a different email address and using a different identifier on the caseworks computer system.

Maintaining boundaries while shifting roles between my role in the Domestic Violence Unit and the counselling unit was also important for my own self-care and wellbeing. Making the
decision to work full time while completing a practicum was a challenge that called me to the highest level of ethical consideration and the need to maintain boundaries, especially surrounding my role as a facilitator in the Domestic Violence Outreach Drop-In Group where I saw an overlap in my client caseload.

Time management was also an important part of shifting roles between my work in the domestic violence unit and my counselling practicum. I divided up my work and practicum time during the week, so time keeping was essential to ensure that I was not blurring my professional roles. This strategy was also helpful in my efforts to maintain personal and professional balance.

7.3 Balancing Power

As mentioned briefly above, when building a therapeutic alliance with a client, a clinician needs to be aware of the power imbalance that can become present in the role of the therapist versus the role of the client. As a therapist, recognizing that the client is the expert in their own lives and believing that they possess the capacity for deep and meaningful healing not only assists with the development of a deep therapeutic relationship, but also aids in the balancing of power between therapist and client. When a therapist is too eager and begins to work harder than the client, this in turn undermines the therapeutic process as it takes the pressure off the individual, making it far too easy for patterns of avoidance to continue to be unchecked, ultimately serving to disempower the client (Herman, 1992).

An ethical issue arose during my practicum regarding obtaining client consent to discuss therapy sessions with clients within this final paper. The decision was made to develop a client consent form (Appendix A) in order to use elements of therapeutic approaches from individual and couples therapy sessions. Being that this issue arose towards the end of my practicum, I had established a strong therapeutic alliance with the clients that I chose to approach to obtain
consent for information from their counselling sessions for use in my paper. The decision to obtain consent from my clients with an alliance already established made a lot of sense to me and I was met with a lot of support from the clients that I chose to ask. This spoke a great deal to me about the level of trust that was established with these clients. It did however strike me that I may not have had the same response from these clients if I would have asked for their consent during the first counselling session and assessment when I was outlining my role as a student counsellor.

Looking at this issue from a client perspective, having a level of trust with a counsellor before they request consent and permission to use information from counselling sessions in a paper (or for video recording purposes) can create a sense of ease that the counsellor has taken the time to deem whether or not it is appropriate to ask. The SASW Standards of Practice for Registered Social Workers in Saskatchewan states that “a social worker shall obtain written informed consent from a client before professional services provided to the client are observed by others or electronically recorded for academic, supervision, research, or consultation purposes” (SASW, 2012b, pg.6).

While it may be comfortable to have a therapeutic alliance established with a client before requesting information, it can raise an ethical issue from a therapist perspective. The question that challenged me in this area was; is it ethical to use the therapeutic alliance to the advantage of the student counsellor for the purpose of the completion of their schooling requirements? “When acting in a professional capacity, social workers place professional service before personal goals or advantage, and use their power and authority in disciplined and responsible ways that serve society” (CASW, 2005a, pg.5). Social workers are often invested in maintaining political neutrality and the social work vision to help and serve others well. We are
led to think in the dualistic conceptual frame of oppression versus anti-oppression, and bad versus good. When we are challenged to recognise our participation in systemic oppression despite our best intention, it is not surprising that a state of cognitive dissonance may result in some denial, resistance and even hostility (Ng, 1993).

7.4 Vicarious Traumatization

Finally, one of the largest risks to human services practitioners working with individuals who have experienced high levels of distress or complex trauma is the internalization of these issues and in turn beginning to exhibit some of the same symptoms of the clients that you are working with. Listening to clients’ traumas can produce symptoms of burnout, as well as secondary traumatic stress and vicarious traumatization (Bride, 2007).

The cumulative experience of this kind of empathetic engagement can have deleterious effects of clinicians, who may experience physical, emotional, and cognitive symptoms similar to those of their traumatized clients (Harrison & Westwood, 2009, pg.203).

When therapists and clinicians continue working, despite suffering from symptoms of vicarious traumatization they are doing a tremendous disservice to the clients they are working with and also to themselves and potentially the community as a whole (Harrison & Westwood, 2009). The Canadian Association of Social Workers states that social workers must adhere to value four of the Code of Ethics; competence in professional practice (2005a). Social workers have a professional obligation to be caring for themselves in a way that would demonstrate competence in practice and the ability to ensure no harm is done to a client in the process of engagement with the clinician. Vicarious traumatization is different from burnout and compassion fatigue, in that it is a layer on top of tiredness, desensitization, being overwhelmed.
and feeling a loss of motivation. We choose to pour our energy, passion, and time into work that is often filled with despair, hopelessness, fear, disconnection and chaos (Enns, 2016).

I came to understand the impacts of vicarious traumatization during the course of my practicum when I began to practice empathy and mindfulness in a more vulnerable way. One of the risks of choosing to be a practitioner that engages with people in a truly vulnerable manner is that it leaves an element of susceptibility to vicarious traumatization without the appropriate self-care and professional standards put into place. “Empathy is a choice, and it is a vulnerable choice because in order to connect with you, I have to connect with something in myself that knows that feeling” (Brown, 2015). There is also a difference between empathy and compassion as empathy may extend to the “taking on” of the pain of others (Dombo & Gray, 2013). We are often taught of the distinction of taking on the suffering of clients in terms of being present with the client but not taking on the suffering into our own bodies and feeling as the client feels. Compassion involves a trust in others’ resiliency and in their ability to heal themselves (Dombo & Gray, 2013). One of the most important lessons that I am taking away from my practicum is the recognition that individuals have the ability to heal themselves and that the practice of empathy and compassion with individuals is the “giving of the heart without giving away of one’s self” (Dombo & Gray, 2013, pg.97).

