A Clinical Counselling Experience at The Caring Place

A Practicum Report
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Abstract

This practicum report is a reflective review of my clinical placement as a University of Regina Master of Social Work student at The Caring Place, Regina, Saskatchewan. My learning goal was to gain foundational knowledge in counselling skills during a clinical practice focusing on narrative therapy and art therapy. The objectives of this clinical placement were to conduct a literature review of narrative therapy and art therapy as a form of counselling and link these connections to practice. My experiences that enhanced my learning from a practicum perspective included attending formal training on narrative therapy and then observing and practicing the techniques. The development of my learning objective is to gain knowledge in the method of art therapy consisting of observing and assisting in group practice, and using this form of therapy in private individual sessions. Other duties that helped to enhance my learning experience included facilitating a drop-in anxiety and depression support group and participating in staff and counsellor meetings. Overall, I acquired the majority of my experience through practicing counselling therapies, and managing a caseload of over thirty individual clients. The development of specific learning goals bridged with identified objectives guided my learning experience and exceeded my expectations by offering me several opportunities to practice and apply newly learned skills in a clinical counselling setting. This practicum placement has aided me to become a more experienced and resourceful counsellor by combining literature, theory and training with direct practice.
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Chapter One: Introduction

Counselling is an integral component of achieving and sustaining overall healthy wellbeing (Dryden, 2011). Everyone, at some point in their life, struggles with challenges such as divorce, loss of a loved one, overwhelming life stress, parenting difficulties, low self-worth, depression, and other emotional and mental health issues. Mental health illnesses are more common than one may realize. The Canadian Mental Health Association identifies one in five adults will be affected by a mental illness at some point in their lives. Most people, during different stages within their lives, could benefit from counselling services. (Canadian Mental Health Association, 2017). The opportunity to speak to a professional about situations that are hindering an individual’s ability to live their life to the fullest potential is of great worth. Furthermore, counselling can be valuable because it has proven to have positive and effective results such as the enhancement of an individual’s wellbeing. According to the Statistics Canada (2013) Canadian Community Health Survey, 67% of the respondents found mental health services beneficial. In addition, Hunsley, Elliott, and Therrian (2013) argue that extensive research identifies the effectiveness of therapy on an individual who may be suffering from a mental health illness and/or various social problems. Their research was conducted across the lifespan and contains hundreds of studies that include both controlled and randomized trials to examine the validity of evidenced-based treatment using clinical counselling methods.

Data from these studies are key to understanding and exploring potential impacts and assisting in developing ways to improve treatment for individuals. Furthermore, these studies were focused on mental illnesses such as anxiety, depression, generalized anxiety, and other related disorders. Hunsley, Elliott, and Therrian (2013) explain the effectiveness and efficacy
of psychotherapy depends on relevant factors such as the competency of the therapist and the proper diagnosis of the client being treated. When there is an inconsistency on either party, treatment may be hindered.

Throughout my professional career, I have conducted numerous counselling sessions, attended counsellor training, and collaborated with other counsellors and colleagues. All of these opportunities have allowed me to develop and increase my knowledge in the field of counselling. I witnessed growth and change in the clients I have worked with, both in my profession and throughout my practicum. I chose this profession based on my belief of its relevance and the impact that evidence based counselling can have on society as a whole. I am passionate about the profession of counselling and I am committed to the practice.

While in my practicum placement, I received feedback from clients articulating how the counselling sessions I conducted helped them improve their mental health and/or reduce their life problems. For example, I recall providing counselling for a client who identified she suffered from extreme anxiety, leaving her completely isolated much of the time. The symptoms she was having were so debilitating that she made three appointments for counselling and cancelled before she was able to get enough strength to leave her house to attend the counselling appointment. Over several sessions, I offered her support by listening and practiced narrative therapy to help her to reduce the symptoms she was experiencing. One of the first narrative therapy questions I asked her was, “Can you recall a time in your life when you were feeling these symptoms and describe what this felt like?” This first question opened her up to sharing many experiences where she felt debilitated by feelings that she referred to as “anxiety.” In her sessions we spent a lot of time talking about this. My next set of questions focused on asking her to share experiences in her life when she did not have these symptoms. My goal in talking
about times when she did not have these symptoms was to help her understand that the feelings
she was experiencing of “anxiety,” which to her might seem to be her whole life, are actually
only a small piece of who she is. Through exploring this part of her experiences, we came to
identify many of her strengths, abilities, and values. Together, the client and I were able to map
the connections to the symptoms she was having, while also connecting events, situations and
people who she felt eliminated these symptoms (Madigan, 2017). I supported her as she slowly
re-engaged in aspects of her life that she once enjoyed and now missed. At first, she was afraid
to expose herself to any situation for fear her symptoms would escalate. However, with support
and guidance she was able to start “living her life” as she explained it. She began to understand
that her fear of the symptoms was the key factor in keeping her isolated.

She was also able to disclose a traumatic moment in her life - the event that was the
trigger for the debilitating symptoms that had “stolen ten years” of her life. Once she gained
insight into the problem, she began to feel empowered as she slowly started to take chances she
never imagined she would do, like going back to work and visiting old friends. I remember her
thanking me for “giving her life back”. I responded to that by explaining to her that she took
her life back by seeking counselling, talking about her situation and taking chances, therefore this
was her accomplishment.

While there are various definitions for “counselling” throughout the literature, The
Canadian Counselling and Psychotherapy Association (2009) has published a list of definitions
defining counselling and therapy that encompass various geographic locations throughout
Canada including organizations such as Canadian Psychological Association, Canadian
Psychiatric Association, World Health Organization, and the Mayo Clinic, to list a few. Each
definition is similar but for the purpose of this report, I will define counselling using the
definition from the Canadian Mental Health Association. They describe counselling as a service provided by professionals including social workers, psychologists, and psychiatrists who practice various forms of psychotherapy. Treatment for a problem includes talking to a trained professional who can help an individual solve or reduce a problem by assisting the individual in developing ways to have more thoughts and feelings that are positive. Currently there are various theories and techniques practiced that are considered to be effective psychotherapy. Varieties of theories of counselling are used in both individual and group formats. Ultimately, counselling refers to services provided by trained professionals who use various theories, skills, and resources to aid clients to restructure thoughts, feelings and/or behaviours so they can live more harmonious lives.

The purpose of this report is to provide a critical reflection of my field practicum experience as part of the final component for completion of a Master’s Degree in Social Work. My past work experience includes a significant number of years in social work settings in non-profit and government organizations. My most recent experience includes working in a post-secondary institution teaching classes; and currently I am an educational counsellor. Through my professional journey, I maintained the expectation of furthering my counselling skills and gaining an in-depth experience in clinical counselling. While I have several years of experience working within a counselling setting, I have not had the opportunity to work in private practice. Therefore, I was interested in a practicum placement in this area.

This report will articulate my personal reflections, experiences and observations of narrative therapy and art therapy utilized for the duration of my practicum placement. The literature review will describe narrative therapy and art therapy, while linking other theories and ideologies used in connection with these approaches. Additionally, this report will note my
personal experiences, observations, insights, ethical dilemmas, and identify theoretical links to social work practice. Lastly, I will write this report from the viewpoint of a student learning and experiencing the role of a supervised counsellor in a private practice for a non-profit organization.

1.1 Rational for Practicum

When I began the journey of pursuing my Master of Social Work (MSW) degree, my core objective was to advance my skills and competencies as a clinical counsellor. I hoped to do so by gaining significant experience in the field of counselling; therefore, I searched for a practicum placement to meet this need. I was surprised to learn while searching for a practicum placement that in Regina, Saskatchewan, that it is a very competitive environment. I discovered that not only did I need to find a practicum placement, but I also needed to find an agency that coincided with my academic needs and I needed to demonstrate why I would potentially be an asset to that agency. In addition to this, many agencies had long waiting lists of MSW students wanting to complete a practicum placement. As a practicum student, I had to understand the requirements of the process. After a considerable amount of time was spent researching possible practicum placements, I discovered The Caring Place. I appreciated this counselling organization for many reasons. The most significant reason was The Caring Place is a non-profit organization. A non-profit organization refers to a legal entity that is separate from its members. A non-profit organization is developed for the purpose of serving the community by the means of providing various services. These types of organizations do not take profits for financial gain. As such, a non-profit organization is formed for the purpose other than to make a profit to be dispersed to its members. A profit can be made, but it must be used to enhance the goals of the agency and not for wealth (Corporation Center Canada, 2017).
Another reason The Caring Place appealed to me was that, unlike similar counselling agencies, it follows a different vision in terms of the financial cost for clients. Their financial expectation of clients encompasses all financial backgrounds because they choose to provide services on a financial sliding scale. As such, their goal is to be inclusive of everyone and provide services to people of all socio-economic backgrounds. Counselling services are often expensive - a large percentage of society may be negatively impacted financially when accessing these services. In addition, many individuals and families will not be able to benefit from counselling services because of financial barriers (Carniol, 2000). Some financial barriers are significant enough to cause marginalization, and one of these top factors is poverty. Other factors include disabilities, addictions, lack of and access to services, housing, discrimination, and others (Dominelli, 2002).

I believe that every person should be able to seek counselling when in need. As a non-profit organization, The Caring Place staff work tirelessly to fundraise so that they can engage community support in order to provide counselling services. I respect and recognize the efforts of this organization in bridging the gaps to provide counselling services for their community. Upon meeting the staff and learning more about the organization, I knew that my values of respect, my desire for social justice, and my commitment to provide caring and supportive counselling services aligned with their values.

1.2 The Agency Overview

The Caring Place was established in 1991 and serves persons from a wide variety of backgrounds, ethnicities, religions, cultures, and sexual orientations. The Caring Place’s mission is to provide a place of safety and trust where people of all ages can find a caring professional to help them successfully deal with personal issues, mental health challenges and
addictions.

The goals of The Caring Place include:

1. To help all persons realize that they do not need to struggle with loneliness, depression, grief, addictions, and other issues alone. There is always a way back to purpose, passion, and joy. The staff are there to walk beside you in this journey.

2. To increase awareness of the services of The Caring Place and their partner organizations.

3. To educate the public on mental illness so that all persons can experience increased support in their workplace, community, and homes (G. Friedrich, personal communication, Regina, SK. November 5, 2017).

