Counselling at the Regina Sexual Assault Centre

A Field Practicum Report
Submitted to the Faculty of Graduate Studies and Research
In Partial Fulfillment of the Requirements
For the Degree of

Master of Social Work
in
Social Work
University of Regina

By

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Regina, Saskatchewan
July 2020

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Abstract

This report outlines my practicum experience providing counselling at the Regina Sexual Assault Centre. The goal of my practicum was to achieve advanced graduate level social work knowledge and the ability to effectively provide individual counselling from a trauma recovery approach working with individuals who have been victims of sexual assault. To successfully achieve the goal of my practicum proposal I immersed myself into studying and practicing trauma informed treatment. I became a team member within Regina Sexual Assault Centre by providing counseling services five days a week and I frequently completed one to five sessions daily.

I began my practicum by enhancing my knowledge so that I could address clients’ needs and be of benefit to the client. I researched various theories and models of trauma counselling through books, academic journal articles and online webinars. The main approach followed at the Regina Sexual Assault Centre is The Three Stages of Trauma Recovery, by Judith Herman (1997). I also gained knowledge of cognitive behavioural therapy, trauma informed cognitive behavioural therapy, dialectic behavioural therapy, somatic experience and eye movement desensitization and reprocessing therapy.

Completing my practicum at the Regina Sexual Assault Centre allowed me the opportunities to build skills in areas related to assisting survivors of sexual abuse who were from different socio-economic backgrounds and lived with intellectual disabilities. As a result of my practicum experience my counselling skills, my confidence as a counsellor and trust in the counselling process have significantly improved and adapted. I experienced growth as a trauma informed counsellor, and was able to acknowledge my personal strengths, limitations and challenges.
Acknowledgements

I have been fortunate enough to have supportive individuals throughout the journey of completing my Master of Social Work. First, and the only way this practicum was made possible was by the strong, courageous survivors at the Regina Sexual Assault Centre who ever so graciously trusted a student to walk beside them at the start of their healing journey. I will forever be grateful to each one of you for opening your heart and souls to me and for allowing yourselves to be vulnerable. Thank you for allowing me into your space and showing me the power of forming trusting relationships and the counseling process.

I want to thank Sarah Sempsrott-Ridley (now Feeney), my Professional Associate who was extremely supportive and encouraging throughout my entire practicum. Witnessing your commitment, determination and passion for clients at the Regina Sexual Assault Centre was empowering and holds a constant reminder and representation for the all the good that encompasses the field of social work.

I would also like to thank all staff members at Regina Sexual Assault Centre for being so welcoming, kind and supportive during my placement. You have all taught me the importance of advocating and staying true to one’s personal and professional morals. I know this little place is going to continue to do enormous things for our city and province. It was a privilege getting to know each of you.

I would like to thank my Academic Supervisor, Dr. Donalda Halabuza who supported me throughout my practicum and writing process, with kindness, patience and encouragement. Thank you, Dr. Kara Fletcher for being my Academic Committee Member and taking the time to support the finalization of my academic journey.
Thank you to my partner, Devin for your encouragement and support; without you this practicum would have never been possible. Your endless devotion to our family does not go unnoticed and is immensely appreciated. Thank you for believing in me.

Finally, thank you to my greatest and most profound joys in my life, Mateo Alexander and Nixon Jamisen. You boys have provided me with the strength to get through the hardest days and unbeknownst to you, the encouragement to apply to the Master of Social Work program and complete my practicum. You both lifted my spirits on days I felt as though getting through was not possible and provided me with the drive needed to complete my degree. My hope for both of you is to continue to be kind, caring, and, eventually, compassionate men that strive for what they believe in. I hope when you are both older, as adults when you look back on the memories we have shared, that you will be proud to call me your mother. I love you both to the moon and back and wish nothing but the stars for you, my sweet boys.
Dedication

I dedicate this paper to my late father, Christopher Ball who was taken from this world far too soon. Losing you at such a young age is what led me down the path of becoming a social worker. I have always wanted to help people heal from their grief and traumas and grow from their pain and this was another step in completing that goal. I hope I have made you proud.
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Chapter One: Introduction

