“It’s not about the waffle maker:”
Trauma-informed social work practice.

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by

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Abstract

This report highlights my Master’s in social work practicum experiences in private practice providing trauma-informed therapy to clients who have experienced varying degrees of interpersonal trauma. The purpose of the practicum was to enrich my theoretical understanding of trauma-informed practice and enhance my clinical skills in direct social work practice with clients who have experienced trauma. This report summarizes my experiences as a clinical social worker in a private practice setting. I begin with an overview of my personal and professional experiences and highlight the rationale for my practicum placement. I then discuss my literature review defining the term ‘trauma,’ and discuss cognitive behavioral therapy (CBT) and attachment theory as foundational theories that guided my clinical work. I outline important aspects of trauma-informed practice and integrate a conceptual framework I used. Throughout this paper, I blend professional and practicum experiences regarding theoretical and practical applications of social work tools to client experiences. I note challenges and ethical considerations of trauma-informed practice and conclude with a brief summary and recommendations for future social work practice.
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Chapter 1: Introduction

I grew up in a world of system failures. My parents divorced in the 80’s, and on the cusp of the deinstitutionalization movement in Canada my dad was diagnosed with bipolar disorder and schizophrenia. Divorce and mental illness were not well understood at this time and largely stigmatized. My friends, family, teachers, and counsellor had very little knowledge or guidance to offer, however, they did their best relative to who they were as genuine empathetic individuals. It was difficult for me as a child who did not understand what was happening in my world, and more difficult to receive little to no validation of my experiences. My mom used to say, “look for the helpers, watch them closely”, so I did. As time went on, I became one of those helpers.

When I went to university, I majored in psychology, sociology and social work. I was focused on human social behaviour and the interworking of the human mind. As my university experiences continued, I was drawn more towards social work as it included the totality of the human mind and focused on individual systems that impact a person’s life. At the time, social work was gaining recognition in clinical counselling and research opportunities in numerous professional disciplines in Saskatchewan, including corrections, social services, education systems, and health. The prospect of expanding my employment opportunities and academic capacity in social work was highly appealing, and these were the reasons I completed an undergraduate degree in social work.

I graduated with an Honors Degree in Arts and Science from the University of Saskatchewan, and a Bachelor of Social Work from the University of Regina. Immediately upon graduation, I secured employment that connected my passion for social work with my sociological background. I was employed with the Ministry of Justice in the Young Offender
Unit and had additional employment experiences with the Ministry of Social Services as a Youth Investigator. I worked collaboratively with youth, their families, community supports, and the legal system, and integrated cognitive behavioral therapy (CBT) and solution-focused therapy as foundational approaches to social work practice. In these positions, I incorporated various tools such as: motivational interviewing, strength-based approaches, and mediation-type programming. I worked with a team of professionals who focused on the best interests of clients.

However, as it goes with any bureaucracy, changes to the programs resulted in workers becoming more accountable to the ‘paperwork’ of our positions, than to our clients. We moved from using empirically-based therapeutic interventions to what our clinical team deemed in the best interests of our clients. As a result, some clients became pigeon-holed into a ‘one-service-fits-all’ framework, and my interpersonal and professional job satisfaction slowly deteriorated. After years of government work, my professional and personal selves fused together, and I lost focus of why I became a social worker. However, completing the Master of Social Work (MSW) program at the University of Regina allowed me to reinvent myself as a social worker, by enhancing my theoretical and practical knowledge as well as skills and abilities in the social work profession. My capacity for social work practice was challenged and developed further in my practicum placement.

1.1 Rationale for Practicum Placement

In consultation with my academic committee, a practicum placement focusing on enhancing my clinical skills, theoretical approaches and modalities in trauma work was the direction decided upon. My end-goal for completing my MSW was to provide therapeutic support to first responders and their families, however, despite many attempts in solidifying this goal, I was unable to develop an in-home counselling support service for first responders. I
connected with my professional associate; a psychologist in private practice who agreed to be my professional associate for my practicum. My professional associate works primarily with adult trauma survivors in individual, couple and family counselling, and offers a range of clinical interventions for her clients. In my practicum placement, my professional associate and I co-facilitated client sessions with individuals, couples and families. I too was given the opportunity to lead sessions and completed 450 hours of clinical practice. All clients discussed within this paper have provided consent and identifying details have been removed to protect their confidentiality. Given that my professional associate was not a social worker, I required a professional associate external to my placement setting with an MSW. Despite differences in their clinical approaches, my professional associates taught me that therapeutic work is in “the best interests of your clients” which requires meeting them where they are at in terms of processing their own trauma.

The next chapter presents the literature review. Here I discuss a broad definition of trauma intrinsic to the theoretical approaches a therapist uses in trauma-informed practice and is foundational to the role of the therapist.
Chapter 2: Literature Review

Trauma-informed practice is a strength-based model that assesses clients’ risk and protective factors relative to an experienced traumatic event(s) (Substance Abuse and Mental Health Services Administration [SAMHSA] and Justice Strategic Initiative, 2014). Trauma-informed practice focuses on trauma in terms of the event, individual experience of the event, and the long-lasting adverse effects the event has on a person’s mental, physical, social, emotional and/or spiritual well-being (SAMHSA and Justice Strategic Initiative, 2014). Trauma-informed practice requires a succinct definition that encompasses the totality of traumatic experiences in order to address what the client deems traumatic (Briere & Scott, 2015). Additionally, defining trauma in broader terms is inclusive of the theoretical approach the therapist uses in trauma-informed practice (Kimberly & Parsons, 2017). This section provides a comprehensive definition of trauma as it relates to trauma-informed practice and incorporates two theoretical approaches I focused on in my practicum placement.

2.1 Defining Trauma

The word ‘trauma’ is a widely known concept with multiple definitions (SAMHSA and Justice Strategic Initiative, 2014) used to attach meanings to disturbing life experiences. Traumatic events or experiences impact people in varying degrees and are typified by psychological distress and/or physical injury (Courtois & Ford, 2009). Major types of trauma include one or a combination of: child abuse, mass interpersonal violence involving high numbers of casualties outside of war, natural disasters, large-scale transportation accidents, fire and burns, motor vehicle accidents sex trafficking, torture, war, or witnessing or being confronted with the homicide or suicide of another person (Briere & Scott, 2015). Typically, clients defined their trauma using categorical definitions such as trauma that occurred in
childhood or adulthood in a sexualized, physical or psychological manner. Some clients experienced Type I traumas, whereas other clients experienced Type II traumas (Meichenbaum, 2003).

Type I traumas are defined as single-incident trauma, or an event that occurred “out of the blue” (Courtois & Ford, 2009, p. 15) such as rape, motor vehicle accidents, a single episode of abuse or assault, and/or witnessing violence (Meichenbaum, 2003). Type II traumas involve complex or repetitive trauma such as ongoing sexual/physical and/or psychological abuse, combat, domestic violence, or community violence (Courtois & Ford, 2009; Meichenbaum, 2003). Type II trauma can interrupt a client’s “emotional and behavioral regulation and stability; the ability to think, learn and concentrate; impulse control; self-image; and attachment relationships with others” (Mirabito, 2017, p. 121). The majority of the clients seen at my practicum placement setting had complex (Type II) traumas which manifested into other diagnoses’ including: psychosis, personality disorders, depressive disorders, anxiety disorders (e.g. obsessive-compulsive disorder), trauma-stressor-related disorders (e.g., post-traumatic stress disorder), eating disorders, substance-related and addictive disorders, dissociative disorders, and somatic symptoms and related disorders. Some clients experienced a combination of traumatic experiences that drew on past and/or present experiences, while others experienced varying degrees of secondary trauma and/or vicarious trauma (VT) that negatively affected past and/or present romantic relationships.