The agency provides services to all persons while recognizing the importance of the Christian faith and strive to model the highest principles of caring and empowerment. The Caring Place has partnerships with a variety of organizations. Some of the churches in partnership with The Caring Place include: Regina Apostolic, Prairie View Community Church, First Baptist Church, St. Luke Anglican Church, and Gateway Christian Fellowship. The agency has counsellors who are approved through employee assistance programs (EAP) (e.g. Homewood Health, Shepell, Solareh, Aspira). The Caring Place provides teaching opportunities for many students through the means of practicums and internships. Some of the schools partnered with The Caring Place include: schools offering marriage and family therapy programs, the Faculty of Social Work at the University of Regina, schools offering the clinical psychology program (Briecrest Seminary, Providence University, College of Manitoba, Yorkville University, University of Regina Educational Psychology). Other organizations
partnered with The Caring Place include: Regina Alternative Measures Program (RAMP), the Saskatchewan Ministry of Social Services, The Regina Open Door Society, The Regina Qu’Appelle Health Region, and Regina Police Services. The Caring Place has developed the practice of accepting practicum students as a way to both give back to the community and engage as a teaching outlet for professionals. This agency also offers counselling services online (e.g. via Skype or video conferencing) in-person, and by telephone when required. All possible steps are taken to ensure the agency is meeting the needs of its clientele (G. Friedrich, personal communication, Regina, SK. November 5, 2017).

Ultimately, The Caring Place offers counselling services to individuals, couples, families, and groups. Services are offered to anyone dealing with personal issues including, but not limited to, marriage and family matters, abuse, trauma, self-esteem issues, grief, crisis, depression, anxiety, conflict resolution, gender issues, pre-marital counselling, sexual harassment, and childhood issues (such as attachment disorder, abuse, trauma, family conflicts, bereavement, etc.). The agency also offers a free drop-in group for adults specifically affected by anxiety and/or depression. Furthermore, artist expression groups are offered for individuals struggling with various difficulties, such as survivors of sexual assault as well as issues experienced by new immigrants to Canada (G. Friedrich, personal communication, Regina, SK. November 5, 2017).

The environment of the Caring Place provides a place of safety and trust where people of all ages from young children to seniors, can develop a relationship with a caring professional. This relationship provides the opportunity to engage the client and successfully manage their personal issues. It also offers counselling services on a financial sliding scale so that more individuals can access support rather than only individuals who have healthcare insurance and/or
are financially capable of paying the full fees. The Caring Place staff structure includes an executive director, ten members of a board of directors, seven counsellors, and one therapist serving as the director of counsellor services and the supervision of student practicum placements. The executive director is responsible for helping the team establish a vision, creating opportunities to realize the vision, working with the board of directors and staff to develop a fund raising strategy that strengthens the organization, and creating leadership, training, and growth opportunities for all staff. The Caring Place has five full-time counsellors and two part-time counsellors. On average, these counsellors provide 5000 counselling hours per year, which equals to about 2000 individual clients served. In addition, an average of 500 intakes are completed each year. Each counsellor typically has 30 to 50 clients on their caseload at any given time (G. Friedrich, personal communication, Regina, SK. November 5, 2017). The Caring Place is open six days a week including evening hours. Counsellors can be available outside of the office hours to ensure they are accessible to their clients’ needs and schedules.

The counsellors specialize in a number of areas such as depression, anxiety, grief, childhood sexual abuse, addictions, relationship issues, post-traumatic stress disorder and other mental health illnesses. Some of the counselling therapies used at The Caring Place include, but are not limited to: cognitive behavioral therapy, solution focused therapy, emotion focused therapy, eye movement integration therapy, narrative therapy, and art therapy. The counsellors receive professional development training on a monthly basis from the counselling supervisor. As well, the counsellors receive a quarter of an hour of administrative time for each counselling session they provide; this time can be used for administrative work, provide presentations for The Caring Place in order to raise awareness about mental health, and to attend training opportunities,
workshops, and professional development conferences. All counsellors are required to have or be working toward a graduate degree in the field of counselling or social work, and be certified as a Certified Professional Counsellor or with the Professional Association of Christian Counsellors and Psychotherapists (G. Friedrich, personal communication, Regina, SK. November 5, 2017).

The Caring Place developed a five-year strategic plan and is currently in year three of that plan. The first of four pillars in their strategic plan includes increasing strategic partners. One way the agency undertook to achieve this goal was their September 2017 Connect Street Fair. It was enormously successful with three thousand attendees. Many mental health organizations were invited to attend and participate and share information about their programs and services in an innovative and fun environment. Over forty different organizations participated in this event. The second pillar of the strategic plan is to increase financial stability. Therefore, the agency is creating a new business plan. The third pillar is to develop new programs and services. Some of the newly added programs include an artistic expression group called “Surviving Childhood Sexual Abuse Together” (a support journey for couples). Soon-to-be-offered programs include an Art and Chat group, and music therapy. Lastly, the fourth pillar is to increase diversity of staff training while supporting environmental and internet technology infrastructure. Overall, The Caring Place is constantly at work ensuring the organization is running at its full potential, while adding new services and developing plans to confirm they are providing the best services possible to meet the needs of their clients (G. Friedrich, personal communication, Regina, SK. November 5, 2017).

The initial meeting with a client is a free thirty-minute session with a counsellor to help determine their needs, identify the issue/issues, and provide the client with time to ensure their
questions are answered. The free intake session is an important part of the process of accessing counselling services at this agency as counsellors are building rapport and can provide services immediately such as suicide intervention and crisis counselling (Miller, 2012).

Though it was my frequent observation which was also reinforced from several clients, I noted it was common for a client to arrive to the intake sessions at an extremely low point in their lives. Clients displayed behaviours and expressed emotions of feeling uncomfortable, shy, and nervous. In general, the ability to meet the counsellor and to become familiar with The Caring Place helped ease the process and reduced the resistance or anxiety associated with seeing a counsellor or therapist. In many intake sessions, I witnessed clients express how relieved they were now that they had met me and came to the agency. They expressed a sense of comfort in knowing what to expect from the process.

1.3 Practicum Learning Objectives

With respect to my planned practicum objectives, my key learning aspiration was to expand and strengthen my counselling abilities by acquiring new skills and obtaining experience in clinical practice.

Specifically, my learning goal was to:

- Gain foundational knowledge in counselling skills in clinical practice, focusing specifically on narrative therapy work with individuals and art therapy for group work with individuals with diverse needs.

Additionally, my proposed practicum learning objectives were:

- Observing counselling sessions conducted by my professional associate,

- Observing art therapy groups sessions conducted by colleagues at The Caring Place, and

- Discussing sessions with my professional associate and linking the observations to the
Throughout my practicum, I was able to apply newly-learned skills, insights, and observations to enhance my professional development in a clinical counselling setting, while specifically focusing on learning about narrative therapy and art therapy.

Learning about the use and practicing narrative therapy and art therapy appeared to be a natural fit with my field practicum objectives. The experience to practice narrative therapy and art therapy in my practicum placement at The Caring Place also allowed me to broaden my abilities and expand my proficiencies as a counsellor. During this practicum, I was able to facilitate an ongoing open support group. I wanted to be able to observe counsellors in practice using various theoretical approaches to counselling, as well as, to challenge myself to grow by discussing my ideas, thoughts and questions with the counsellors while linking social work practice to the literature.

The proposed activities I planned to perform to meet my learning objectives included:

- Observing and assisting in an art therapy group for individuals with diverse needs.
- Observing and assisting in a weekly drop-in counselling group for individuals dealing with anxiety and/or depression.
- Observing and then practicing narrative therapy with four to six clients.
- Participating in weekly staff meetings and weekly counsellor case study meetings.

In collaboration with my learning goals, I will now discuss my experiences co-facilitating the art therapy sessions.

One of my practicum duties was to co-facilitate an eight-week art therapy group for new immigrants to Canada. This group developed to assist immigrants to deal with various emotions and challenges specific to residing in a foreign country and to address feelings of
loneliness and estrangement. My role in this group was to observe, assist, and facilitate weekly sessions. I was fortunate to work with a counsellor trained in art therapy and who has a passion for this form of counselling. In addition, he had a great deal of experience offering these types of groups. Some of the art therapy groups offered included adult couples who are survivors of child sexual abuse, and immigrants to Canada who are experiencing various challenges related to living in a new country. The art therapy sessions were located in the basement of The Caring Place. This space is designed specifically for art therapy and is equipped with various resources such as paint, canvases, paint easels, brushes, wood supplies, tools, markers, art paper, to name a few. These supplies facilitated different forms of art creation. There was also a library of literature on art therapy, and a large long table situated in the middle of the room so the group could sit together and complete their art projects. In addition, painted artwork and various types of art projects were displayed around the room. The room was set up as a safe place for individuals to explore themselves through various means of art creation while allowing for insight and reflection.

I found the art room intriguing and overwhelming. However, the more I learned about it the more I wanted to expand my knowledge in art therapy. I recall wondering about an item in the room that was a wooden object called “The Chest of Drawers”. The facilitator explained this was a project completed in one of the previously offered groups. The participants who were survivors of sexual assault made a wooden chest of drawers and chose what they would place in the drawers and what they would want to release from the drawers. The drawers were used as a metaphor for survivors of sexual assault. Through this activity, the individual is potentially able to free themselves from the secrets and the pain of sexual assault.

This section included a brief description of the art therapy program, during which I
briefly explained resources used and I listed some of the activities used within the group sessions. The next section briefly explains my experience during my practicum involving my participation in the training workshop for narrative therapy and how I applied these newly learned skills in practice.

I attended a three-day workshop on narrative therapy during which I learned applicable theory and techniques to practice in counselling sessions. I observed my professional associate practice narrative therapy. Later, I conducted several counselling sessions using narrative therapy and managed my own caseload.

Throughout the duration of my practicum placement, I applied recently learned skills in narrative therapy and art therapy methodologies. These skills included the use of art as an intervention framework where individuals come together for a common experience to create art. It is through this process that individuals are able to express emotions which promote healing. The process also encourages clients to relate their narrative and build on strengths and support. In turn, clients are able to identify their unique outcomes or times in their lives when the problem they are currently struggling with was not present (Malchiodi, 2012; White, 2007).

I quickly came to realize both forms of counselling, narrative therapy and art therapy, could be integrated into individual counselling sessions. Other duties I performed that helped to develop my counselling skills included facilitating a weekly drop-in group for clients dealing with anxiety and/or depression. In addition, I participated in weekly staff meetings and attending weekly counsellor meetings where I shared my experiences using these approaches. Counsellor meetings provided several opportunities to obtain feedback, direction and support from the counselling staff. I also completed numerous intake sessions, which included assessment of the client problems, client referral to the appropriate counsellor, and provided
immediate crisis counselling as necessary. All of these experiences illustrate the roles I assumed at The Caring Place to assist with my learning and my development as a counsellor.