Regina Sexual Assault Centre

Regina Sexual Assault Centre (RSAC) is located in Regina, Saskatchewan. I selected this agency because I was interested in a field placement that offered clinical counselling to members of the community from a variety of cultural and socioeconomic backgrounds. RSAC’s vision is “to reduce the risk of abusive behaviours and sexual violence through education, prevention and support in our community” (RSAC Policy, 2019). During 2018-2019, RSAC provided 1,500 hours of clinical counseling, answered 360 calls on their crisis line and delivered 300 hours of education throughout the community (“Regina Sexual Assault Centre”, n.d.). The mission statement is as follows, “we are an inclusive, non-profit organization of trained counsellors and advocates who are dedicated to helping reduce the trauma of inter-relationship violence and sexual assault” (RSAC Policy, 2019). RSAC accomplishes their goals by providing free, effective counseling, public education and advocacy. They provide support services and referrals to other agencies for anyone, including family members who have been impacted by sexual and interpersonal violence, regardless of gender, sex or sexual orientation (RSAC Policy, 2019). At the time of my practicum, RSAC employed three full time clinical counsellors to meet the counseling needs of the clients they serve.

RSAC is the “only place in Regina that offers long term counselling, with specific help for sexual violence” (Soloducha & Pasiuk, 2019). There has been an increased awareness around sexual violence, due to the #MeToo movement; significantly more people are reaching out for help. However, RSAC does not have enough counsellors to see everyone in a timely matter. At the time of my practicum placement, there was an average of an 8-9 month wait list for individual counseling services. RSAC not only covers the city of Regina, but also Moose Jaw
and Assiniboia area. The provincial government provided $236,234 to RSAC for the 2019-2020 fiscal year. The remainder of the operating costs, which is 33%, comes from individual grants or fundraising (Soloducha & Pasiuk, 2019). RSAC receives funding through the Ministry of Justice, and none from the Ministry of Health. Both government ministries must take accountability towards financial contribution. According to the Executive Director of RSAC, Lisa Miller, sexual assault is a health issue, one she claims as multi-ministerial. She also stated, “on-going clinical counseling is a means of prevention towards sexual assault” (Soloducha & Pasiuk, 2019, p. 20).

RSAC also provides services to children who have been sexually abused. RSAC has one clinician who provides counselling to children because of her knowledge and experience with children. During my time at RSAC, I did not provide services to children. The Provincial Child Abuse Protocol (2019) in Saskatchewan describes child sexual abuse as occurring when a child has been exposed to harmful interaction for a sexual purpose by a parent, caretaker, any person in a position of trust and/or any other person. It can include both physical and/or nonphysical contact. Examples include, but are not limited to, engaging in child sexual acts, obscene acts, taking pictures of a sexual nature, pornography, voyeurism, exhibitionism and threatening sexual assault, in addition to the use of grooming techniques. Although I did not see children during my time at RSAC, it is of importance to note that 1/3 of all females and 1/5 of all males experience sexual assault by the age of 18 (“Regina Sexual Assault Centre, n.d.). The majority of individuals whom I saw at RSAC had experienced childhood sexual abuse. Although the initial plan was for me to see recent sexual assault victims or victims of interpersonal violence, this was not always possible. Often, individuals do not disclose all sexual assaults during their initial
phone call, and a full disclosure often happens during intake sessions or after building trust with a clinician, as was my experience at RSAC.