Secondary trauma refers to negative emotions expressed by a person who has intimate contact with a traumatized person (Arzi, Solomon, & Dekel, 2000). Effects are ‘secondary’ as they have not experienced the trauma event directly (Nelson Goff, & Smith, 2005). Contrary, VT, “is the negative transformation in the helper that results from empathic engagement with
trauma survivors and their trauma material, combined with a commitment or responsibility to help them” (Pearlman & Caringi, 2009, pp. 202-203). Both secondary trauma and VT play a vital role in working with individuals experiencing direct trauma. These are important concepts for therapists to be aware of while working with trauma survivors, and equally as important to recognize the effects secondary trauma and VT have in clients’ romantic relationships.

For the purposes of this report, when I speak of trauma, I focus on two definitions of trauma, as each independent definition does not encompass the totality of trauma experiences. First, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) defines trauma as:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. directly experiencing the traumatic event(s);
2. witnessing, in person, the event(s) as it occurred to others;
3. earning that the traumatic event(s) occurred to a close family member or close friend – in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental;
4. experience repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officer repeatedly exposed to details of child abuse).

(Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure if work related) (p. 271).

The DSM-5 definition connects trauma experiences to diagnostic criteria such as post-traumatic stress disorder (PTSD), and other acute stress disorders. The DSM-5 fails to, “consider events to
be traumatic if they are merely highly upsetting but not life threatening – for example, extreme emotional abuse, major losses of separations, degradation or humiliation, and coerced (but not physically violent) sexual experiences” (Briere & Scott, 2015, pp. 9-10). Given the limits of the DSM-5 definition of trauma, I also include Briere & Scott’s (2015) definition of trauma stated as “extremely upsetting, at least temporarily overwhelms the individual’s internal resources, and produced lasting psychological symptoms” (p. 10). Together with the DSM-5 definition of trauma, the cumulative nature and adversities of clients’ experiences are brought to the forefront of therapy. Defining trauma is an integral part of trauma-informed practice and is inclusive to which theoretical approach the therapist uses in his/her practice.

2.2 Theoretical Approaches to Trauma-Informed Practice

There are numerous theoretical approaches a therapist can use in trauma-informed practice. The choice of what therapy to use is largely based on therapist discretion, typified by empirical research the therapist orientates towards. Additionally, the choice of theoretical approach is largely dependent on where the client is at in their trauma processing, recognizing that not every client fits with one specific theory. In my practicum, my professional associates had strong orientations toward CBT and attachment theory. Additionally, in my previous employment, CBT was a foundational theoretical approach to crime reduction. As a result, I focused on these two theoretical approaches as the main underlying theories in the work I did with clients.

2.2.1 Cognitive behavioral theory and trauma-informed practice. Cognitive behavioral theory (CBT) is an empirically based theory that was developed in the 1950’s (Sweet, 2010), and has been integrated into social work practice since the 1960’s (Thomlison & Thomlison, 2017). CBT is an effective therapy for an array of client issues and is the basis of
many treatment modalities used to combat symptomology associated with trauma (e.g.,
prescription medications, eye-movement desensitization reprocessing, touch therapy etc.).
(Sweet, 2010; Thomlison & Thomlison, 2017). The goal of CBT, “is to help people identify
distorted thinking and to modify existing beliefs, so that they are better able to cope and change
problematic behaviors” (Cusack, et al., 2016, p. 131). Behavioral changes are accompanied by
shifts in cognitive processing about the traumatic experiences that supports long-term adaptive
change (Thomlison & Thomlison, 2017, p. 60). This requires that problem behaviors can be
identified and changed, that there is a belief that cognitions shape behaviors, and that effecting
behavioral change requires a systematic approach (Thomlison & Thomlison, 2017). CBT offers
the therapist a guide to assist clients in addressing erroneous thinking relative to their perceived
problems by the use of cognitive restructuring.

In my previous social work experience, cognitive restructuring was paramount to the core
correctional practices of the ministry. Cognitive restructuring focuses on collecting information
in an objective and non-judgemental way and asking questions about the circumstances
surrounding the behaviour in order to establish a link between thinking, feeling and behaving.
Identifying and correcting erroneous thoughts, feelings and behaviours are paramount to
cognitive restructuring, which enable clients to reach established goals. Additionally, CBT has
been used to treat complex traumatic stress disorders and has filtered its applicability into other
cognitive-behavioural interventions including: prolonged exposure (PE), cognitive processing
therapy (CPT), eye movement desensitization and reprocessing (EMDR) and stress inoculation
therapy (SIT) (Cloitre, Jackson, & Nissenson, 2009).

CBT has gained widespread adoption in trauma-informed practice as clinical treatment,
as it is client-dependent and focuses on present circumstances of the client (Thomlison &
Thomlison, 2017). CBT assists in challenging the beliefs or meanings clients attach to these events by separating thoughts, feelings and behaviors relative to the presenting problem (Sweet, 2010, Thomlison & Thomlison, 2017). Challenging clients’ personal beliefs systems includes discussion of their morality, and views of themselves, others and of the world (Scott, 2013). It also includes a discussion regarding internalized rules and ideas and any interpersonal distortions (Sweet, 2010), which can be daunting for trauma survivors to endure.

My experiences with CBT in my practicum were vastly different than my previous employment experiences. In my practicum, I experienced an array of client distortion between thinking, feeling, and behaving versus how the client defined their traumatic experiences. Typically, the stronger the traumatic impact, the less likely the client was to have insight into their erroneous ways of thinking, feeling or behaving. These reactions were typified through the use of behavioural controls they had in past and present relationships and manifested into catastrophic ways of thinking about the world. As such, it was difficult to learn how to untangle thinking errors when it was engrained into their everyday self-talk. For example, most clients were taught “not to feel” at a young age, either by their perpetrator, through system failures, or as a survival mechanism for them both historically and presently. These clients appeared to have one foot in the present and one in the past and were not fully engaged in the therapeutic process.

Michael Scott (2013) is a Consultant Psychologist, currently working in private practice in Liverpool. He has a particular interest in Post-Traumatic Stress Disorder and CBT and has been an expert witness for 20 years. He provides individual treatment and workshops and is the author of twelve books. Scott (2013) describes this half-view of clients as the Treadmill of the PTSD Sufferer, which I incorporated in my practicum with clients who experienced trauma.
According to Scott (2013), the Treadmill of the PTSD sufferer starts with the client being unable to manage daily life hassles (e.g., undelegated household responsibilities), which manifest into poor problem-solving communication wherein the client spins daily life hassles into their trauma experiences. Typically, clients respond with anger, which manifests into alienating-type behaviors where the client silently removes himself/herself from family, friends, colleagues and professionals (Scott, 2013). As a result, clients become enmeshed in a negative mood that interrupts their ability to tackle a new daily hassle (Scott, 2013).

In my practicum, I used a visual representation of the Treadmill of the PTSD Sufferer with clients, which assisted clients to stay present during cognitive processing. For example, I worked with a First Responder who regularly shut-down during cognitive processing. The client minimized their own traumatic experiences based on witnessing other horrific events involving decapitation, death and destruction, and did not feel supported by their co-workers, family or friends. The client became angry, isolated, and was reported by their family as negative. Correcting thinking errors in the context of First Responder trauma is difficult, as minimizing traumatic experiences is a self-defence mechanism, and psychological denial is often supported by other members of their profession (Kirschman, Kamena, & Fay, 2014). Using a visual representation of the Treadmill of the PTSD Sufferer with the client, the client began to acknowledge their traumatic experiences and start to cognitively process through those experiences.