The Caring Place not only supports its clients; it also supports its staff. As such, it recognizes the importance of a counsellor’s emotional and physical well-being and demonstrates this through the center’s daily routine. The staff come together weekly to pray as a team. They also choose a verse or two from the Bible and reflect on how they can incorporate that into their personal lives and in the agency. It was my observation that every staff member believes in the mission of The Caring Place by showing respect and care for all individuals. However, clients do not have to be affiliated with any particular religious denomination and they do not have to believe in any faith to seek counselling at The Caring Place. A client can choose to have faith-based counselling. Faith-based counselling works on the premise of the combination of psychology and faith (one’s religious beliefs). This type of counselling can include counsellors incorporating religious scripture in the session to help guide the client through challenging life issues while respecting the client’s faith (McClure, 2011).

It is through these opportunities I learned about narrative therapy and art therapy for counselling purposes. I expanded my knowledge and skills through group work. In all of these experiences, I gained more insight and knowledge as a counsellor. All of these situations helped to enrich my learning experience.

While learning objectives and personal reflection are essential to a practicum experience, a literature review of current counselling theories and practices is essential to any practicum experience. The focus and analysis of the literature review in this report is on narrative therapy and art therapy as well as solution focused therapy, that can be integrated with both narrative and art therapy. In addition, the literature review will also include a description of postmodern theory.
which provides a theoretical base for these therapies; as well as a description of counselling ideology which supports a combined methods or integrated approach to counselling.
Chapter Two:  Theory and Ideology

2.1 Narrative Therapy

Narrative therapy is a modern form of psychotherapy that seeks to help people find meaning in their lived experiences while identifying their values, skills, and knowledge. Michael White and David Epston co-created narrative therapy; and turned to the post-structural theories while moving away from the mainstream widespread theories of individualism, which includes many psychological and psychiatric models (White, 2007; Madigan, 2011). Narrative therapy is a modern form of therapy in comparison to many forms of therapy used in counselling practice. During the 1970’s and into the 1980’s, White and Epston developed this form of therapy and it was officially founded in 1989. Ultimately, post-structuralism theories provided a foundation for narrative therapy (Madigan, 2011). Post-structuralism examines how meaning is constructed through language. It is language that shapes an individual’s understanding of the world. In addition, discourses (also known as stories or views of the world) influence how individuals view the world around them. Post-structuralism looks at how these discourses come to be and how they are given meaning, believing that views can be changed by the way one thinks (Castree, Kitchin, & Rogers, 2013).

Epston (2008) and White (2007) turned away from all theories that referred to individualism - believing that the self is not individual but rather formed through the culture and the world around it. Consequently, relationships have an important impact on the development of identity and how individuals view themselves. These constructs are defined as relational; therefore, the relationships individuals have to knowledge, inequalities, and power have a vast influence on the problem an individual is experiencing. Moreover, narrative ideology claims it is impossible to separate the world around the individual from the individual. According to this
ideology, the idea of “self” is perceived differently than how mainstream psychology views the “self”. Narrative therapy does not delineate the biological idea of “self” but rather focuses on a picture of the world around the “self”. As part of this perspective, narrative therapy is concerned with questioning the politics of the making of an identity and who has the rights to the stories that are told (Madigan, 2011; White 2007; Kottler, 2015; White & Epston 1990).

According to Stephen Madigan (2017) when a client comes to see a narrative therapy counsellor, the counsellor is not interested in the cause of the problem nor the cure. Additionally, narrative therapists do not focus on diagnoses; believing that focusing on a diagnosis and labels does not help the client and instead incites the client to the labels. The problem is not located in the individual contrary to the medical model, but rather is viewed as separate to the individual. Various professionals such as psychologists, psychiatrists, medical physicians, and other professionals use the medical model of disability for diagnosis, prognosis, procedures and treatment of the illness. In reference to psychology, this term identifies abnormal behaviour because of physical problems and needs to be medically treated. The traditional medical model approach is to diagnose and provide treatment for the defect or dysfunction (Harris & White, 2013). The medical model does not reflect that individuals have many strengths, abilities, beliefs, and competencies that can change their relationship with their current problems and issues (White, 2007).

White and Epston (1990) believe that if a client can change how he/she views the problem, he/she can change how the problem is impacting his/her life. For example, if clients have multiple stories identifying that they do not belong in their social environment, then the clients are likely going to believe they do not belong. The practice of narrative therapy would support the client by drawing on stories where they do belong, questioning how they came to
understand that they do not belong, and consequently shifting the client to living their newly authored stories of belonging (Mehl-Madrowna, 2010; Madigan 2011).

Therapists hold a crucial role and are entrusted with immense responsibility when providing counselling to clients. When a client seeks help it is often a moment in an individual’s life when they can no longer manage a problem. Alternatively, a client may be in a stage of crisis. Typically, this is the point at which clients seek counselling services. Using their theoretical knowledge and practical skills, counsellors focus on addressing the problem in cooperation with the client in an effort to reduce the problem and help the client develop strategies for solutions (Hays, 2013). Narrative therapy views problems as only a part of the whole person, emphasizing Freeman’s ideas by identifying that the primary focus of a narrative approach in counselling includes the significance of peoples’ expressions of their lived experiences (Freeman, 2011). The expressions of the client’s environment supply meaning to their experiences. Furthermore, expressions always have a cultural context, it is through expressions that people shape and re-shape their lives. Freeman (2011) states that the cultural context can include various factors such as race, gender, sexual orientation, disabilities, ethnicity, language, and social class. Therefore, expanding on cultural context in narrative practice is an important part of healing. Stories shared by the client help the counsellor to understand the cultural context of clients’ narratives and how this influences perception and provides insight into the client’s problem. Practicing effective therapy, practitioners must be competent in understanding how cultural context is embodied in clients’ stories. When clients are expressing their narratives, they always have a cultural context and are influenced by the knowledge of life that is culturally determined (White, 2007; Madigan, 2011; Freeman, 2011).

It is important not to disregard the cultural relationship and the cultural connection the
client has with his/her community. When this connection is overlooked, it is impossible to separate the person from the problem. Discourses are the systems’ institutional ways of speaking (Madigan, 2011). Language discourses support the structure of power and privilege, allowing many groups to be oppressed by them. Power of the dominant culture creates the opportunity for individuals to internalize messages from the dominant discourse, thus forming their identities from these messages. Adopting a postmodern, narrative and social-constructive view exposes how power and knowledge are negotiated in social and cultural contexts (Freedman & Combs, 1996). Post-modern approaches argue there are multiple realities, multiple truths, and reject the idea that reality is external. These approaches in counselling avoid pathologizing the client, avoid making a diagnosis, avoid locating an underlying problem and place high priority on the client’s strengthens and abilities (Choate, 2008; White 2007). Stories of individuals’ lives are enriched with history and this cannot be left out or disregarded when considering whom this individual is and what problem or problems they currently face. Madigan (2011) explains

…we are historical beings, living out of traditions that have been bequeathed to us by others. And although we may be taking up traditions in many different ways, they are still the source of who we are and how we shape our lives. The echoes of history are inadvertently and deliberately inviting us into both past and new ways of being present. We live in a world that recedes into the past and extends into the future, so rather than pitting ourselves against history, we need to remember, recollect and recall it. (p. 64) Epston, (2008) Madigan, (2011) and White, (2007) explain that all action is influenced by the cultural world around us. Therefore, even the practice of narrative therapy cannot be neutral. If we cannot be neutral, then we need to be curious about how these discourse communities
influence the therapeutic view and affect the therapeutic practice. Moreover, cultural traditions supported through social systems impact and influence practice. For example, in the medical model, a client who views herself as worthless may be treated through the medical model of disability, specifically The Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM V), with a possible diagnosis of depression or other various mental health diagnoses specific to have symptoms of worthlessness. Treatment for this symptom could include attendance at self-esteem empowerment groups. In contrast, narrative practice would involve a different approach; the therapist would likely want to know more about this client’s story and ask narrative questions which may include: inquiring about when he/she began to feel worthless; what worthless looks like for he/she; and times in his/her life when he/she did not feel worthless. In narrative practice mapping the connections to the problem are more important than the problem itself. In various psychotherapy approaches the “why” is not explored. Symptoms are explained and a diagnosis is given and treatment follows (White & Epston, 1990; Madigan, 2011; Kottler, 2015). However… “a narrative therapist might inquire about the relational and interactional means through which this person came to know herself or himself in this less-than-worthy way” (Madigan, 2011, p.53). Exploring the narrative questions gives depth to the client’s problem, while it helps both the client and therapist gain insight to his/her views; and how the problem came to be. Through narrative practice, the therapist is able to help the client make new meaning and new possibilities from re-authoring their story rather than augment meaning and understanding through preconceived imposed theory of importance and values. In addition, the ideology of listening to a client without judgement, blame, or labelling is important. This practice is consistent with feminist theory and social work practice (Choate, 2008). Feminist therapy also puts power at the core of the practice, building on the premise that it is
imperative to consider that both culture and social context can contribute to a problem, as well as, to help understand the client. Feminist theory also examines the client’s lived experiences and views problems in a socio-political and cultural context rather than an individual one (Hutchinson & Hutchinson, 2015). Unlike the medical model, the practice of narrative therapy strays away from labels while focusing on the individual’s experience without judgment or preconceived notions of what is best for the client. This approach leaves the expertise to the client himself/herself, believing that it is in fact only the client that truly knows what is best. The power of stories told about an individual, especially from the dominant culture, can have a very powerful and negative effect on how that person view’s himself/herself and the problem he/she has that is affecting his/her life (White, 2007).

Dominelli (2002) suggests that in traditional psychotherapy, there is an unequal balance of power that exists within the client-therapist relationship. This is turn, sets a context for a dynamic of power over the client rather than an equalitarian relationship. As a result, a dominant discourse is reinforced. The expert who is the therapist provides traditional therapy to the client; the therapist is seen as having expert knowledge and therefore, knows best what the client needs, what is the problem and what the treatment plan should be (Madigan 2011). Narrative therapy challenges this conventional dynamic by working to create an equal relationship between the therapist and client or a partnership between the two.

This equal relationship is achieved in various ways. First, the therapist does not diagnose or label the client; the therapeutic relationship is set up for the client to tell his or her story. The therapist asks carefully crafted questions. These questions aid the client to externalize the problem while the therapist seeks to identify unique outcomes. Finally, re-authoring is developed, during this stage, the client begins to live their newly re-authored
narrative, in which the problem is reduced or eliminated (Madigan, 2011; White, 2007). By re-authoring conversations, clients are invited to do what they normally do, which is linking events in their lives that have meaning and connection (White, 2005, Madigan 2017). A collaborative approach is established with a special focus on the client’s story or stories while the therapist is searching for unique outcomes or alternative stories. Mehl-Madrowska (2010) defines the narrative approach to involve a shift in focus from most traditional theories of therapy. A collective system is established between the client and therapist, and through this process, a special focus is given to the client as he/she tells his/her story/stories. During this process, the therapist is diligently searching for key moments or points in the story telling that reveal evidence contrary to the story being told.