Macy, Martin, Ogbonnaya and Rizo (2016) provide information that service providers need to know about survivors to successfully deliver services to clients. These authors state survivors often report physical and mental health problems such as sleep disturbances, chronic pain, suicidal ideation, anxiety, post-traumatic stress disorder, depression and low self-esteem (Macy et al., 2016, p. 29). Survivors also experience financial, social and family impairments that are both, directly and indirectly related to their abuse experiences. Agencies that assist survivors are often faced with difficult tasks in regard to assessing survivor’s most urgent needs, tailoring a plan for short and long term services and determining the survivors’ needs and developing service plans when the survivor is suffering the aftermath of crisis (Macy et al., 2016, p. 32). Due to the length of the wait list and time period one waits for services, some survivors do not require the services when their name comes up. When calling individuals off the waitlist to offer them short term counseling services, some explained they had already accessed private services or worked through their issues on their own. Although self-determination is seen as a positive trait, I often found myself wondering if individuals simply internalized their traumas and found it easier to not deal with their experiences.

As Macy et al. (2016) further attest sexual assault services must be tailored to meet the individualized needs for survivors. At RSAC, meeting clients’ needs is done by having counsellors assess survivor’s needs and goals, along with input from their clients. A comprehensive assessment must be completed to allow for helpful safety planning and advocacy. The majority of intake assessments that I completed at RSAC took approximately two to three sessions, in order to compile all necessary information to make an adequate assessment and
assist with proper planning for each client. Macy et al. (2016) further discussed crisis services being a recommendation for sexual assault service providers. However, the literature acknowledges that it is often impossible for service providers to collect detailed survivor information in the context of crisis intervention due to interaction often being brief and only occurring once (Macy et al., 2016, p. 33). RSAC ensures its 24-hour crisis line volunteers are trained and follow up always occurs during the next business day.

**Personal and Professional History**

I chose to complete my practicum at the Regina Sexual Assault Centre because I wanted an opportunity to expand my counselling skills and gain knowledge around trauma. I wanted to know how to successfully assist clients in a community-based setting. Prior to completing my practicum, my social work experience was in vastly different settings. I worked in child protection, both in urban and rural settings, for several years. My first experience was with Yorkton Tribal Council Child and Family Services (YTC CFS) for two years, followed by the Ministry of Social Services for two years. Missing the focus of family reunification and the desire to gain additional cultural competency, I returned to YTC CFS for another four years. My background experience allowed for me to assist families with several challenges, such as addiction, sexual assault, mental illness, family conflicts, etc. Having the privilege of working for a First Nations agency, I was able to see first-hand the impacts of colonization and how the cycle of abuse continued to affect current and future generations.

I knew I wanted to gain clinical skills to better assist families in addressing the root causes that lead to child protection involvement, and trauma. I eventually worked as a mental health therapist, which assisted me in learning about the therapeutic relationship and basic skills in assisting clients suffering from depression and anxiety. I began working as a medical social
worker in the emergency department at Regina General Hospital and Pasqua Hospital which allowed me to gain crisis intervention skills and assist families dealing with grief and the impacts of significant trauma. However, I still noticed clients experiencing trauma symptoms, such as substance use issues or specific mental illnesses. I often found myself asking why we only treat the presenting concern and trauma symptoms, rather than the underlying issue, often being historical trauma.

The experience in my practicum at RSAC has allowed for me to have a more nuanced lens when assessing patients in the emergency department. Rather than only addressing the need for support to assist with an individual’s current situation, I am more confident in opening a dialogue about past traumas and experiences. I can also say with full confidence that I have a calmness and deeper understanding that is now integrated in my approach in assisting patients who have been sexually assaulted. Being able to provide fellow colleagues and patients with psychoeducation around sexual assault has become vastly beneficial.

My passion has always been around wanting to assist children, however after my practicum experience and learning about the realities of sexual assault; I realized that the majority of clients I encountered are dealing with trauma from their childhoods. In order to complete a healing journey, adults need to acknowledge that their past traumas cannot be changed and work towards acceptance. Unfortunately, many children do not receive the support they require, and they are left to pick up the pieces when they are adults and chose to address their traumatic experiences.