Although CBT is used in trauma-informed practice as an empirically based treatment modality, it assumes that client motivation will be consistent across sessions and fails to account for relationship attachments clients have that impact their ability to follow through in attaining their goals (Thomlison & Thomlison, 2017). The use of CBT has been criticized as a simplistic
approach focusing on thinking and feeling relative to trauma processing. Trauma can override once ‘normal’ thinking and feelings. Not all ‘irrational’ thoughts, feelings or behaviors are in fact irrational, and may be products of the traumatic experience or event (Beidel & Turner, 1986). Being unable to discern what caused irrational thoughts and/or feelings without consideration of past experiences is one of the critiques of CBT (Thomlison & Thomlison, 2017). Understanding specifically that type II or complex trauma can disrupt relationship attachments (Mirabito, 2017), it is important to include annotations of a clients’ past experiences. Clients’ relationships, “determine social and emotional functioning beyond infancy and across the life span” (Page, 2017, p. 11), and provide insights in trauma-informed practice. Attachment theory moves beyond identifying and correcting irrational or erroneous cognitions or perceptions as it allows for the client to connect to their experiences. This theory is rooted in both of my professional associates’ orientation toward trauma-informed practice.

2.2.2 Attachment theory and trauma-informed practice. John Bowlby (1958, 1982) and Mary Ainsworth’s (1978) attachment theory refers to the early bonds between the child and caregiver(s) or ‘attachment figure(s)’ such as parents, older siblings, other relatives, or close relationships with non-family members (Ainsworth, 1978; Bowlby, 1958, 1982). Attachment is based on the quality of interaction between infant and caregiver(s) or persons perceived as stronger than them (Holmes, 1993; Page, 2017). Early attachment bonds form the basis of internal working model (IWM) of how clients view themselves and others, and influence thoughts, emotions and behaviors in close relationships (Cobb & Davila, 2009). Relationship bonds “provide a template for future relationships” (Greenman & Johnson, 2012, p. 562), and are characterized by the need for children to feel safe and protected (Rasmussen, 2012). The stronger and healthier the bond between a child and his/her attachment figure(s), the more likely a child
would feel secure in his/her attachment to the primary caregiver (Page, 2017; Rasmussen, 2012). Secure attachments are “the basis for the acquisition of critical social skills that determine social and emotional functioning beyond infancy and across the lifespan” (Page, 2017, p. 11). In contrast, attachments rooted in weaker or unhealthy bonds between the child and his/her attachment figure, the more likely an insecure attachment would form towards his/her caregiver (Page, 2017; Rasmussen, 2012). An attachment figure that resorts to physical or psychological power over an infant or child has shown to negatively impact a child’s perception of safety and trust with themselves and other adults (Page, 2017). Secure and insecure attachment bonds continue throughout the lifespan, unless there is a, “reestablishment of confidence in the safety and protection of the caregiving environment” (Page, 2017, p. 12), or re-established in adolescent and adult relationships (Rasmussen, 2012).

Both secure and insecure attachments can be seen in the lives of people who have experienced trauma (Holmes, 1993). In private practice, categorical types of trauma (e.g., childhood sexual abuse, physical trauma, and psychological trauma) were commonly associated with insecure attachments the client had with an attachment figure. In my practicum, a client was repeatedly sexually abused by her father from childhood into adulthood. She was ‘paid’ in various ways through gift-giving, until she became addicted to drugs. Despite her recognition of these wrongdoings, she believed the sexual abuse to be ‘normal,’ as the perpetrator was her father. Working with her, my professional associate and I created a safe environment absent of the judgement and ridicule she was accustom to. We assisted her in recognizing how the lack of current appropriate adult relationship bonds was relatable to her past traumatic experiences, and how these relationships continued to negatively impact her current functioning. We focused on
immediate correction of her self-blame and exclusive behaviors and allowed her the space and opportunity to feel her trauma.

The formation of attachments beyond childhood are important factors to consider in trauma-informed practice (Page, 2017). Present trauma can also interrupt once secure attachments, as internalizing trauma disrupts the internal working model (IWM) and can cause distortions of one’s view of themselves and others. Additionally, internalizing trauma can negatively influence thoughts, feelings and behaviors in close relationships. In my practicum, my professional associate and I worked with a First Responder who described how his type II traumatic work experiences disrupted secure attachments with his friends and family. His experiences included pulling dead bodies from buildings, and incidents wherein he was unable to save people despite being so close to doing so. He talked in depth about flashbacks and night terrors of the victims he could not save, and the turmoil it created with his friends and family. He no longer felt supported by his friends or families’ inability to understand what he experienced and became isolated and depressed. He catastrophized his relationship with his wife and his children. He used verbal aggression with his family in order to explain himself; often involving threats to them should they leave. He checked household alarms multiple times throughout the day and night, encouraging his friends multiple times in a day to do the same; overly afraid that they may stop working at any moment and someone he loved would get hurt or die. Resentment and animosity became the new discourse in his home.

This client’s job created his insecure attachments, and his processing of trauma created catastrophized thinking errors that became enmeshed in his life. He alienated himself from his immediate and extended family, friends and community and believed that no one cared about him. There were no early childhood attachments injuries, nor previous trauma that would explain
his alienating behaviors. We were able to work with him in dissecting his trauma and categorically placing his insecurities where they belonged; with his job. My professional associate and I assisted him in recognizing where he concentrated his energy, and the ways in which it was creating issues within his family and community. We discussed triggering feelings, emotions, and perceptions and provided him with tools he could use when he felt himself escalating. We continued to work towards him feeling more secure in his own body and in his relationships. Adding his family to the therapeutic process would come later, as he continued to work towards reducing his interpersonal hypervigilance in order to be in a better place to work effectively with his family.

This example illustrates that focusing on historical attachments may not provide an explanation in trauma-informed practice. By incorporating CBT and attachment theory together, attachments can threaten the very existence of a person’s thinking errors, which can manifest into the Treadmill of the PTSD sufferer and continue to interrupt daily life functioning. Trauma can create insecurities in once secure relationships, change peoples’ moods and thought processes, and negatively impact the way in which people function in their daily lives. The way in which people internalize their trauma experiences cannot be answered by a single theory as people are multifaceted in their individualized experiences (Kimberly & Parsons, 2017). By using two alternate theories as the foundational underpinnings of trauma-informed practice, I was able to expand my theoretical orientations regarding trauma-informed therapy. While there is no right or wrong way to connect theoretical foundations to trauma-informed practice, there is an understanding by trauma theorists that focusing on one or two therapeutic approaches can hinder client results (Kimberly & Parsons, 2017). Providing an eclectic approach for clients allows the therapist and client to work collaboratively in dissecting trauma, identifying the
strengths of the client, creating achievable goals and working towards reducing the impact trauma has on the client’s life. CBT and attachment theory were the foundational theories I used in trauma-informed practice, and in the application of a conceptual framework for trauma-informed practice.

The next chapter highlights important aspect of trauma-informed practice as it relates to my practicum experiences. I discuss the importance of: using a conceptual framework in trauma-informed practice, client communication, the role of the therapist, and the advanced clinical skill set essential for trauma-informed practice.
Chapter 3: Trauma-Informed Practice

Trauma-informed practice emphasizes the importance to avoid re-traumatization of client experiences (SAMHSA and Justice Strategic Initiative, 2014). One of the challenges I found in working with clients who have experienced trauma was that while there were guidelines for trauma-informed practice, there was not a prescribed roadmap for sessions. Sessions were determined by where the client was at in terms of cognitive trauma processing and rooted in their experiences from the last session to present session. Given that my previous work in government had an ascribed way of assessing client risks and needs, I often found myself struggling in private practice on where to take the client in a session. Additionally, I felt internal pressure to not re-victimize long-term clients who had made significant progress in processing their own traumatic experiences. I discussed this in a supervision meeting with my professional associates, and my external professional associate responded by providing a cohesive conceptual framework that he developed and uses when working with new and existing clients (shared with permission from D. Ebert, 2018). While this framework was designed specifically for families and couples, its adaptability and fluidity allowed for its use in trauma-informed practice (see Appendix A: D. Ebert’s Mini-Schema for Assessing Families and Couples).