White (2007) explains these portions of a client’s story are referred to as unique outcomes or alternatives to the story. Specially crafted questions are designed by the therapist to assist the client in identifying unique outcomes (times when the problem story is not dominant and/or is reduced or eliminated, and a person’s strengths, attributes, abilities and skills are dominant, resulting in new meaning in their narrative). Questions are important to engage the client, to facilitate and explore, and to avoid diagnosing or labelling the client. The therapist assists the client in mapping the influence of the problem in their life, while separating the client from the problem story. The problem story is often deeply rooted in the client’s thoughts and beliefs. Externalizing the problem helps the client to be able to re-author a new story that can become the dominant story; and thus reduces or abolishes the dominant problem story (Madigan, 2011; White 2007).

Relational externalizing conversation establishes the context where clients experience themselves separate from the problem. Since stories shape an individual’s reality, they
therefore become the individual’s truth, through social and cultural contexts. It is through this process that the client does not assume the role of the pathological victim, but rather the individual emerges as courageous victor who has enriched dominant stories to recount. Through the re-authoring, change begins to happen and this advances empowerment. This process is unique to counselling, as the majority of counselling theory views the person and the problem as one (White, 2007; Morgan, 2000). Madigan (2011) explains that one of the differences in narrative therapy in comparison to most psychotherapy theories is that a narrative counsellor will never assume he or she knows more about the client’s life than they do. The client is the primary interpreter of his or her life stories and experiences; the client is viewed as an active agent who can create meaning out of his or her own lived experiences. Change is never directed by the therapist but rather identified by the client. This concept can be difficult for new therapists to grasp.

2.2 Solution Focused Therapy

Many of the principles of solution focused therapy are similar in both art therapy and narrative therapy and these forms of counselling can be integrated together. Solution focused therapy was derived out of brief family therapy in the late 1980’s (Lipchik, 2002). This type of counselling focuses on solutions rather than problems the client is facing. This model of counselling helps individuals to achieve their preferred outcomes while co-constructing solutions to the problems they are facing. This model chooses to focus on the here and now and identifies clear and specific attainable goals in an achievable time frame.

It is important to note that the relationship between the therapist and the client is imperative to the success of the session. Solution focused therapists believe it is not beneficial to focus on early experiences and past history that may be causing negative symptoms for the
client. Ultimately, counsellors who focus on past historical traumatic events can create a prolonged need for counselling services (O’Connell, 2012).

Hoyt (2009) explains this form of therapy differs from traditional therapies by avoiding the past in favour of both the present and the future. It is focused on what is possible now and there is little to no interest in gaining insight into understanding the problem. This ideology suggests it is not necessary to know the cause of a problem to solve it. Thus, gathering information about the problem is not necessary for the individual to change. In this model clients choose the goals they wish to accomplish and very little or no attention is given to diagnosis. This therapy is grounded on the assumption that individuals are both healthy and competent; and they carry the necessary attributes to construct solutions that improve their lives. The role of the therapist is to help the client identify and acknowledge their competencies. A solution focused therapy approach creates a dynamic whereby clients with the guidance of their counsellor, can find meaningful solutions to their problems while focusing on exceptions to the problems (Connie & Metcalf, 2009). Solution focused therapy believes that the cause of symptoms the client is currently experiencing are specifically related to the negative thoughts they have about the problem; that they can get stuck on reasons for the problem; and lastly, that they are not able to find exceptions to the problem (O’Connell, 2012).

There are some guidelines to use when practising solution focused therapy (O’Connell, 2012). The therapist should find out what the client wants to achieve in the session while being mindful of importance of the client-counsellor relationship. Secondly, the counsellor should not look for pathology nor should they diagnose or assign a label to a client’s problem. Thirdly it is important to confirm what is not working for the client and then the counsellor can gently encourage the individual in a different direction. And lastly, it is important for the counsellor to
see each session as it could be the last one. The ultimate goal in each counselling session is to find exceptions to the problem and guide the client to solutions (Lipchik, 2002).

The next portion of this report will link how narrative therapy and solution focused therapy can be integrated with art therapy.

2.3 Art Therapy

Art therapy can be used in many forms of art, for example, both creative and expressive art. It can involve painting, drawing, photography, sculpting, dance, music, drama and digital art, to name a few forms of art. People have been using art to express themselves since the beginning of time. Historically, the form of art was used to express emotion and creativity. It is not only practical but also effective to use this mode of expression in application with counselling practices. The creation and interpretation of art for the purposes of counselling can help assist individuals to express themselves when words cannot; and therefore this can aid in personal growth and emotional healing (McNiff, 1986; Rubin, 2011). Regardless of art’s existence as a longstanding mode of communication and creative expression, this form of therapy was not truly recognized until thousands of years later. Once discovered it continues to grow and evolve as research continues to understand the benefits (Rubin, 2011). Art therapy is a method used in counselling practice that can enhance additional opportunity for the client to heal because it serves many purposes such as to assist the client to gain deeper insight into herself; and it can also be used alone or in combination with other forms of therapy.

Malchiodi (2012) states,

Choice and change in counseling are the results of clients’ consideration of aspects of life that, heretofore, have gone unnoticed. Art serves as both a catalyst and a conduit for understanding oneself in a larger world context. It does so through stirring up and
opening up possibilities. Thus through affect and awareness, the use of art in counseling creates possibilities and broadens horizons so that the world becomes ever new and the view of what can be, if worked on, becomes what is. (p. 272-273)

Despite the existence of art being ancient, the idea of using art as a form of therapy and being used in counselling practice only commenced around the 1970’s. The use of art as a creative expression to improve one’s emotional, physical and/or mental wellbeing was first established at the Leslie College Graduate School in Cambridge, Massachusetts (Knill, Levine, & Levine, 2005). Paolo Knill, a leader in using art as therapy, was employed at this school. He eventually founded the International Network of Expressive Arts Therapy Training Centers. It was during this time that art therapy began to be recognized as a distinct practice. It has continued to grow, becoming a largely recognized form of therapy used by various professions today (Knill et al., 2005).

McNiff (2004) explains the process of healing belongs to the realm of spirituality, which is different from clinical treatment; as this is much more technical, and is strongly guided by the professional. He states, “Our culture had lost the ancient insights of Socrates who chided Charmides for trying to heal the body without first engaging the soul” (p.1). When treating a person, alleviating the soul can be an important part to the treatment. A person’s soul is their spiritual being which can include spiritually and/or religious beliefs. It can be therapeutic and beneficial to be aware and comfortable with the client’s spiritual being when considering treatment (McClure, 2011). Holistic treatment, therapy and/or counselling includes the whole self, mind, body, and soul and it is essential to understand the need to treat all of these components to achieve healing benefits. Generally, traditional psychotherapy does not include the person’s soul as a part of the whole self but art therapy can include this aspect (Knill et al.,
Malchiodi (2012) identifies using art as a form of therapy and counselling are in fact effective, with all individuals from child to adult, coupled with more and more professionals such as counsellors, psychologists, psychiatrists and social workers using the form of expressive art to increase emotional wellness. Throughout the field of counselling there is increased pressure to complete sessions quicker, reduce the number of sessions less, with fewer visits because of various reasons such as staff limitations and restraints in budgets/funding resources. Clients can also be limited with time and the amount they can financially spend on counselling because of insurance thresholds or financial restraints, etc. (Miller, 2012). Art therapy can be a useful way to address these problems because benefits from art therapy can be seen in just one session, and the client can continue to use art for therapeutic benefits on their own if they choose to do so. The American Art Therapy Association (2009) identifies that the making of art is healing and life enhancing. Thus, art as form of therapy can be a valuable resource when providing counselling.

Art therapy is used for a wide range of problems such as chronic illness, anxiety, depression, addictions, mental and emotional problems, relationship issues, abuse, social and emotional difficulties, trauma, grief, physical, cognitive, neurological and psychosocial issues, etc (McNiff, 1992). Additionally, this form of therapy can be used with all demographic ages, from children to the elderly. Furthermore, it can be used when language is not possible or restricted. Artistic expression is used as a modality for the client to express herself and connect emotionally to what she is feeling and thinking. Through the making of art, individuals are able to gain insight and a deeper understanding for self-awareness and express or release emotions. Creating art allows the person to tell a story and connect to their narrative (Malchiodi, 2012). Art can be used to articulate emotions that words cannot express, or reach to emotional
communication when a person does not have the verbal ability to connect their words with emotions. Moreover, using art can not only provide recovering therapy to individuals, but it can be the most realistic mode of communicating at a deeper level. McNiff (2004) explains this form of counselling has been used for non-verbal children, youth and adults, in addition, it has been effective for people diagnosed with disorders and illnesses that may influence their ability to express themselves verbally, such as an individuals diagnosed with autism, fetal alcohol spectrum disorder, and attachment disorder. Art therapy can also be a safer way for clients to share because it is their artwork and is subject to the client’s interpretation; they can choose what they reveal and what they elect not to.

In addition to art therapy being a useful resource in counselling, it is also a compatible form of counselling in collaboration with both solution focused therapy and narrative therapy. In order to use these approaches, the professional must disregard the traditional pathology-oriented theories in order of accepting the client as the expert in their treatment and healing process. Art therapy can add a supplementary dimension to the counselling experience by allowing a visual component (Riley & Malchiodi, 2004). Allowing the use of these three approaches (solution focused therapy, narrative therapy and art therapy) can accelerate the therapeutic change by the use of specific interventions, as well as creative expression (Riley & Malchiodi, 2004).

Malchiodi (2012) explains;

Solution focused and narrative approaches support the idea of the therapist and the client as partners and collaborators in problem solving. Art expression complements the approaches addressed…because imagery assists both therapist and client in finding alternative solutions to problem-saturated stories. (p. 112)
Malchiodi (2012) claims these forms of therapy are more effective in comparison to traditional forms of therapy because they are offering new ways of approaching and addressing the problem that is change-worthy. This approach appears to be solitary in which the internal process is both tangible and visible, and therefore, is a unique element of the counselling regime that offers the potential for a successful outcome (Lipchik, 2002; Malchiodi, 2012).