Maintaining clear boundaries and honouring one’s limitations as a practitioner is a vital part of curbing counter-transference and vicarious traumatization. Maintaining clear and consistent boundaries, maximizing professional limitations with clients, and holding realistic expectations for one’s self and others not only creates clarity in being able to distinguish between sympathy and empathy, but also in awareness for potential vicarious traumatization when it presents itself (Harrison & Westwood, 2009). Identification of the importance of self-care and
how that equates to being present in counselling with a client and being confident in your abilities and limitations is crucial for self-awareness and awareness of areas where one may be susceptible to vicarious traumatization.

Through critical reflection social workers and helping professionals can begin a dialogue to create and sustain awareness of the ethical issues that can arise both personally and professionally. I have learned that challenges are often the biggest opportunity for personal growth and working alongside other counsellors in the Agency to openly engage in collaboration around ethical issues was immensely helpful. Continuing to engage in open dialogue about the challenges that I faced as a student counsellor helped as well to recognize that critical reflection and collaboration with others are ongoing processes that will continue throughout my career as a social worker.
Chapter 8: Conclusion

This chapter concludes my experience as a practicum student at Family Service Regina. The chapter provides final comments; includes my future plans as a social work practitioner and general comments on the future of social work practice and how my practicum experience has impacted my future as a social worker and counsellor.

8.1 Implications for Future Social Work Practice

This practicum experience has been invaluable to my growth and development as a professional and as a future counsellor. I have a desire to continue in the area of clinical counselling with a focus on assisting individuals and families from a holistic, client centered perspective. I plan to continue professional development to continue adding to my “toolbox” of therapeutic approaches to meet the needs of the clients I work with.

I also have a desire to continue working from an anti-oppressive social work perspective and incorporating mindfulness and self-awareness to continue enhancing awareness around the role that oppression plays in all levels of social work practice. The practice of mindfulness will not only serve me in future clinical practice, but also in everyday life as I continue to balance career goals with family life.

My practicum experience at Family Service Regina has taught me the importance of vulnerability, self-awareness, boundaries and connection as a means of learning and growth. Through reflection and connecting with others who have served to mentor me in counselling skills and in life, I have grown considerably not only as a professional, but as a person. Learning to exercise professional boundaries has also been a skill that has helped me to develop the balancing act of work and practicum and called me to a high standard of both professionalism and self-care.

8.2 Final Comments and Recommendations
Building self-awareness and mindfulness into the educational structures of social work as a profession and recognizing that there is room within professional practice for mindfulness and vulnerability is crucial to begin creating space for dialogue. Critical reflection can create understanding and awareness of how dominant ideology and societal pressures can influence social work practice. Opening up this awareness can create space for dialogue, empathy and compassion for social justice issues and the individuals that we as social workers serve.

Social work as a profession, and Family Service Regina as an Agency, continue to believe in the dignity and respect of all individuals; and anti-oppressive social work more specifically serves to highlight the pursuit of social justice. Social workers often consider their practice to be politically neutral; however, social work organizations typically abhor oppression and injustice (Gil, 2013). Thus, I believe it is appropriate, regardless of the type of social work generally practiced within Family Service Regina as an Agency, to continue to challenge systemic sources of oppression and break down barriers that hinder healthy and strong families and communities.
References


77


Miller, S., Duncan, B., & Johnson, L. (2002). *SRS V.3.0: Session Rating Scale*. Institute For the


Appendix A

Client Consent Form

You have agreed to receive counselling support from a practicum student completing a Master’s of Social Work degree through the University of Regina. As part of the practicum, the student is required to submit a final report outlining and discussing knowledge and skills gained from the practicum experience.

The purpose of the final report is to discuss aspects of the student counsellor’s learning experience. This integrative report will reflect on practice and theory and will discuss skill development within the context of counselling sessions under supervision.

You are being asked permission to have elements of your counselling experience with this student counsellor included in the student’s final report. Elements included in the report will focus on information related to skill development and counselling process, and will not include identifying information that you decide to share as a client.

Confidentiality:

- To ensure confidentiality, clients will not be identified by name and identifying information will not be used in any portion of the final report or in drafts leading up to the completion of the final report. The final report will strive to highlight strengths of the client sessions and the counselling process.

Right to Withdraw:

- You have the right to agree/not agree to the inclusion of aforementioned elements of your work in counselling sessions into this final student report. The availability and quality of services provided to you will not be impacted by this decision.

- Should you change your mind and wish to withdraw information related to your situation from the report at a later date, you must contact the student by May 30, 2016. After this date, the information cannot be removed, as the final report will already be submitted for review and approval. The student can be contact by phone at: 306-757-6675.

- MSW student reports are posted on the University of Regina Library website within one year of degree completion.

SIGNED CONSENT

I have read and understand the information provided; I have had an opportunity to ask questions, and my questions have been answered. A copy of this Consent Form has been given to me for my records.

I, __________________________ give permission to
________________________________________

to incorporate elements of my counselling sessions with him/her, as a student counsellor during this practicum placement, into his/her final practicum report. I understand that this final report is submitted to the Faculty of Graduate Studies and Research at the University of Regina as required for completion of a
Master’s Degree in Social Work. I understand that a copy of this form will be placed in my Agency counselling file.

__________________________  ______________________
(Client’s signature)           (Date)

____________________________
(Student Counsellor’s Signature)

____________________________
(Witness)