This conceptual framework was rooted in CBT and attachment theory, and yielded important information regarding: client communication, their interpretation of their presenting problem, and highlighted clients coping strategies. When I applied this framework to trauma-informed practice, existing clients were able to speed through the process without re-traumatization of their experiences. For new clients, this framework was a succinct way to illicit information, and was an integral component to my practicum experiences. This chapter integrates the use of my external professional associate’s conceptual framework for practice with
the six key principles of trauma-informed practice: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical and gendered differences in trauma processing (SAMHSA and Justice Strategic Initiative, 2014).

3.1 Client Communication in Trauma-Informed Practice

During my practicum experience, emphasis was strongly placed on clients’ verbal and nonverbal communication. Verbal communication focused on the linguistics clients used to define their trauma, descriptions they attached to people in their life, and how clients generally communicated. For example, one client repeatedly used words like “bull-shit,” or “god-damn,” but this was how he generally communicated. Verbal communication also included assessing where the client placed blame (e.g., on themselves, others, and/or systems), nick-names they gave to others, and sentimental or foul language clients use to depict people in their stories. In one example, I asked a client to describe the relationship she had with her parents. When describing her father, her voice was elevated, she was physically uncomfortable, and she would only use his first name and an assortment of ‘colourful’ adjectives to describe him. On the contrary, when she spoke of her mother, her voice and physical presence was calm, and called her ‘mom,’ and used words like ‘sweet’ or ‘lovely’ to describe their relationship. Verbal communication is a key component to trauma-informed practice and elicits information regarding clients’ mind-body connection/disconnection.

The mind-body connection/disconnection is rooted in the linguistic way in which clients express themselves and highlights the key principle of recognizing clients’ cultural and historical traumatization (SAMHSA and Justice Strategic Initiative, 2014). For example, we worked with a client who had a history of disordered eating and was presently experiencing physical pain as a result of a car accident. She had a history of dissociation stemming from sexual abuse, and when
in a dissociated state, she would be unaware of her present circumstances, while seemingly verbalizing in a coherent and concise manner. In session, she prefaced parts of her body with the word “the” as in “the leg,” or “the arm.” My professional associate quickly noted her disconnection between her mind/body and assisted her in correcting her language to ensure she was connecting with her body. She asked the client to refer to her body parts as “my” not “the” in order for her to connect to herself and her experiences. While the client over-emphasised the word “my” throughout the session, her focus shifted from being disconnected from her body, to owning her body and thereby owning her experiences.

Nonverbal communication focused on the clients’ physical reactions in sessions when discussing their experiences. These included head-tilts, shifting, change in communicative language and other nervous gestures. One client we worked with would often stop talking when she was processing her trauma and dissociated herself from the session. While not diagnosed with a dissociative disorder, she did experience dissociative phenomenon as a learned behavior resulting from being the victim of extreme childhood sexual abuse. Another example involved a client who was sexually abused as a child and throughout her adulthood. While she was able to recall each unwanted sexualized encounter, she was not able to express how she felt during each encounter. During her traumatic experiences, she was ‘out of her body’ as opposed to working from within herself; a dissociation she learned at a young age that resulted in an effective coping mechanism.

Identifying when clients are ‘present’ versus when they are not is essential to trauma-informed practice (Scott, 2013). Not every client who comes to session is in a stable position to be working on cognitive processing and being able to recognize disassociation is a tell-all symptom informs the therapist when the client needs a break, and/or requires the use of other
therapeutic modalities. When clients are not present, using “guided imagery creates a deeply receptive mind, body, psyche, and spirit state during which change becomes possible” (Curran, 2013, p. 19). Guided imagery was an effective way for some clients to connect their mind to their body, however, guided imagery was not appropriate for all clients. Not every client was receptive to ‘closing their eyes’ as some clients were hypervigilant and anxious about doing so. Having them close their eyes in a guided imagery technique could have potentially done more harm than good. In these incidents, we asked clients to eat ice as a way to reduce traumatic processing anxieties. Having a client eat ice can seem elementary in its delivery, however, it was effective in my practicum experiences, and provided clients with another way in which to reduce situational anxiety. As learned from my previous employment, the process of eating ice creates a crunching sound the mind re-orientates too, and the cold sensation that ice produces distracts the mind from over-processing.

Client communication is an important factor to consider in trauma-informed practice. Preparing clients for cognitive work is based on where the client is in the present moment and recognizing that not every client is in a position to do cognitive work at that exact moment is essential in trauma-informed practice. It not only includes assessing for verbal and nonverbal language, but also assess for emotional expression and emotional closeness the client expresses about their traumatic experience/event.

3.1.1 Emotional expression. Emotional expression is a component of the conceptual framework for trauma-informed practice. Emotional expression involves the therapist assessing how the client attaches their emotions to their experiences; that is, where clients put their energy. It involves assessing clients’ emotional expression of feelings to the stimulus. Any discrepancies in emotional expressions needs to be identified and sorted out between the therapist and the
client. For example, we worked with a male client who had his own trauma history that coincided with vicarious trauma of his spouse. His responses to ‘normal’ stimuli were disproportionate to his emotional response. On three occasions, he talked about his daughter using a waffle maker after supper had already been prepared. He was enraged that she “simply couldn’t eat what was already there.” When he talked of his experiences, his voice was elevated, he spoke in angry tones and he was physically ramped up. While I struggled to understand why he repeatedly referred to the waffle maker experience, my professional associate pointed out that his experiences were not about the waffle maker per se, it was about him having to clean up another life mess.

A client who shifts their energy into the themes of the session is an important aspect in trauma-informed practice. Most clients I worked with were unable to connect their emotionality to their experiences, and by acknowledging the energy that matched the themes in session, clients felt as though we understood their experiences. When clients had difficulty expressing their true feelings regarding their traumatic experiences, we assisted by reflecting what they had expressed in a genuine, trustworthy and honest way. Another example involved a client who had a trauma history regarding childhood sexual abuse, accompanied with systemic trauma who needed a wheelchair ramp in the front of her house that she refused to have installed there. I was confused as to why she would refuse something that aided in her rehabilitation. My professional associate noted that it was not about the wheelchair ramp, it was about being her trauma being noticed by her neighbours and her trauma being put on display for everyone to see. It was easy for me to get caught up in the details of client experiences and lose sight of the meanings associated with them, which is reflected in my previous employment experiences that focused on facts and solutions. Identifying fact-based details are important, but “it’s not about the waffle
maker”. It is about how historical and present trauma can impact various systems in a client’s life, which can be empowering for clients during the therapeutic process. By minimizing client details, I was able to identify the emotion they were experiencing and extract more information regarding how the trauma has impacted their overall life.

Attaching clients’ emotional connection to their trauma allowed me to focus on clients’ emotional attachment to everyday life events. Some clients had varying degrees of emotional expression, however, some had difficulty understanding why something like a waffle maker or a wheelchair ramp elicited such strong feelings. In fact, more often than not, some clients did not even recognize their own disproportionate emotional responses. For example, we worked collaboratively with a married couple; each of who had an independent trauma history, current traumatic experiences and vicarious trauma which impacted them in varying degrees. The husband was heightened throughout sessions, and unable to see the impact his misappropriation of his emotions was having on his relationship with his wife. My professional associate randomly asked about his feelings about Donald Trump, and despite him being taken back by the question, he discussed his views of Donald Trump in a somber, clear and calm way. She asked him if talking about Donald Trump felt different than him talking about his current traumatic experiences. He agreed, and my professional associate took time to educate him on recognizing his escalation behaviours, specific to him, and encouraged him to focus on his emotional misappropriation. Focusing on the body to guide the mind is an important aspect of trauma therapy and assisted this client in identifying escalating behaviors.