The use of art used explicitly in conjunction with narrative therapy, allows for the client to provide creative ways of externalizing, which is defined as the client viewing the problem separate from herself. Thus, the problem is external, having various factors such as culture, social norms and societal hierarchy that can influence the relationship the person has to the problem (White, 2007; White & Epston, 1990). Since the art product that is created by the clients to express the problem they are dealing with is physically external to their being, the clients then can connect the idea that the problem itself is also external to them. In narrative practice, externalizing can be a complex and difficult concept to understand from the client’s perception; the use of visual art helps to provide insight to this concept (White, 2007). By combining solution focused therapy and narrative therapy in conjunction with art therapy, the client is given an opportunity to focus on resolutions and newly re-authored stories through the use of art as an alternative to focusing on the problem and/or staying in the dominant problem story. Creating artwork with the focus of expressing the problem story can assist the client in separating herself from the problem, which is an effective concept used in a narrative approach (Riley & Malchiodi, 2004; Madigan, 2011). In narrative theory, one of the main objectives is for the clients to separate themselves from the problem that is currently affecting their lives. By externalizing this problem, clients no longer identify the problem story as their identity. Once this is accomplished, the individual can begin to identify so many more compartments of their
intrinsic worth including hopes, dreams, strengths, attributes and abilities (White, 2007).

2.4 Post-Modernism Theory

The most significant paradigm shift in post-modernism theory is counselling shifting from problem-focused to solution-focused. Carniol (2000) claims post-modernism theory identifies the importance power plays in relationships, understanding that the dominant population who holds the power determines the worldview of reality. This theory rejects that there is an objective reality that applies to everyone. One’s own reality depends on the meanings individuals construct in the context of their lives. White (2007) believes that because power shapes reality, then reality itself is impossible to define and it is, in fact, not objective. There is no one single truth but rather reality is socially constructed through the process of human interaction.

White (2007) and Madigan (2011) identify post-modernism ideology in counselling as a means of focusing on deconstructing the well-known common beliefs and ideas. These common beliefs and ideas are formed through culture, language, social norms, and beliefs. It is important for counsellors to understand post-modernism theories and therefore acknowledge how culture, language and social norms may affect the client, and how the client views himself/herself. Thus, post-modernist counselling emphasizes the importance of a collaborative relationship between the client and the professional, rather than the professional being in a position of authority. Furthermore, post-modernism believes the person is not the problem and that the problem is the problem. A post-modern counselling perspective also advocates the client’s reality and not relying on observational processes, therefore accepting the client’s problem as fact because it is the client’s reality.

Another concept included in the post-modern counselling perspective is the ability to see
the problem separate from the person. This allows both the counsellor and client to look for exceptions to the problem (i.e. in narrative therapy could be considered looking for unique outcomes). In this approach, therapy consists of a collaborative dialogue that involves both the therapist and the client as co-creating solutions while maintaining an equal power dynamic (Rivett & Street, 2003; Madigan, 2011).

Post-modernism theory believes individuals seek counselling when they have deviated from the objective norm, while believing they measure their personal norm with what society sets as a standard. For example, a client thinks he/she is depressed because society tells him/her that having a lack of interest in social interactions is a sign of depression. It could also be possible that this specific individual has the traits of one who is introverted and enjoys time alone (Carniol, 2000). Post-modernism philosophy recognizes historically a strong state of interdependence between client and the professional. This interdependence creates the authoritarian relationship, ultimately keeping the client in a state of oppression (Hansen, 2006). Post-modern approaches align with the ethical practice framework of social work. Other forms of counselling that position the counsellor as the expert could indirectly oppress a client who has been subjected by systematic oppression and power imbalances (Bishop, 2002).

Many professionals working with the traditional medical model (i.e., locating the problem within the individual) reject the post-modern theoretical framework because it contradicts current theory in practice. However, some psychotherapists and other professionals are beginning to integrate this model; and some are completely changing their counselling practices to incorporate post-modernism (Cloninger, 2004). Art and narrative therapy are post-modern forms of counselling which allow the client to lead the counselling process. Art therapy allows the client to choose what art they want to express. The client also decides what they are willing to share
with the counsellor regarding their artwork as well as the emotions and their narrative story attached to the art. This process leaves the client empowered and in control of the sessions. Narrative therapy allows the client to be the leader in their narrative using language to explore and discover new insights, while the counsellor gently guides the process and helps the client to identify undiscovered or unrecognized values, attributes and abilities, ultimately re-authoring their new reality. When practicing counselling, it is valuable to adopt approaches that provide the client opportunity for insight and growth. This in turn eliminates the chance that a client will become problem focused and in a state of interdependence on counselling services.

2.5 Counselling Ideology

Johnson (1998) explains when one chooses to become a counsellor, he/she ultimately wants to help people with their problems that are affecting their lives in negative ways. As part of this process, counsellors should be aware of their limits and access information and resources to improve their knowledge and skill base. In addition, counsellors should refer the client to other services when the counsellor does not have the necessary skills to help the client with their issue. The counsellor should be able to demonstrate a genuine acceptance for the client they are providing service for. Additionally, it is important for counsellors to know their limitations and remain non-judgemental. Counsellors are expected to adhere to ethical and moral standards. When a client presents a problem that is an ethical conflict of interest for the counsellor, and knowing they cannot remain unbiased, the counsellor must recognize this fact and refer the client to the appropriate professional (Wills & Sanders, 2013).

Many counsellors practice a type of integrated therapy, using dominant plural evidenced based ideologies, which have proven effectiveness. Some of these dominant evidence based ideologies are behavioural, psychoanalytical, psychodynamic, and humanistic therapies. By
using an integrated approach, counsellors are able to blend specific types and techniques (Hansen, 2006). In addition to an integrated approach, some professionals take elements of different models and combine them. The use of combined methods will depend on the needs of the client and an assessment of the client’s problem (Hays, 2013). Counsellors should be knowledgeable of abilities, skills, resources, and limitations when applying theory to practice.

The following chapter goes into detail about my experiences while at my practicum placement, learning to link specific therapies (narrative, art, and solution focussed) to practice. I provide insight and understanding into my learning journey, while reflecting on my educational development in linking theory to practice.
Chapter Three: Practicum Experience

3.1 Art Therapy Group

The artistic expression group I co-facilitated during my practicum was offered once a week for two hours on Tuesday mornings from 9:00 am to 11:00 am over an eight-week period. The group was open to clients who were new to Canada and it was offered free of charge. Translators assisted because the clients were not fluent in or could not speak the English language. There were eight participants in the group. My experience with art therapy prior to my practicum was limited. I had the impression that art therapy would involve the expression of one’s feelings through the form of art and professional assessment. This process would incorporate advising the client what the identified issue is and/or discussion surrounding the client’s emotions in the moment. The thought of this process made me nervous. I had the impression that issues, thoughts, and feelings would be imposed on clients. I felt uncomfortable about the thought of artwork in general as I do not view myself as very artistic and I was unsure if I would be able to offer much value to the group.

The first day I attended the group was the first day I co-facilitated along with another staff member of The Caring Place. Session one of the eight-week group started with an introduction to art therapy, explaining a summary of art therapy and the details for the group. These details included the length and time of the group, facility details (location of washroom, when breaks are, snacks and drinks provided), and group rules and expectations. All participants were assured that having art experience is not a requirement to participate.

The next task for the facilitators was to assist the group members to become comfortable with the group setting. This task was accomplished by welcoming each member to the group
and by asking each group participant to answer a couple of questions. Some of the questions that were used to assist in establishing a sense of comfort within the group members included asking their names, reasons for attending, goals for the group, and country of origin.

Following this activity, the facilitator provided an explanation of the daily group activities. I noticed the facilitator allowed for many questions and comments during the introduction. After questions were answered, the group started with the first art project: each participant was to paint on a plastic mask how he/she saw and felt about his/herself in that moment with reference to any problem that were currently affecting their lives. Participants were to share this experience with the group, however, sharing was optional and there was the right to pass. Prior to the start of the group, the co-facilitator went over the process with me by explaining the group outline, process, expectations, and shared that he would be participating in all the art activities and encouraged me to do so as well. He also explained the importance of the facilitators participating in the art activities because this helped the group members feel more comfortable. In addition, the facilitator participation demonstrates that everyone has artistic ability within them when one connects emotions and feelings to the art project they are completing.

I, of course agreed to complete each art project. However, I was thinking to myself I was not very artistic and felt nervous about my skills despite being told anyone can partake in this group without needing any art experience or ability (Miller, 2012). In this respect, I immediately made a connection with the group members. I thought ‘If I am nervous as a facilitator I wonder if the members could be feeling something similar?’ To my surprise, I did this activity quite easily. Through the painting process, I began to express my emotions. When
it was my turn to share, I felt an intense connection to my emotions; and I came to realize how powerful and healing art therapy can be. These emotions were unexpected. I thought I was completing an art activity as a support to the group and while I was not there as a participant, I was stimulated emotionally by the experience. My emotional connection to the art project allowed me to safely express emotions, thoughts, and worries that I was having in my life. I thought if I felt these intense emotions as a facilitator I could only imagine how much more intense this could have been as a client.

I also concluded (which was confirmed on several occasions and reinforced with each group that I co-facilitated), one does not need to have an artistic background or certain skillset to participate and benefit from art therapy. I knew this from the research but I also experienced this first hand. The therapy of art is from the process of making the art, not from the outcome of what was made (Miller, 2012). There are many misconceptions about art therapy. One of these includes the idea that art therapy is an assessment of an individual’s ability to create art, therefore to partake in art therapy, an individual should have artistic ability. This is simply not true, art therapists are interested in an individual’s engagement in the process as well as their reflections and insights, not their techniques (Knill et al., 2005).

Throughout the group, various forms of art were used including scribble art, acrylic, paint, blob art, clay art, and more. Each week, participants of the art therapy group were encouraged to complete artwork journals at home, drawing from the different forms of art demonstrated each week, and then were encouraged to share one of their journal entries.

Journals can be beneficial for a number of reasons. Journals help encourage participants to continue to use art to help them with thoughts and feelings. It helps participants to remember the different types of art work as they were asked to date and title their journals and write the
type of art used in the journal. Additionally, it also helps the group to bond and share with one another (McNiff, 2004). I too, participated in art journaling and I shared my artwork weekly with the group. I found art journaling to be rewarding by helping me to relax, reduce stress and express emotions I had bottled up.

I observed the group connecting with each other through means of sharing their artwork, emotions, and expressions of their hopes and dreams. The use of mindfulness activities such as deep breathing, spatial awareness, relaxing music, introduction to calm quiet space, muscle tension/relaxation, were incorporated into the group. The inclusion of these activities appeared to enhance the experiences for the participants, giving the group members additional resources to use outside of the group.