Personally, I have wanted to be in a helping profession for as long as I can recall. I tragically lost my father at a very young age and wished I had the support I required at that time. However, it was not until my teenage years and as an adult that I sought out the assistance from
counselling services. Throughout the positive experiences I encountered in therapy, I was able to choose social work as a specific area of study. My career in social work led me to be in some roles I did not fully enjoy. Eventually, I found myself questioning if this was truly the career I wanted. However, I can say, with all honesty, completing my practicum has assured me that being a counsellor is a role I hope to carry for many years to come. Being part of an agency where there was mutual respect and admiration for one another, and being in a supportive environment allowed for me to have the realization I needed at the time and provided me with a new lens to the field of social work. Understanding the need to start each session where your client is at and to trust the counselling process has allowed me to have a deeper connection and appreciation for our role as social workers.

**Sexual Assault and Complex Trauma**

According to RSAC policy (p. 1, 2019):

“sexual assault involves any sexual contact without an individual’s permission. This includes unwanted kissing, fondling, touching of sexual body parts, and/or forced sexual intercourse. Sexual assault is sexual activity that is unwanted but occurs due to force, coercion, threats or guilt. Sexual assault occurs when a person is too intoxicated to consent, or when an offender uses drugs or alcohol, or a combination of both, to incapacitate their victims. Sexual assault is never a victim’s fault.”

The policy goes on to explain, sexual assault impacts survivors in many ways, including feelings of guilt, shame, hopelessness, negative body image, increase or decrease in sexual intimacy, mood swings, self-harm and nightmares. Responses vary due to past experiences, support networks, the severity of assault and physical harm, and a person’s experiences with first responders, such as police, doctors and counsellors.
According to Klump (2006), sexual assault of women is a pervasive crime that indiscriminately affects not only the victims of rape and sexual assault but also the communities in which these women live. Women who are sexually assaulted are college students, mothers, spouses, friends, sisters, next door neighbours and co-workers, and many of the lives connected to these women feel the impact of crime (Klump, 2016, p. 67). Violence against women, particularly rape, informs socio-political attitudes about the value of women’s lives and reinforces the power differential that exists between men and women. The psychological effects of sexual assault can be devastating and life-long, because the consequences of sexual assault are substantial, clinicians working with survivors must be knowledgeable about various aspects of the trauma (Klump, 2016, p. 68). Of importance to note is the amount of psychoeducation I required around the psychopathology surrounding victims of sexual assault. In order to best assist clients, I forced myself to learn as much as I could prior to and during the beginning of my practicum. I felt I could not be a benefit to the women I had the privilege of working with if I did not review sufficient literature to prepare.

As further discussed by Klemp (2006), sexual assault is a traumatic event with deleterious effects on the mental and physical health of victims (p. 69). While symptoms such as numbing, intense fear, increased anxiety and dissociation are common responses following a traumatic event, not all victims maintain high levels of intense distress (Klemp, 2006, p. 76). Leung (2017) offers insight as to why most sexual assault survivors decide to keep the incident to themselves. He explains, some of the reasons are self-blame, the seriousness of the injury, the rape experience not matching stereotypical conceptions, protection of themselves from further harm, fear and retaliation, or distrust with the systems in place to protect them (Leung, 2017, p. 928). Literature and discussions with clients suggest, survivors are more likely to seek support
from informal social networks, including family members and friends, rather than seek support from police and social workers due to fear.

Azzopardi and Smith (2018) discuss that sexual violence is a pervasive public health problem and gendered human rights violation. The world has experienced a critical transformation based on the #MeToo movement in how we understand, respond to, and resist sexual violence (Azzopardi & Smith, 2018, p. 213). The #MeToo movement, originated from the work of Tarana Burk and the power of digital feminist activism in October 2017. This movement ignited a wave of consciousness raising, dialogue, and advocacy on an international scale. Since the movement began, millions of women have been empowered to share their stories of sexual assault across all platforms, bringing to light the widespread prevalence of sexism and misogyny (Azzopardi and Smith, 2018, p.213). The #MeToo movement has addressed the social stigma and shame often associated with sexual assault. Sexual assault is the only crime that has not observed a steady decline in Canada. As stated earlier, it is estimated that one in three females are affected by sexual violence in their lifetime (Azzopardi & Smith 2018, 214).