3.1.2 Emotional closeness. Another component of client communication and of the conceptual framework for trauma-informed practice involves assessing for clients’ emotional closeness or distance to their experiences. Emotional closeness includes painful emotions, such
as, anger, sadness and/or fear, and pleasurable emotions, such as joy, happiness, excitement. It is imperative for the therapist to weigh which emotions are locked at the expense of another. For example, we worked with a client who was locked into anger when discussing her trauma and descriptions she had about people in her life. Anger was the primary emotion she was shown growing up, and one of the only emotions she knew how to feel. As a result, she did not allow herself the opportunity to feel sadness when she talked about her inevitable death from cancer. However, through soft correction of her language, and redirecting her emotionality to the trauma is originated, we created space she gave herself permission to feel sadness. It allowed her to fully express other locked up feelings of grief as well and put her energy into acceptance as opposed to denial. Inherent to client communication and trauma-informed practice is how the therapist also presents to the client.

3.2 The Role of the Therapist in Trauma-Informed Practice

In my practicum experiences, the role of the therapist was essential to trauma-informed practice and included rapport building, transparency, self as instrument, and enhanced skill development. Each of these highlighted different key principles of trauma-informed practice and started with balancing the mirroring of direct and/or indirect communicative styles. For me, recognizing that some clients preferred a direct approach over an indirect approach was based on how they expressed themselves in terms of generalized statements. For example, one client said, “all people have problems, I don’t understand why mine affected me this way.” Her comparative trauma statement was a way for her to deflect from her own traumatic experiences, yet at the same time, blame herself for her traumatic experiences. Making this generalized statement made me switch to a more indirect way of communicating wherein I used softer language. I worked with another client who directly spoke of how he needed to be in therapy and listed off the
adverse effects his traumatic experiences had on varying parts of himself. The way in which he
directly communicated with me allowed me to remain direct in my questioning and
communicative statements with him. While there is a switch between being indirect and direct,
the interchange of each form of therapist communication in session is an important aspect of
trauma-informed practice and enhances rapport and trustworthiness between the client-therapist.

3.2.1 Rapport building. Although rapport building is a critical part of developing an
alliance with clients, I was surprised by how quickly rapport was established with clients in
private practice. Clients need to feel physically and psychologically safe in order to tell their
story (SAMHSA and Justice Strategic Initiative, 2014). New private practice clients were
required to read and sign a straight-forward document regarding informed consent for therapy.
Informed consent highlighted the client as the driving force for sessions in terms of their defined
problems and goals of therapy. It outlined the therapists’ professional responsibility in terms of
record keeping, defined boundaries between the client and therapist, and provided specifics about
the limits of confidentiality. Limitations of confidentiality were highlighted in situations when a
court demands client records through a subpoena or the testimony of the therapist, and when
there is an emergency and the therapist believes the client may harm themselves or others, or
when the therapist has reasonable grounds to believe that a child is at risk of being abused or is
being abused. My professional associate would clarify any questions the client had regarding
informed consent and reiterate important pieces of consent. For existing clients, my professional
associate would often begin sessions by acknowledging the clients’ strength and resilience in
returning to therapy and highlight their safety within the confines of her physical place of
business and the limits of confidentiality. Regardless if the client was new or ongoing, my
professional associate always ensured the client felt physically and psychologically safe in order
to effectively engage in the therapeutic process. If a client appeared resistant to the therapeutic process, my professional associate would explore those feelings with the client and, more often than not, clients who expressed reluctance were not there of their own accord.

Client resistance was typical in situations wherein one person would refer their spouse to therapy without providing a clear explanation of their purpose. Some clients wanted their spouse to attend counselling with them in order to rectify marital discord. Other clients wanted their romantic partner in counselling with them in order for them to become more attuned to their needs and wants from their relationship. Reassuring the client about the value of the therapeutic support role a romantic partner can have was paramount to resistant clients feeling psychologically supported during counselling. A therapeutic session would not continue if the client remained resistant to the process. Informed consent was crucial in the rapport building process, as was orientating ourselves to why my professional associate and I believe in trauma-informed practice as a therapeutic modality in the reduction of trauma symptomology. Additionally, therapist transparency is also an important aspect of trauma-informed practice.

3.2.2 Transparency. Generally speaking, trauma survivors can detect when a person is being dishonest or when they feel they are being misled. As a practicum student in this role, it was important to never pretend to know what I did not know, as most clients saw right through that. By being transparent, clients saw the humanity in who I was in my role and supported the trustworthiness principle of trauma-informed practice. Being transparent amplified meaning in the work we did in future sessions. Trauma-informed practice is about the therapist being genuine and true to the process of trauma dissection and guiding the client to a place of ease and creating safe space so they can tell their story (SAMHSA and Justice Strategic Initiative, 2014). What helped me through this process was constantly evaluating my connection to myself in
relation to clients’ disclosures. I frequently checked-in with myself, assessing my level of focus and engagement I had in sessions. Too much or too little focus and engagement both indicated to me that I may be mentally distracted. When I found myself mentally distracted, I realized the client had moved off topic and I encouraged the client to re-direct back to the session. Self-reflection and evaluation of competencies was an integral component of ethical practice that governed my practicum experiences and assisted in enhancing my professional development.

In working with trauma survivors, I realized quickly that the message sent, is not always the message received. Most trauma clients have a tendency to ‘spin’ all experiences into one traumatic chaotic ball; without separating generalized life experiences from their defined problem. As a result, it is important to ask the client to reiterate back what is being said in their own language; ensuring the message sent has being appropriately received. This is especially important with clients who were abuse survivors, as they received many types of mixed messages throughout their life. Additionally, being transparent in therapy ensures minimalized communicative errors between the therapist and client and increases trustworthiness with clients.

3.3.3 Self as instrument. Using self as instrument was essential in the work we did with clients and was two-fold; dissecting client trauma and situating our own experiences within the therapy session. At times, dissecting client trauma involved the use of self as therapist that reflected clients’ emotional discourse. In the example involving the client and the waffle maker, my professional associate used herself as an instrument in the therapeutic process; noting her emotionality she felt when he talked in angry tones about the waffle maker and asked him if he could feel himself in his responses. This allowed us to work towards dissecting the emotional closeness he had to the waffle maker, and for him to process understand the true meaning behind what the waffle maker actually represented for him; cleaning up another life mess. We used our
feelings as interpreted by clients’ emotional discourse to assist them in identifying the intensity, (or lack thereof), they bring to their experiences. We also used self as instrument in relation to our own trauma and the gift that trauma can bring to a therapeutic session.

Given that my practicum experiences far exceeded my original clinical skill set, at times I felt inadequate in sessions. My professional associates provided direction in this regard and highlighted the importance of connecting feelings of inadequacy to self-awareness. Self-awareness moves beyond who we are as therapists and in the work that we do. It involves checking in with ourselves, and constantly evaluating our own meanings and experiences we attach to various situations. For me, recognizing my discomfort in client disclosure was essential to becoming more self-aware as a therapist. There is a gift in trauma, and unfortunately for me, I lost that gift along the way which limited my ability to act on my intuition and gut feelings in session; both of which are relied upon in trauma work.