For example, mindfulness meditation is the practice of being in a state of conscious awareness of one’s being, thoughts, feelings, and sensations. This includes being in the moment and awakening one’s awareness of the world around oneself and how one feels in it (Keown, 2004). Kalmanowitz and Ho’s (2016) research findings in relation to the combination use of art therapy and mindfulness techniques specifically for the treatment of refugees dealing with trauma stated;

It was found that by combining art therapy and mindfulness, the Inhabited Studio structure could respond to changing needs. It could contain and regulate as well as allow for expression of emotion and sharing of narrative. The ability to regulate emotions as opposed to being under their control, led to a sense of emotional safety and present moment awareness facilitated this possibility. (p. 58)

Overall, I found the group to be eye opening and engaging, as I was able to witness the personal growth made by each of the participants. At the last group, each participant did
another mask similar to the one they completed on the first day of the group. This mask was to represent how they felt now, what their hopes and dreams are and what growth they have made since the start of the group. It was amazing to hear clients express how grateful they were to have been a part of the group; and how they were able to use their newly learned skills. Many shared that they were going to continue to use art for therapeutic reasons.

I hoped to use this newly acquired knowledge and experiences as I moved forward in my practicum placement, and apply this to the drop-in support group for anxiety and depression as well as to individual counselling sessions that I conducted. I believe there may be clients either in the group sessions or in private individual counselling sessions that may appreciate and benefit from the use of either art journaling or art therapy, enhancing the counselling experience. I also hoped that I would be able to provide clients with mindfulness techniques that may help them when they were experiencing feelings of anxiety.

3.2 Drop-In Support Group for Anxiety and Depression

For the first two months of my practicum, I observed and then facilitated a weekly drop-in support group for adults living with anxiety and/or depression. In support groups, peer interaction and relational insight between group members is important. The ability to see, connect and support peers in a group environment has a lasting positive impact (Baker, 2005; Zastrow, 2006). Support groups are defined as one of the ways to effectively help individuals cope, manage, and heal from symptoms associated with anxiety and depression (Brown, 2013). Support groups are also known to be effective for various reasons. Some of these reasons include the sharing of knowledge and information; social companionship can be provided through the group members; and the interactions amongst the members can lead to increased self-esteem. The realization that the individual is not alone and suffering in silence because they are in a
group of peers with similar problems can help to reduce isolation (Nichols & Jenkinson, 2006; Albrecht & Herrick, 2011). Feminist theories along with social work practice supported the development of these groups for many reasons. One such reason is to change the hierarchy of traditional therapy where the therapist is situated in a position of power. In a group setting, it is plausible for the group members to feel as though they are in a role of equality, as each member has contributions to offer the group, along with their own knowledge and experiences (Dolgoff, Loewenberg & Harrington, 2005).

The anxiety and depression drop-in support group is provided free of charge to participants and it operates ongoing throughout the year; each group that I facilitated had on average ten to twenty people in attendance; and, the room would typically be full. I often had to move the furniture around to make more space in the room in order to add additional chairs to accommodate all the people showing up for the group. Initially, I did not know who would attend the drop-in group; and I admittedly was surprised that many people showed up for each group regularly.

The group was made up of mostly middle class males of various ethnic backgrounds, with only a few female participants. Drawing from my own experience facilitating groups, I was surprised to learn how many men attended the group, since my experience led me to believe engaging males to attend support and counselling groups was difficult at times. My past work experience included facilitating groups for fifteen years, during this time the majority of the participants were female and it was always a struggle to engage and sustain male group members. Members that attended the drop-in anxiety and depression group were referred to the group or had responded to community advertisements. Clients wanting to join this group did not need to have a formal diagnosis of anxiety and/or depression; they could attend if there was
room available in the group and they felt that they may benefit from the group. Participants confirmed registration when they contacted The Caring Place.

The group’s format was flexible allowing individuals to speak when and if they chose. At the beginning of the group, I as the facilitator, with the assistance of the clients, read aloud the rules and expectations of the group. The members of the group with the support of the facilitators defined the rules of the group. I confirmed at the beginning of each group if any changes or additions needed to be made to the group rules. Some of these rules included confidentiality and the limitations of it, the right to pass, the right to respect, no swearing, and no sharing of prescriptions or medical information. My responsibility as the facilitator was to ensure that the group participants were developing ownership of the group, making progress, and contributing to the group in some way. One benefit to having the group members participate in determining group rules or norms is that this activity helps members to feel a sense of ownership for the group. They also can feel valued and needed as a group member (Nichols & Jenkinson 2006; Zastrow, 2006).

The group facilitators (i.e., counsellors from The Caring Place and/or myself and at times I facilitated the group by myself) have the designated responsibility to ensure everyone in the group feels safe, included, follows the rules and also to intervene when misinformation is given or conflict arises. Group rules also defined as group norms are imperative to ensure effectiveness of desired outcomes, compliance with policies and that privacy is protected. These rules are common to counselling groups and they help guide appropriate behavior of the group members. In open groups, it is important to recognize that new members can feel apprehension; therefore, providing the rules at the beginning of each group can help ease this uncomfortableness because the new member then understands what is allowed and what to
expect (Johnson, 1998).

Zastrow (2006) explains the importance of building trust as the leader of the group. Trust is imperative to a groups’ efficacy; the building of trust supports group members to develop a sense of safety; by doing this the members can feel more confident that the facilitator(s) can effectively carry out the goals of the group. Developed trust within the group provides a stable environment where group members can feel secure sharing personal details about themselves. Furthermore, the group, as a whole, must feel confident about participating in personal discussions with the understanding that confidentiality will be kept by all who attend. When lack of trust is a factor in the group, the validity of the group’s process is compromised. The group must trust that the facilitator or group leader is competent and confident in their role.

At the third group meeting I attended, I was in charge of leading the session. Given my understanding from reading the literature, training and experience with facilitating groups, I knew developing trust and rapport with group members is often not a simple task to achieve. I was able to establish this first by introducing myself and then by expressing empathy for the symptoms the group members may be dealing with. Next, I gave a synopsis of the knowledge I have about anxiety and depression and how it can impact an individual’s life with symptoms of insomnia, persistent sadness, restlessness, irritability, feeling of hopelessness, helplessness and worthlessness, change in appetite, isolation, difficulties with remembering and concentration, etc. (Albrecht & Herrick 2011; Vasey, & Dadds, 2001; Zastrow, 2006). Then I explained to the participants that they have taken a big step just by attending the group, because anxiety and depression can leave a person feeling isolated and alone. The very thought of leaving the house came be debilitating of itself (Albrecht & Herrick, 2011; Vasey & Dadds, 2001). I wanted to acknowledge the very act of making the decision to attend the group and following through with
it was a major accomplishment. I articulated to the group members that they should feel proud of the progress that they had made.

I found it beneficial to be open with the group and share who I am and why this group is important to me. Initially, I explained that I had many years of experience with group facilitation of various groups such as support groups, information groups, life skills development groups; and I was also a participant of a bereavement group at one point in my life. Thus, I was able to see the benefits of groups, both professionally and personally. Secondly, I wanted to let the group know I was privileged that they allowed me in their group as a co-facilitator, and also as a student. Because they did this, I experienced an enriched learning opportunity within my practicum journey. The group members were supportive and welcoming to me as they conveyed their acceptance of me in the group. After introductions were completed, I had the group members share the groups’ rules.

Once this was completed, I wanted to try a different technique as opposed to the current format of sharing, which included the process of any client speaking and sharing, when and if, he or she chose to do so. This decision came from my experience, previous observation of the group, and recognizing the more reserved or quiet individuals. I noticed in the previous two sessions that I had co-facilitated, this style may have inhibited some members of the group from speaking. These participants likely had a lot to contribute, but for various reasons they refrained from sharing (Zastrow, 2006). I wanted to change the format of the group as I saw potential value to it and so I shared this with the participants.

I knew I was taking a risk by making a change and I hoped the group members would support and trust my lead. I informed the group I would like to suggest using a circle method process for sharing; they agreed to this new format. This is a group format that involves
passing an item around in a circle. When an individual has been given the item it is his/her turn to speak. One of the reasons this technique is used in group settings is to encourage participants to share who otherwise may not feel comfortable speaking out. When they get the item passed to them, they can feel a sense of comfortableness because it is seen as their turn to speak (Brown, 2013). I reminded the participants they always have the right to pass and they are not forced to share when the object is handed to them. I asked for a volunteer and it went from there, by the time group was over, every person in the group had shared personal information.

When the group ended two of the participants asked to speak with me; they wanted to thank me for running the group in this different format. They explained how they noticed two members of the group shared their stories and these two members have been attending the weekly group for months but had never said one word prior to that day.

Through this experience, I found that group facilitation is an ongoing learning process. Prior to this opportunity, I felt confident with my group facilitation skills but I learned quickly that you can never fully prepare for what might take place in a group. I felt I did my best to meet the objectives and the needs of the group; and I was thankful I had past experiences I could draw on when times were challenging. A group leader should have a level of comfortableness and skills to facilitate the groups, however, groups themselves are not predictable. Group leaders must always be resourceful and able to adapt to the needs of the group (Zastrow, 2006). For example, a new participant showed up for the group five minutes before it was to start and this new member was not able to use the stairs to the “group room” so I had to compromise and be flexible to move the group quickly to a new location that could accommodate her needs. Another example involved two members who started talking negatively to each other, I quickly had to intervene and remind participants of the groups rules, which included respect and to be
non-judgmental. I also recall sitting on the floor in the corner of the group room at times, just so that every group member that showed up would have comfortable place to sit. All of these above examples involve times when I facilitated the group alone and I had to make these decisions on my own and trust my ability.

These experiences also made me realize just how debilitating anxiety and depression can be and just how common it is to suffer from these illnesses. Depression and anxiety are two of the top mental illnesses affecting individuals in Canada. The Canadian Mental Health Association (2017) provides this statistic from 2012, that two-thirds (67%) of Canadians have had experience with depression or anxiety, with 36% saying they have suffered from it themselves.

3.3Narrative Therapy Training

I was excited about the narrative therapy training. I was looking forward to the opportunity to acquire various new counselling skills and also allow me to learn a new therapy approach to draw from in the future. Throughout my professional career I have implemented diverse forms of counselling, such as solution focused therapy and cognitive behavioural therapy, while applying a strengths-based perspective and feminist ideology. I strive to improve my abilities in order to become more effective and resourceful when counselling individuals. Narrative therapy was not new to me, however, my knowledge was limited, but I became intrigued and wanted to learn more. My professional associate had a wealth of knowledge and experience in the field of narrative therapy and was willing to teach and guide me through this learning curve.

At the beginning of my practicum, I had the opportunity and honor of attending a three-day workshop that was facilitated by Dr. Stephen Madigan. Michael White (one of the two
founders of narrative therapy) provided ongoing training and support to Dr. Madigan as he continually developed and perfected his skills in narrative therapy and eventually he too became an expert in the field.