**Interpersonal Violence**

Intimate partner violence refers to current or former marital partners, separated marital partners, current and formal cohabitations, or current and former same sex partners, and it is gender neutral (Barnett, Miller-Perrin, & Perrin, 2005, p. 253). Intimate partner violence was a common occurrence with the majority of my clients. Within the framework of violence against women, violence against intimate partners consists of three kinds of behaviours, physical violence, sexual violence and threats of physical and/or sexual violence (Barnett et al., 2005, p. 254). Intimate partner sexual assault is the most prevalent kind of rape. I noticed during my practicum that several women did not know they had been sexually assaulted. Many women felt
they were required to have intercourse with their husbands simply because it was their “duty” or role as a wife. I often found myself providing basic education around the definition of sexual violence and that unwanted intentional touching of genitals or breasts was an act of sexual violence. One needs to have a knowledgeable understanding of intimate partner violence to understand the impacts of sexual violence and all it encompasses.

**Trauma and the Brain**

Judith Herman is one of the pioneering clinicians in the field of trauma. Herman (1997) states that a traumatic event overwhelms the ordinary human adaptations to life (p. 33). She goes on to add, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence or death (Herman, 1997, p. 34). Suleiman (2008) explains that a traumatic event produces an excess of external stimuli and a corresponding excess of excitation in the brain. When an individual is attacked in this way, the brain is not able to fully process the event and responds through various mechanisms such as the shutting down of normal emotional responses (Suleiman, 2008, p. 276). Dissociation often takes place in these situations. Dissociation is when the individual splits off part of themselves from the experience, producing multiples personalities, which are also viewed as repressed memory, or traumatic amnesia (Boon, Steele, & Van Der Hart, 2011, p. 32). Clinician, Judith Herman and researcher, Bessel van der Kolk (2014) both have researched dissociation extensively. During my practicum placement, dissociation was evident in many women I worked with. The more intense and prolonged the trauma was, the more likely the client had to dissociate and had no conscious memory of the traumatic event occurring. As explained by Suleiman (2008), a child that was sexually abused by a family member may not recall memories until they enter therapy as an adult
Often, memories are recovered gradually, and it is not until the repressed trauma is remembered that a client can truly move on.

**Trauma Informed Practice**

Adult survivors of childhood trauma are an especially challenging group of clients because of the long-term effects of the victimization and the present-day difficulties these individuals face (Knight, 2015, p. 25). Trauma informed clinicians must be sensitive to the ways in which the clients’ current stressors can be understood in the context of past traumas. Social workers must validate and normalize the client’s experience. As Knight (2015) explains, emphasis needs to be placed on helping survivors understand how their past traumas influence their present lives and then to empower them to manage the present moments effectively, using common skills within the realm of social work. Trauma informed practice does not mean that the practitioner assumes the client is a survivor; it also does not mean that the focus of counselling will be on the past trauma. Trauma informed practice helps survivors develop their capacities for managing distress and for engaging in more effective daily functioning (Knight, 2015, p. 26). Trauma informed practice recognizes that the working alliance can provide a corrective emotional experience for survivors and the relationship can challenge thought distortions regarding self and others (Knight, 2015, p. 27). Trauma informed practitioners are well served by their core training as social workers (Knight, 2015, p. 37). Social workers are educated in childhood development and understanding the basic impacts sexual abuse has on stages of development aids trauma informed practice.

Elliot, Bjelajac, Fallot, Markoff and Reed (2005) explain trauma-informed services are those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimization on an individual’s life and development (p. 462). All staff, including
receptionists, direct care workers and board of directors, must understand how sexual assault impacts the lives of the clients being served, so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization. To achieve a trauma informed setting, RSAC staff members all make a commitment to integrate knowledge about sexual assault into the service delivery practices of their organization. RSAC provides an emotionally safe place and empowering environment for survivors, while understanding the pervasive long-term impacts of trauma. During my placement at RSAC I noted they recognize the impact of violence and victimization and empowered clients in all domains from intake to group work. RSAC allows women to have control over their choices (to report or not), collaborate positively within the community, and are accepting of all individuals and cultural backgrounds. RSAC listens to the needs of their clients.