My external professional associate noted the importance of making statements like “it’s my understanding that…" without disclosing personal experiences and staying with the client. This allowed me to regain pieces of my trauma intuition which was an invaluable component of moving forward in my career. Danylchuk (2015) highlights the importance of therapists to, “know their own psychic structure; their own inner landscape, family-of-origin issues, roles played, defensive system used; the manner in which they could or could not express emotions; expectations of self and others; and the impact of their culture is a life-long journey” (p. 2). Self-awareness and consultation with supervisors helps to protects us from vicarious trauma in our work (Pearlman & Caringi, 2009). Essentially, a healthy therapist can attest to move beyond basic communicative skills into advanced forms of communication with clients. A
key component in advancing these skills involved the true understanding of vicarious trauma and the impact working with trauma survivors can have on the self.

VT can have serious implications on a therapist’s overall mental and physical wellbeing. Internalizing client traumatic memories into their own memory systems may result in a therapist experiencing PTSD symptomology such as intrusive thoughts, images and/or painful reactions (McCann & Pearlman, 1990). Additional research on VT suggests that, “vicarious traumatization can lead to changes in cognitive beliefs/schemes” (Măirean & Turliuc, 2013, p. 424). Therapists who have certain personality dispositions such as high levels of neuroticism (Mairean & Turliuc, 2012), or their own trauma history are more likely to experience VT (Rasmussen, 2012). Protecting oneself from VT includes: therapist awareness relative to their own trauma, peer support, positive and nurturing self-care strategies, high levels of job satisfaction, and being able to balance work and life (Bober & Regehr, 2006, Litt et Phil, Hocking & Hampson, 2013; Măirean & Turliuc, 2013, Pearlman & Caringi, 2009; Rasmussen, 2012;).

VT is not only important in terms of therapist-as-person, it can also impact how the therapist may relate to their clients (Rasmussen, 2012). Learning about the effects of VT and how it can disrupt daily functioning was an integral part of my practicum experience. My professional associates and I discussed the importance of self-care and the need for peer support in order to survive working with survivors. Our peer support team met once a month to de-brief, and we are always there for each other outside our scheduled meetings. We debriefed about our experiences in a safe and supportive environment which allowed us to connect on a more emotional level. VT is real and the things we do to care for ourselves ultimately affects who we are as people and professionals. Additionally, I have taken up Pilates, found solace in exercise, and take time daily to ‘disconnect’ from the virtual world and reconnect with myself as a person.
and as a professional. Understanding VT was never discussed in my previous years as a social worker working in government, nor did I fully understand the impact VT can have on the self as a person and as a professional until my practicum placement.

3.3 Skill Enhancement in Trauma-Informed Practice

Despite 10 years of social work experience, my practicum placement enhanced my basic clinical skill set to advanced clinical skills necessary in trauma-informed practice. I am more confident in my clinical skills today, as I have firm grasp on the totality of what trauma-informed practice entails, and how with ongoing clinical practice and education that my skills will continue to advance. In my practicum, particular emphasis was placed on the importance of open-ended statements (not questions), addition to what has been presented, there are a few highlights from my practicum that enhanced my overall clinical skill set and include: the use of open-ended questions, active interrupting, and understanding gendered differences in trauma processing, and recognizing the resilience of the trauma survivor.

3.3.1 The use of open-ended statements. Once clients felt physically and psychologically safe, they were asked to define their traumatic experiences in their own terms; void of diagnoses and other externalized representations of their concerns. Some clients would discern their trauma based on their past or present experiences and/or a combination of both. Typically, clients defined their presenting problem as involuntary or forced traumatic events placed into broad categorical trauma descriptions (e.g., sexual abuse, physical abuse, and psychological abuse). Other clients defined their presenting problem as voluntary trauma precipitated by their employment or another externalized factor (e.g., First Responders, a work-related injury, and/or previous or current medical conditions). For the most part, clients were unable to tell their story without the use of medical labels they received. For example, I asked a
client to discuss what brought her to therapy, she told me she had anxiety, depression, and post-traumatic stress disorder. When I asked her to specifically define her presenting issue(s) without the use of labels, she reiterated a list of her current diagnoses. She, like most clients, could not separate the medicalization of their problem to the traumatic experiences that precipitated the medical diagnosis. Starting with an open-ended statement like, “what was happening in your life when you were first diagnosed with…” was integral in allowing the client to define her presenting problem in her own language. Open-ended statements are essential in trauma-informed practice as it allows the client to remain in control of the session and attach their voice to their experience.

Focusing on the client’s interpretation of his/her presenting problem allowed the client to own his/her story using their own language. At times however, most clients would deflect away focus from their experiences; hence learning never to ask open-ended questions. While deflection is important for reducing therapeutic anxieties (Courtois & Ford, 2009), refocusing the therapeutic session by active interrupting was essential to return the session back to its therapeutic purpose.

3.3.2 The art of active interrupting. When I was completing my undergraduate degree in social work, we were taught how to actively listen to clients. Reflecting back, we were told to not have barriers such as a desk between you and the client, to lean forward and actively engage in what the client is saying. However, I was never introduced to the concept of active interrupting before my practicum experience. In my practicum, I learned that active interrupting is a skill wherein the therapist interrupts a client’s inconsequential discourse. In trauma work, every client would have gladly talked about anything else other than their trauma. Although deflection is a healthy way to take the pressure off, at times, clients talking about the weather
could have lasted the entire session. For example, one client talked extensively about where she thought she should go for a vacation. I wanted to stop her as I was finding myself being less engaged with what she was saying but did not know how to interrupt her story. My professional associate gently interrupted her and brought her back to the session by reminding her where we left off last session. She was quick, genuine and thoughtful in her approach and the client was able to gently redirect herself back to the session.

I used these skills in a later session with individuals and couples as a way to refocus the session. I continued to practice active interrupting and am now able to redirect the conversation to where it needs to go. As ‘voluntary’ as clients are in private practice, I was amazed at the amount of times a client deflected from themselves; protecting their safety from their trauma. Active interrupting is a key component of cognitive restructuring with clients and is an integral piece to trauma-informed practice as it supports empowerment, voice and choice principle of trauma-informed practice. Interestingly, in my practicum experience, men appeared to deflect more than the women we worked with in sessions. Understanding gendered differences in terms of trauma processing was another key principle in trauma-informed practice.

3.3.3 Men versus women: Product versus process. In my practicum, I learned that men and women can be inherently different in how they define their trauma and how they cope with their own trauma experiences or that of their significant others. When working with couples, I found it intriguing to note the differences in gendered traumatic experiences, and how some men did not appear to understand the woman’s perspective, and vice-versa. In one session, a couple had a hard time relating to one another in their relationship. My professional associate explained that some men are more product orientated, while some women are more process orientated in providing meaning to experiences. According to my professional associate, being product
orientated involves seeking the answers and fixing the problem, but at times, there is no clear answer, and some men resort to shutting down in session. She noted that some women tend to be more process orientated; seeing all the possible scenarios to one or many situations. Some women will exclude their male partners in their process as they see them as possibly unhelpful given their product orientation. For example, I worked with a couple and the husband asked me, “when is she gonna get better?” I asked him if this was his way of saying that he does not have much more in him to keep going. He began to cry and said, “That’s exactly it,” and felt defeated. He did not want to admit his defeat to his wife, as he was “the fixer” in their relationship. When he could not ‘fix’ it anymore, he felt hopeless. His wife was shocked to learn where he was in the process as from her perspective, “he always presents the same.” This understanding afforded the couple the clarity to move forward in their relationship and the therapeutic process.

At times, gendered differences do not always account for marital discord. In my practicum, there were times when both partners were either process or product oriented. Being similarly oriented in the ways in which client’s process their experiences created difficulties in assessing their progress. The difficulty in working with two process-oriented couples, was that each person would spin their trauma in their own relationship. Very seldom did issues get addressed, as both people spent so much time processing and very little time making a decision. Similarly, working with two product-oriented people (e.g., two First Responders) involved deciphering the ‘solutions’ they created for themselves, that, more often than not, were void of any emotional closeness to their experiences.