It was through education and experience that Dr. Madigan became an expert in the field of narrative therapy. He is also intensely passionate about his work. Dr. Madigan’s journey of becoming an expert began when he attended Michael White’s workshop in 1986. Shortly after the workshop ended, Dr. Madigan offered an additional learning opportunity that involved observing Michael White’s work firsthand as he interviewed a 10-year-old boy (Madigan, 2011). Madigan (2011) states,

That night I sat behind a one-way mirror and had my first experience of Michael White in therapy. I sat alongside Karl Tomm (the workshop’s host) and four other therapists. Michael’s practice blew my mind, and as a group we seemed quietly mesmerized by the unusual therapeutic conversations we were witnessing. (p. xv)

I felt blessed to have such an elite guru of narrative therapy teaching me my first experience and introduction into this practice. My feelings reflected those of Dr. Madigan as he first watched narrative therapy being performed by an expert in the field.

The workshop as a whole was a remarkable experience, enriched with knowledge and expertise. The classroom (training room) was set up for exploring skills and abilities. Dr. Madigan spent an extensive amount of time explaining the theory of narrative therapy and facilitated live modeling of the practice in front of the group. Dr. Madigan informed the class that the workshop participants would be volunteering, emphasized how important it is to use a genuine problem in our lives, and confirmed that narrative therapy is to be practiced in complete authenticity. Part of the idea behind this practice is the ability for the practitioner to have an
actual interest and sincerity about wanting to hear a clients’ narrative (Madigan, 2017). He used different participant volunteers as clients, allowing each participant to observe first and then practice the techniques he/she had recently been exposed to.

Every time Dr. Madigan spoke, everyone seemed to very engaged in his presentation. I thought about what I was learning, and it seemed to be such a simple yet profound therapy. Narrative therapy concepts entail that the clients are the experts in their own lives; the world around us influences how we view ourselves; and, the counsellor and client have an egalitarianism relationship. I could not help but question why this therapy is not being practiced by all professionals working with individuals in counselling and/or social work. Narrative therapy seems to be so logical, yet many professionals are not using it.

The training room was located at the First Nations University of Canada, in a small room with large windows, which assisted in setting the environment for an intimate group. The participants consisted of mostly counsellors in private practice, government social workers, and non-profit service providers whose backgrounds included social work, psychology and theology. The diverse collection of professionals enhanced this experience for various reasons; one reason includes the different perspectives and insights each participant had to offer. This provided members with the capacity to consider questions and insights from different perspectives. Further, I found it valuable to observe Dr. Madigan at work and to be able to practice the skills while he in return observed and provided feedback. I recall someone asking a question about how Dr. Madigan has the ability to remain so connected and focused in every therapeutic conversation he has. His response was “because I truly care and I am genuinely interested in what they have to say” (Madigan, 2017). I remember thinking what a simple answer that holds so much power and truth. It is important for counsellors to have a sincere and true passion
when working with clients (Hepworth, Rooney, Rooney, Strom-Gottfried & Larson, 2006).

The above-noted training I experienced was a humbling experience, and it was a privilege to be taught by an expert in the field. Through continued research on narrative therapy, I explored it further by way of literature reviews and videos of Dr. Madigan that included live narrative practice. Overall, my learning objective to develop the skills and practice narrative therapy has been deeply enriched through the training I was afforded.

3.4 Narrative Therapy in Practice

Throughout my practicum, I spent numerous hours in sessions practicing the recently learned skills in narrative therapy. I was able to apply theory to practice with over thirty clients. With the counselling sessions I conducted, I was mindful to ask narrative questions and I strived to stay focused in a narrative frame of mind. I assisted clients to understand that the problem is separate to him/her and is situated outside of the body, while I supported clients to reflect on how social context influences behaviours.

Throughout the sessions I would look for key words and phrases the clients used, referred to as unique or alternative outcomes in narrative therapy. I helped clients to identify times in their lives when the problem story was not present or in control and to acknowledge the clients’ values, attributes, behaviours, and strengths. It was through this work that I both witnessed and was told by clients that the narrative therapy they had received in the sessions I conducted had positively influenced them (Madigan, 2011; White, 2007; White & Epston, 1990).

Some of the difficulties I encountered while utilizing narrative therapy during the practicum included asking “narrative questions” which can be perceived as odd or uncomfortable for a new practitioner and a client. Examples of narrative questions include the following: how has this person come to know themselves in this particular way; how do the demands of drinking
“alcohol” steal time in your life; can you imagine a time that you might defy the perfection anorexia demands and to give yourself a break; what rules of depression did you have to break to come here today (Madigan 2011; White 2007). Occasionally I would resort back to the type of counselling approaches that I was comfortable with using such therapies as solution focused and strengths-based theories and techniques.

I understand that what works for one client may not be effective for another. I recall a client getting frustrated with me and questioning my methods of counselling. I attempted to ask her narrative questions, to seek unique outcomes to help her re-author her story (White, 2005). The client’s expectation of the counselling session involved her disclosing the issue; and my role would be to solve or lead her to make a decision. I explained to her that it was not my role to decide what was in her best interests. I explained narrative therapy and its process. I provided the client with an example of a negative outcome and the consequences of a counsellor directing the client to make valuable life decisions. The client appreciated the concept of narrative therapy; and successfully completed the session using this practice (Madigan, 2011).

3.5 Clinical Counselling from a Student Perspective

For the purpose of my practicum, one of the learning objectives I developed included practicing narrative therapy with four to six clients. In the beginning, I shared with my professional associate that I was unsure of my ability to reach four to six clients as projected. My questions about this projected number evolved from the idea that clients would view me as a student, hence creating difficulties building rapport. These feelings of insecurity diminished through successful counselling outcomes: and clients began to request my services. Shortly thereafter, my caseload grew to thirty-seven clients.

The clients’ demographics varied in age from as young as a four-year-old girl to a sixty-
seven-year-old man. The gender of the clients included males and females. Clients came for counselling sessions for various reasons, such as, relationship issues, survivors of sexual assault and other abuses, separation and divorce dynamics and complications, thoughts of suicide, obsessive-compulsive behaviours, discrimination, and addictions. Sixteen clients reported having symptoms of and wanted counselling for anxiety and/or depression.

My experiences were positive with clients and aided my confidence and my ability to be an effective counsellor. I recognize my attributes that include caring, empathetic, knowledgeable, resourceful and my ability to know my limitations. I encountered a few clients requesting that I provide marriage counselling. I was able to discuss my limited experience in this area of counselling and I provided a recommendation for an appropriate counsellor. The importance of competency and being aware of the limits of my knowledge is imperative when practicing as a counsellor (CASW, 2005).

I was also mindful of the start and end date of my practicum. This prompted me to develop a contingency plan to assure my clients’ needs would continue to be met. This included advising clients at the time of intake and at their first counselling session of my departure date as well as the closure and transferring of files. Social work practice encourages all professionals to discuss the client-professional relationship, limitations, expectations and termination of the relationship. It is important for clients to know the plan and the expectations; this assists with building rapport and transparency with the client and strengthens the professional relationship (Johnson, 1998).

The next chapter will discuss ethical dilemmas and implications that I encountered while completing my practicum. Throughout this experience, I was able to use insight while applying theory to practice. In addition, I consulted with professionals when my professional ethics were
challenged. As a counsellor, it is important to always adhere to a code of ethics. My code of ethics was through the Canadian Association of Social Work (CASW, 2005).
Chapter Four: Ethical Dilemmas & Implications for Social Work Practice

4.1 Ethical Dilemmas in Social Work Practice

As a practicing social worker, I needed to be vigilant in upholding the Saskatchewan Social Worker Code of Ethics. I was working in an organization with professional counsellors from a variety of backgrounds. Interestingly, only one other counsellor had a social work background like mine. Each professional working in the organization had diverse professional ethical standards that they adhered to. As a practicing social worker and a student, I was very aware of this. I found myself in a few situations where my ethics were challenged.

One situation that stands out from the rest involved a time when I was completing an intake with a new client. The client requested counselling through the form of art. She and her mom both expressed the importance of artistic expression in counselling and how effective this form of counselling had been in the past for them. I thought right away this client would be a perfect fit for me. This would be an excellent match with my learning objectives and provide me an opportunity to explore this field of art therapy one-on-one with a client in a counselling session. There seemed to be an established rapport developed between the client and myself. The client requested my services as her assigned counsellor for her therapy. The client also expressed her plan of having counselling sessions take place monthly on a long-term basis, though ideally counselling would continue indefinitely. I considered her request for her counselling services to be long-term and as such, I realized I could not fulfill this request as I was a student with a start and end date. I then explained to the client that my practicum ended in August therefore, I was not able to fulfill her wishes for ongoing counselling and referred her to a counsellor experienced in art therapy who could carry out her wishes for ongoing counselling. This situation initially posed a challenge for me. I had to make the ethical decision of what is in
the best interest of the client. In this situation I was challenged with the social work code of ethics “Value 3: Service to Humanity” (CASW, 2005) that states it is essential to always put the needs of the client above a social worker’s self-interest.

As the practicum student, one of my assigned duties was to complete a large majority of the intakes. The intake process included the following: determining why the client was seeking counselling, establishing the fees for service (depending on their financial situation), matching the client with the appropriate counsellor, and at times offering immediate crisis counselling. During the intake sessions, often times the clients would request me as their counsellor and occasionally such requests did not coincide with my abilities in a specific area of counselling. I was vigilant about identifying my limitations with regard to specific counselling areas and referred clients to the appropriate counsellor. The referral process was to allow clients to make an informed decision. This challenge I encountered involved Value 6: Competence in Professional Practice” (CASW, 2005). Due to my mindfulness of limited knowledge in specific areas, the Canadian Social Code of Ethics Value 6 challenged me to build a caseload of clients and provide services that were in the best interest of the client. Further, it was imperative clients received all available information so they could make an informed decision.

4.2 Social Work Practice-Ethical Alliance at The Caring Place

While there were times during my placement when my social work code of ethics was challenged, there was also many times where my ethics seemed to be a natural fit with The Caring Place due to their aligned ethical practice. For example, “Value 1: Respect for the Inherent Dignity and Worth of Persons” (CASW, 2005) is a natural alignment with The Caring Place as this organization accepts people of all demographic backgrounds. They are non-judgemental and open to a diverse population. The client is always the expert in their journey
through counselling. The Caring Place staff show an extreme sense of compassion and caring for each client.

“Value 2: Pursuit for Social Justice” (CASW, 2005) is another value I saw implemented. The Caring Place is one of the few counselling agencies that offer clients services regardless of their financial situation. In addition to this, the executive director, board of directors and staff organize and participate in various events in an effort to fundraise for the sole purpose of offsetting the cost of counselling for clients.