Alessi and Kahn (2019) state trauma informed practitioners acknowledge that trauma is widespread and can impact functioning, recognize the symptoms of trauma in clients and their families, and seek to avoid traumatizing clients (p. 28). The first and most vital step of trauma informed practice is to establish a therapeutic relationship with the client; through this relationship, the social worker facilitates relational and internal safety. I noted this firsthand during my practicum experience. By witnessing the clients’ suffering and assisting in breaking through the sense of isolation often affiliated with the traumatic experience of sexual assault, I was successfully able to create safety with my clients. After clients felt safe, they were then able to better manage strong emotions without feeling overwhelmed or completely shutting down. Based on Alessi and Kahn’s (2019) review, trauma informed practice positions the therapeutic relationship as the means through which recovery is promoted (p. 29).
Practicum Proposal

My practicum at Regina Sexual Assault Centre consisted of 450 hours on a fulltime basis from September 3, 2019 until November 29, 2019. During the month of December I attended for 7 days throughout the month as a means to offer clients additional counselling sessions. In my practicum proposal, I outlined one specific goal to achieve during my placement which was to develop graduate level social work knowledge and skills to effectively implement individual counselling skills within a clinical setting, working with individuals who have been victims of sexual assault from a trauma recovery approach. During my placement, all of my clients were female; therefore the language used throughout this paper will be based on women. This is not to minimize or deny the experience of male sexual assault survivors, but for the purpose of concision.

I identified several learning objectives that would support achieving my practicum goal. My first learning objective was to critically analyze and gain an understanding of the Three Stages of Trauma Recovery model utilized by the professional associate and other counsellors at the Regina Sexual Assault Centre. This objective was achieved by completing literature reviews on work completed by Judith Herman, in addition to reading her books. The second learning objective was to equip myself for effective clinical practice by becoming familiar with the roles and counsellors at RSAC. This objective was achieved by gaining an understanding of their roles as community stake holders by learning the goals, objectives and values utilized within RSAC by reviewing manuals, having open discussions and being an active participant with the organization.

My third learning objective was to obtain graduate level understanding of trauma and the recovery process and to acquire knowledge of the current research and best practice models for
counselling individuals who have been victims of sexual abuse. By reviewing policies, reading literature on trauma recovery and through discussions with my Professional Associate this objective was achieved. I used active listening skills in sessions to develop a therapeutic alliance with my clients, which achieved my fourth learning objective. My fourth objective was to gain exposure to various styles of engaging and building therapeutic relationships with the client groups served at RSAC. My fifth learning objective was to become competent and gain advanced graduate skills in the treatment planning process. I met this objective by learning the administrative counselling skills completed at RSAC including the process of intake, clinical note taking, assessment and trauma informed intervention.

My sixth learning objective was to deepen my knowledge of cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT) as well as to gain knowledge of eye movement desensitization and reprocessing therapy (EMDR). Through discussions with my Professional Associate, reviewing literature and observing counselling sessions, this objective was achieved. My seventh learning objective was to become skilled at recognizing dissociation and the process of assisting clients by understanding catalysts. In addition, I wanted to know how to intervene and re-ground the client, help clients restore a sense of safety during sessions and within the therapeutic relationship. By reading books and consulting with colleagues and practicing grounding and containment exercises the objective was achieved. My eighth learning objective was to write journal reflections and insights daily throughout the practicum experience. This was completed as a means of developing advanced graduate level intrinsic practice and proficient use of self to grow and better meet the needs of clients. My ninth learning objective was to facilitate a final presentation at the end of the practicum placement and to complete the practicum report in a timely manner that will include literature and theory of clinical practice as
it relates to assisting clients who are victims of sexual abuse. The objective is achieved by the completion of this paper and a presentation commencing shortly after. The tenth and final learning objective was to prepare myself for clinical practice by carrying a caseload between 10-15 clients under clinical supervision of my Professional Associate. This was achieved by having hour long meetings with my Professional Associate on a bi-weekly basis where I discussed areas of personal strength and progress, application of clinical approaches, treatment planning goals and set plans for areas in need of growth or adaptations.