Identifying process or product orientation in relationships is a helpful and meaningful part of trauma-informed practice. It allows for empathetic insight, and the ability for clients to label outgoing meta-messages for what they are; that of product or process. Additionally,
identifying process and product orientation can change unhealthy discourses in relationships, while highlighting survival techniques of client who are experiencing trauma.

3.3.4 Survival for the trauma survivor. Trauma elicits a host of reactions that can be scary or unfamiliar. As a result, coping (or problem solutions) with one’s trauma transcends to what has either previously worked for them in the past, or what is familiar or safe to them. Coping for trauma survivors is about recognizing that, regardless of how maladaptive it is or was, it was functional in that moment for the client. We worked with an adult who was sexually abused by her father when she was a young child. She blamed herself for not having stood-up to him over the years of sexualized abuse and hated herself now for dissociating in intimate relations with her partner. Reviewing the importance of dissociation as a survival mechanism was paramount to her therapeutic process. In another example, we worked with a First Responder who was having difficulty processing traumatic experiences. He possessed a hypervigilance about the world around him that was ingrained into who he was a person as a result of his profession. Understanding hypervigilance as a coping mechanism allowed us to work together in uncovering what created the hypervigilance in the first place. In other words, “it’s not about the waffle maker.”

Focusing on problem solutions also includes discerning if problems solved were at the expense of the client, the family unit, and/or if solutions lead to growth. As in the case example involving the client who was sexually abused by her father, she was told that being sexually abused was a ‘normal’ thing to do in their family, and if she would tell anyone about the abuse she would be responsible for breaking up the family. Over the years, she used drugs and alcohol as coping mechanisms, and had a difficult time forming appropriate attachment bonds with other adults. For her, problem solutions cost her dearly at the expense of her feeling responsible to
preserve her family unity. Contrary, some clients had used therapy before to assist in coping with their traumatic experiences and found it beneficial in times of crisis.

In my practicum, we worked with clients who cut themselves, others who burnt themselves; each as a means of coping. Varying degrees of coping mechanisms clients used during their traumatic experience identifies who and/or what supports were available to the client at the time of their trauma and allows the therapist to explore who and/or what still exists for them in terms of coping. It is important to be aware of past behaviors of coping, as these can be the best predictors of possible future risks. For example, we worked with a man who was four years sober, and while drugs and alcohol were attractive alternatives to coping, he wanted another option. Understanding where he was in terms of his own process allowed us to explore alternatives for healing and allows clients to discover alternate ways of coping. Putting in safety measures such as a sponsor and revisiting his original sobriety plan was an integral part of his therapeutic process and of trauma-informed practice.

Recognizing what solutions worked, did not work, and what and/or who was available as support is an essential piece of trauma-informed practice. Additionally, recognizing how clients deflect or protect the self during therapeutic sessions, plays an important role in the therapeutic process. It allows the therapist to mirror clients’ coping styles in session. For example, some clients used humour as a way to deflect from painful experiences. When used appropriately and in a timely manner, the use of humour with the client assisted in reducing the relived traumatic experiences. Given the adverse effects trauma can have on clients’ mental, physical, and emotional state, not all clients were able to verbally discuss their problem solutions.

By using my external professional associate’s conceptual framework for practice, I gained valuable information from clients in a concrete, coherent and structured manner that was
different than what I had been practicing in government work. Having a conceptual framework for practice assisted me in dissecting clients’ trauma, recognizing and validating the importance of survival for the trauma survivor, while discerning client communicative patterns and emotional discourse in the course of the therapeutic process. Additionally, this framework allowed me to understand behavioural controls that may impede or excel client process. It was an invaluable tool that allowed me to connect with clients, and more specifically to connect to the six key principles of trauma-informed practice (safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice and cultural, historical and gendered issues). My overall practicum experience enhanced my clinical skills and assisted in my understanding regarding the totality of trauma-informed practice. I did, however, encounter challenges and ethical dilemmas that were integral to my experiences and are discussed in the next chapter.
Chapter 4: Challenges

One of the challenges I faced in working with trauma clients was the lack of preparedness I felt as a graduate level student. While I do believe my classes assisted in enhancing my learning in differing ways, class selection involving clinical skill development was limited. I was fortunate enough to have taken Social Work Practice with Couples, which focused on different clinical approaches to couple therapy. This class assisted me in recognizing the limitations I had on my own clinical skill set and was one of the defining reasons I switched from writing a thesis to completing a practicum. Having additional classes focused on clinical social work practice would have decreased the slope of my learning curve and could have better prepared me for clinical work in trauma-informed practice.

Another challenge I encountered, was the skill disconnect between my years of previous social work employment and my practicum experiences. Given that my social work background originated and continued through government work, my skills in providing therapeutic treatments were limited by the system in which I worked. Being detailed orientated and solution focused was essential to the work I had previously done, however, in private practice, being preoccupied with the details of clients’ experiences initially hindered my ability to process client emotions and find meaning where the clients struggled to do so. “It is not about the waffle maker”, nor is it about providing solutions either. Throughout my practicum experiences, my clinical skill set and knowledge base regarding importance aspects of trauma-informed practice was enhanced. Being uncomfortable with the unfamiliar was humbling and made me realize my infallibilities as a social worker and challenged me to work harder. While I understand that gaining more experience will continue to assist me in skill development, I found value in connecting with my professional associates and my clinical support team.
Consistent with the Guidelines for Ethical Practice (2005b), I am a part of a team of psychologists that meet regularly to enhance our skills and expand our experiences as helping professionals. Our team connection moves beyond education and skill development and encompasses mitigating effects of vicarious or secondary trauma therapists encounter when working with trauma survivors. With assistance from my professional associates and from my clinical support team, I now place extreme value on the importance of collaboration and consultation as a means to expand my competence in professional practice (Canadian Association of Social Workers [CASW], 2005a). Additionally, my professional support network has taught me the importance of taking care of the self as therapist as imperative to trauma-informed practice.

4.1 Ethical Dilemmas

As we worked with trauma survivors, I encountered a number of ethical dilemmas. One of these was working with minors; children under 18 years old (Schirr, n.d.). In order to do clinical work with children under the age of 18, both parents (regardless of their relationship) have to consent to the process. In one instance, we could not work with a 16-year-old who wanted counselling as both parents would not provide consent (Schirr, n.d.). While we encouraged the consenting parent to return the matter back to family court, we could not help but feel let-down by the rules that govern our professions. In my previous professional experiences, some adolescents who were not given an opportunity to address their issues in their own terms acted out maliciously and/or illegally. I struggle in finding balance between promoting social justice and not being able to assist those who express the desire for therapeutic assistance.

Trauma-informed practice mirrors the Canadian Association of Social Workers [CASW] (2005a) Code of Ethics. Trauma-informed practice respects the inherent dignity and worth of all
people (CASW, 2005a) as it identifies trauma survivors’ vulnerabilities and reduces re-traumatization of clients’ experiences (Kimberly & Parsons 2017). There are, however, ethical dilemmas that transpired across my practicum experiences. The overarching theme regarding ethical concerns involved creating boundaries with clients. While boundary stipulations were laid out specifically in informed consent documents, there was an instance wherein a new client leaned in for a hug post-session. I was taken back by this request for affection, but followed my professional associates lead by offering a handshake instead.