The Caring Place follows “Value 3: Service to Humanity” (CASW, 2005) by consistently offering programs free of charge and events to serve the community to improve and support mental health wellness. During the length of my practicum, the executive director, along with other staff, was planning to offer a free street fair to the community which included food, entertainment with special focus on recasting reconciliation and exploring diversity through culture and art. These are just a few examples of how The Caring Place is in line with the ethical practice of social work. Because of this, I was able to strengthen my skills and abilities while meeting my learning objectives.

4.3 Implications for Counselling-Personal Reflection

While acquiring new counselling skills are incredibly valuable, I found a few drawbacks to using narrative therapy in practice. Narrative therapy can be very time consuming, as each session can be directed by an entirely new story the client is telling (Madigan, 2011; Madigan 2017). This can be problematic if sessions are limited and can additionally cause financial strain on the paying client. In some counselling settings, the client is only seen once and/or the time is very limited. This could influence the experience or the validity of the services offered if the therapist is not given the appropriate time to hear the whole story and thoroughly go
through the process of narrative practice, which includes externalizing, unique outcomes and re-authoring. This can be a significant amount of information to cover in a single session and likely not feasible. This form of counselling may not be used to its full potential if it is practiced in an agency that has time restrictions and/or limited resources.

Nevertheless, I found in situations where counselling was brief for various reasons, I would use aspects of solution-focused therapy with a narrative aspect. Since solution focused therapy refers to any one session and the desire is to provide therapeutic impact, this framework is ideal for therapists working with clients in single sessions. The goal is to make progress and for the client to find the session useful. This view is consistent with general social work practice (Miller, 2012). O’Connell (2012) identifies the first session as potentially the most therapeutic and can often have the greatest influence on the outcome of therapy. Furthermore, most clients prefer therapy to be as brief as possible (O’Connell, 2012). Solution focused therapy has commonalities with narrative therapy, which include the importance given to the development of a positive alliance between counsellor and client; and, focusing on achievable goals which is similar to narrative therapy unique outcomes. Both therapies emphasize on strengths and competencies; and both models believe in assisting the client to see perceptions and the impact to the client (Lipchik, 2002; White, 2007).

Another implication observed when practicing narrative therapy refers to how the client perceives the therapist as the expert. In these situations, clients would insist on being directed, given homework, resources and/or techniques to address the problem. When using a narrative approach, the client is the expert and the counsellor is there to facilitate the process, but in no way does the counsellor give direction to the client (Kottler, 2015).

In some situations, during counselling sessions, clients would request I provide direction
for the problem they were encountering and even at times wanting a diagnosis. In these situations, I would explain the type of counselling I was practicing; if the client still wanted direction I would use other counselling theories in addition to narrative therapy, such as strengths-based perspective, solution focused therapy, cognitive behavioural therapy and art therapy, to name a few. I found that narrative therapy is an effective model in combination with other forms of therapy that would often complement one another.

I quickly learned that narrative therapy takes a lot of practice and narrative questions did not come naturally to me. I really had to work hard to become comfortable using this model. I knew I needed to keep practicing this model to be more efficient at asking narrative questions, which was confirmed through research, training, and working with professionals. It takes practice to view and work from a narrative perspective. Occasionally, when I was practicing narrative therapy the questions seem odd to me or I was uncomfortable and I thought that the client could sense this. If the client senses the counsellor is uncomfortable then that can have undesirable effects on the therapeutic relationship (Hepworth et al., 2006). For example, a narrative question could be, “how did you come to know yourself as an “addict”?” These types of questions often would perplex clients but it would also help them to analyze the relationships they have with the problem. Once they gain insight to the problem, they then can work towards externalizing the issue at hand.

As noted above, narrative questions at times can come across as confusing for clients. I knew the benefits of using this form of counselling so I would continue to ask narrative questions. I noticed at times clients would stop and think about the questions asked and then appeared to gain insight to the problem they identified with. For example, I recall a time when I was providing narrative therapy in a session with a client who identified as being an alcoholic.
I asked her the question, “How did you come to know you are an alcoholic?” The client answered by stating, “What do you mean how do I know this? Everyone around me tells me I am an alcoholic”. However, during this specific counselling session as I continued to use narrative therapy in practice, I observed the client having a startling discovery in which she explained she was able to map the stories in her life that helped her to believe she held the identity of an alcoholic. Through further exploring her narrative, she came to realize her label was not a problem in her life, but rather this was a label the dominant culture gave her, therefore, she was attempting to live up to her label. Once she was able to identify how she connected to this label, she was able to note some situations where alcohol use had created problems in her life but the choice to use alcohol was in her control. She then was able to re-author her story without this problem.

By the end of our sessions together, the client came to the actualization that she no longer was going to live with this label and she expressed feeling a sense of freedom to choose her life destiny. The result was very powerful and moving when the client was able to re-author her story leaving out the title of “alcoholic” because it was not her story but rather someone else’s story given to her.

Narrative therapy is a contemporary way of thinking about and approaching counselling. The questions used in this mode of counselling were different than what I had been accustomed too and because of this, it has taken a lot of practice to become comfortable using this therapy. As a student counsellor of narrative therapy, I found myself wanting to quickly speed up the process. This was not helpful to the client. The client is to direct the process, not me (Epston, 2008). It is my belief that there is not just one form of counselling theory or model that is superior over another, but a combination and collaboration of resources can be most beneficial.
for each client’s success.

It is important to have a solid understanding of various factors for each client such as their culture, history, presenting problem, personality, dynamics and time allotted for counselling (Dryden, 2011). Having this knowledge can help to determine which model to practice. Despite having knowledge and skills in various approaches to use when providing counselling, sometimes trial and error is explored before knowing which approach is most helpful for a client. The focal point is to have a wide range of resources and approaches as a practicing social worker. If a counsellor becomes stuck on one model, it can be detrimental to a client’s success because humans are complex beings; what approach helps one person may not work for another. A successful counsellor needs to have a variety of tools to draw upon (Dryden, 2011).

At the beginning of my field practicum journey when I attended the narrative therapy training, I recall one general comment in particular was made that “all social workers should be using narrative therapy” (author unknown). I kept analyzing how narrative therapy could work in every situation of counselling. I researched it, I practiced it, I asked other professionals these questions and I came to the same conclusion - yes, narrative therapy works in any counselling situation. I questioned how this could be true. As social workers, we are taught various theories and models to have at our disposal. How could this be the ultimate form of counselling? Did we no longer need all these resources if one method worked in every situation? I struggled immensely with this idea and challenged it many times. Personally, I concluded that narrative therapy starts with a client telling their story and so parts of narrative therapy have always been in use. Narrative therapy is a useful form of counselling and it can be combined with other forms such as art therapy.

An example of this would involve a time when I was working with a very young girl,
whom I will call Sue. Sue came to counselling because she was struggling with adapting to changes within the family unit. I approached this session using narrative therapy, but I incorporated art therapy to allow Sue to tell her story. Sue drew several pictures of her past family, current family and what she hoped her future family would look like. This art work was a powerful piece in the course of her counselling journey as it helped her family better understand what she was feeling inside.

I found art therapy can be difficult for anyone who does not feel comfortable with using this mode to express themselves. When this happens, the client can get caught up in their own insecurities pertaining to their artwork, rather than allowing their emotions to guide them. They may not be comfortable sharing artwork and this affects the therapeutic aspect. During my time in the art therapy group, both the other facilitator and I participated in each art activity and shared our artwork with the group, which involved sharing our feelings, meanings and the stories attached to our art work. At first I felt insecure about my own artwork so I know this personally impacted my ability to be really free to express myself through art. I can only assume if I felt this way as a counsellor, then it is not unreasonable to assume others could feel this way too.

Despite any implications, both forms of counselling, narrative therapy and art therapy are powerful resources that can be therapeutic for clients. Ultimately, it is the counsellor’s responsibility to ensure the mode of counselling used is providing the required help for the client.
Chapter 5: Conclusion

My practicum experience provided recognition that clinical counselling is a diverse field treating a wide range of the population. The need for counselling services does not discriminate; individuals seek assistance for a variety of symptoms and areas that they struggle with. The overall goal in clinical counselling practice is to assist individuals in reducing and/or eliminating the circumstances that are resulting in unpleasant symptoms.

Throughout this report, I have examined different counselling theories such as narrative therapy and art therapy and applied these theories to direct practice. I had opportunities to gain insight and growth throughout both my practicum experience and my literature review. I have utilized examples from my practicum experience while applying newly learned skills and theory to understand the role of a counsellor. All of this has helped aid me to develop a deeper perspective of theories and counselling approaches in practice. This process has encouraged me to consider the values of social work practice and linking them to counselling approaches in order to understand how they harmonize collaboratively.

Clinical counselling utilizes theories such as narrative therapy, art therapy and solution-focused therapy through post-modernism ideologies, recognizing that commonalities exist in all approaches. These include the respect for the equal relationship between client and therapist and understanding the importance of building a genuine working relationship founded through a quality of respect. The examples related earlier demonstrate the benefit of the therapist having a genuine interest in understanding the clients through discovery questions to develop expectations, unique outcomes, and the re-authoring of their stories.

Throughout my practicum experience, I was able to observe many clients progress while I used various approaches to counselling. I had several opportunities to work with a variety of
diverse clients from various socio-economic backgrounds that had a wide range of presenting problems. This opportunity provided me a wealth of experience and opportunity to apply newly learned skills to practice. I was able to guide clients through counselling approaches that led them to either reduce or eliminate the identified issue. I was honoured to have been able to establish a trusting rapport with the clients I was supporting.

I recognize although this work can be rewarding, it is important for me as a counsellor to be attentive to my self-care, limitations, and mental health. It is not uncommon to experience “burnout” in this field; therefore, professionals need to have knowledge and awareness of this, recognize the signs, and ultimately take care of themselves which includes a healthy life balance of work and personal life (Dryden, 2011). My own self-care plan involved a reduction in my current employment so that I was not taking on too much. I wanted to make sure I was able to give my energy and attention to the practicum placement and be able to enjoy the entire experience. I consulted with my professional associates and professional supervisor if I had questions or concerns. I also made sure to take time for myself and my family, time away from work and my practicum by going camping and fishing with my family. This activity was an excellent de-stressor for me because I was able to get away from the city life, enjoy nature and spend time with loved ones.

This experience on a whole has given me the opportunity to develop, learn and practice different therapeutic models to enhance my counselling skills. I gained confidence in my practice through my interactions with clients and professionals at The Caring Place. My experiences, my knowledge and direct practice skills travel with me as I continue to grow my competencies as a counsellor. I complete this journey with a deeper knowledge and appreciation for the profession of social work, counselling and therapy.
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