Talking about it afterwards, my professional associate noted the importance of establishing an internalized system of rules to determine the reciprocity of physical touch. For some clients, a hug is a natural response and is an important part of the therapeutic process for them. CASW (2005b) outlines specifically the avoidance pf physical contact with clients: “Social workers avoid engaging in physical contact with clients when there is a possibility of harm to the client as a result of the contact” (p. 12). What I struggle with is the word “possibility.” In the case example above, she was a new client. How am I expected to know what is “possibly” going to cause harm after one appointment? I continue to struggle with this vague description within the guidelines for ethical practice. After further consultation with my professional associates, I learned the importance for therapists to find a balance between one’s own comfort with reciprocal physical gestures made by clients, and the therapeutic value it holds for some clients. While I am not one for physical touch, I question at what point a hug turns into something more than just a hug. Transference is a real expression that can happen between the client and therapist. My ongoing internal debate of “do I/don’t I” allowed me to self-reflect and make a set of internalized rules that assist me in making the decision to reciprocate a hug should a client initiate such contact.
Another ethical dilemma involved reporting child protection concerns to Social Services. My professional associate and I worked with a client who disclosed her suspicions regarding her child being sexually molested by her step-father. In consultation with my professional associates, my knee-jerk reaction in contacting social services was not warranted, as the client had no evidence to support her claims, had reported her suspicions previously, was in a position to protect her child from ongoing abuse, and would be removed from the house and be unable to protect her son. Ongoing ethical dilemmas are a natural occurrence in all forms of therapeutic practice. I respect guidelines imposed by governing associations, and while there are some gray areas noted, I will continue to balance my own interpersonal conjecture with these guidelines and my ethical obligations to social work practice.

Another challenge I faced in my practicum involved highlighting some injustices of social work values when I worked for the government. When I worked with young offenders, I was assigned a file, and there was a structured assessment we used to identify risk/need areas and strength areas with the client. We worked on dissecting thinking errors through cognitive restructuring techniques and set goals for successful completion of their orders. The work I did with youth paid specific attention to the events leading up to the criminal act itself and was often void of client trauma. While each youth’s history was accounted for, increased caseloads, time constraints of court orders, and lack of worker training often did not address clients’ underlying issue(s) that influenced criminal behavior. Additionally, the systems allowed for workers to ‘refer out’ if identified risks included specialized services such as addictions or forensic counselling. There was an overarching theme of trauma, but seldom was this dissected by the worker to inform clinical decisions. As a result, some youth were often pigeon-holed into services that may not have been in their best interests, and their most identified risk area was
treated in isolation from complex trauma experiences. It was not until my practicum placement that I recognized the injustice of the justice system. While I believe my previous employment experience assisted me in having base knowledge and a skill set, I do find myself questioning the validity of the social work discipline within government bureaucracy. My practicum experiences in clinical work have shown me the true nature of social work inherent to its place in trauma-informed practice.
Chapter 5: Conclusion

This report summarized my practicum experiences in private practice providing trauma-informed therapy to people who have experienced varying degrees of interpersonal trauma. Working with clients who have experienced trauma, there are a number of factors inclusive to trauma-informed practice. Having an operational definition of trauma that encompasses the totality of clients’ experiences allows the therapist to work from a broad spectrum of theoretical approaches, while working towards reducing the impact of clients’ traumatic experiences. By using primarily cognitive behavioral and attachment theories as underpinnings for the work I did with clients, I enhanced my theoretical orientations to trauma-informed practice and expanded my clinical skill set.

Trauma-informed practice is an ever-evolving practice that involves various dynamic techniques and numerous working pieces. Sifting through clients’ verbal and nonverbal language is an important factor in dissecting the client’s presenting issue, however, some clients use protective factors that may be adaptive or maladaptive coping strategies they have as an internalized protective mechanism. One way to help clients gain the most insight from the therapeutic process is through active listening and active interrupting. When done in a respectful way, active interrupting allows the client to refocus on the task at hand in a way that is meaningful to the therapeutic process. It allows the therapist intuitive information regarding client experiences while balancing the mind-body connection/disconnection, and the clients’ emotional cost of reliving their experiences. This delicate balance is dependent on where clients are in terms of cognitive processing, supports they have available to them, and their investment in the healing process.
Using a conceptual framework for practice was essential for me when working with clients. I gained valuable information from our clients in a concrete, coherent and structured manner that was different than what I had been practicing in government work. It acted as an invaluable tool that allowed me to connect with the clients and assisted me in dissecting clients’ trauma by not re-victimizing them further. The conceptual framework for practice highlighted the clients’ presenting problem and assisted in recognizing the importance of clients’ verbal and nonverbal language. Additionally, it stressed the importance of connecting clients’ emotional expression and closeness to their defined problem and identifying behavioral controls that exist within their relationships. Furthermore, this framework assisted me in recognizing and addressing thematic underpinnings of trauma such as gendered coping, and the importance of trauma survivor coping mechanisms. I will continue to use my external professional associate’s conceptual framework for trauma-informed practice moving forward in my career as a social worker.

I came into the MSW program with 10 years of social work experience, however, the amount of enhanced knowledge, experience and skills set I now has primed me to be a more eclectically informed social worker. I recognize the utility in using an array of theoretical modalities in trauma-informed practice and understand that my skills and knowledge will only continue to develop as I develop my educational and professional career further. My pursuit for knowledge will always be engrained in the experiences I have and will continue to assist in informing people of the importance of trauma-informed practice. I do believe that trauma-informed practices should be included within the social work curriculum as this practice reinforces the theoretical orientations social workers hold on to and underpins the clinical work social workers do with every client in practice. My thoughts, experiences and educational
pursuits continue to highlight who I am as a person, and where I situate myself in the social work profession.
References


Appendix A: D. Ebert’s Mini-Schema for Assessing Families and Couples

1. **Presenting Problem:**
   - Who presents the problem? Is participation:
     - Voluntary?
     - With assistance?
     - Involuntary?
   - To whom is the problem prescribed?
   - How does the client present the problem?
     - “Let’s find a solution”
     - Are they angry?
     - Are they defeated: “I don’t care” or “I’m used to it”

2. **Problem Solutions:**
   - Who tries to solve the problem?
   - Is the attempted solution appropriate?
   - Who participates in solving the problem?
   - How have problems been solved in the past?
   - Are problems solved at the expense of an individual, the total family or do solutions lead to growth?

3. **Communication:**
   - Do you understand the communication or is it unclear?
   - Is the communication directed to the appropriate person?
   - Is the message understood in the same way it is sent?
- Does the verbal world coincide with the non-verbal communication? E.g., facial expression, body posture, tone of voice, etc.

*Remember: one cannot not communicate

4. **Expression of Feelings:**

   - Every person should be able to express a broad range of feelings – both quantitative and qualitative

   - Some of the feelings are: anger, sadness, depression, tenderness, joy

   - Is the patient expressing the appropriate emotion for the situation they are experiencing?

   - Does the patient express another feeling to defend against their ‘real feelings’?

   - Does the verbal expression of emotion match the non-verbal?

5. **Emotional Involvement:**

   - Human relationships involve a degree of emotional involvement, or conversely emotional distance.

   - To some extent, we all struggle with closeness and intimacy.

   - In families and marriages, one must have sufficient sense of the self (identity) to become emotionally involved in the relationship(s). Can family members be involved and also allowed to be individuals?

   - Do all family members feel comfortable with the degree of involvement? Or are some comfortable at the expense of others?

   - Are needs for intimacy met within or outside of the family?

   - Is this appropriate?
6. **Roles:**

   - Roles are uniquely defined by each family. Roles are conflict free if they are complimentary and are not defined at the expense of another individual(s).

   - Are all members satisfied with the definition of roles?

   - If roles are in a state of imbalance attempts are made to achieve equilibrium.

   - How is this being attempted?
     - Coaxing?
     - Coercing?
     - Compromise?
     - Discussion?

   - Are parents able to meet both parental and marital roles?