The clinicians at Regina Sexual Assault Centre carry a caseload of approximately 40 clients. For the purpose of my practicum, I maintained a reduced caseload to allow time for research, reading the literature on trauma, preparing for sessions, debriefing after sessions and having time for self-care. Through individual clinical supervision, group supervision with the counsellors at RSAC, and ongoing conversations with colleagues I was able to learn clinical skills. I presented specific case examples and was provided with an opportunity to debrief and receive efficient support and feedback. During my placement, I also completed intakes by answering the crisis line and facilitated a two-hour group for survivors of sexual abuse entitled Trauma and You. I also took part in the event Take Back the Night, which was held at the University of Regina and is a walk and candlelight vigil to end sexual violence. The event included speeches by counsellors at RSAC, guest speakers and a musical performance.
Chapter 2: Ideology and Values

Values at Regina Sexual Assault Centre

Forty-five years ago, the Regina Sexual Assault Centre (RSAC), formerly known as Regina Women’s Community Centre, became a feminist collective (“Regina Sexual Assault Centre”, n.d.). Although the governance structure has changed throughout the years, decision-making principles remain consistent. RSAC currently employs three counsellors, one full-time administrative assistant and a full-time Executive Director. Counselling staff have a Master's level education and are overseen by a clinical supervisor, who holds an MSW. Volunteer board members oversee the operations of the Centre and approximately fifty-five volunteer advocates work on the sexual assault crisis line (“Regina Sexual Assault Centre”, n.d.).

“Regina Sexual Assault Centre” (n.d.) states that, in the late 1960's and early 1970's, western societies experienced a resurgence of feminist collective activism. This activism focused on addressing the inequalities that women were experiencing in all contexts of their lives. In June 1975, Denise Hildebrand and Abby Ulmer opened the doors of the Regina Women's Community Centre with a vision of promoting the equality of women within their own community. An initial grant from the Province of Saskatchewan enabled the Centre to provide a drop-in, referral, and counselling service for Regina women. Services such as medical, legal and agency referrals, a lending library, crisis pregnancy counselling and supportive counselling services were provided. The Centre became active in public education, advocacy in the areas of sexual health, welfare rights, violence against women, and structural inequality.

In February 1977, the addition of a sexual assault crisis line improved the Centre's ability to respond to survivors of sexual violence by and providing crisis and long-term counselling. In 1978 RSAC began training volunteers to assist on their crisis line. Also, in 1978 the Centre
received its first annual grant from the Department of Social Services. This grant enabled the Centre to stabilize programs and services (“Regina Sexual Assault Centre”, n.d.) In 1987, as a result of changes to provincial funding for non-governmental organizations, the Centre began a series of creative and well organized fundraising efforts in order to maintain its programming. Due to the Centre's efforts in public education and advocacy, there was a dramatic increase in the demand for its services. In response, the Centre developed additional funding partnerships with the Ministry of Justice and the City of Regina (“Regina Sexual Assault Centre, n.d.) In January 2013, the Centre changed its name to the Regina Sexual Assault Centre. Changing the name was done in effort to open the doors to male adult survivors of sexual violence. The change was made to reflect the diverse individuals they serve and make the Centre accessible to all survivors (“Regina Sexual Assault Centre”, n.d).

Elliot et al. (2005) suggest crisis occurs well before recovery is established as the process of accessing services and healing can be lengthy. The goal of trauma informed crisis intervention is to allow the victim to retain as much control as possible, the client controls what will happen, what services will be assessed and who will be involved. RSAC has a 24 hour crisis line that meets all of the same criteria. Power and control are left up to victim, all while the volunteer remains supportive and available to the client. Volunteers assist with the process that occurs after someone has been sexually assaulted and explain all service options, from reporting to the police to attending hospital. Outreach and engagement activities seek to identify individuals who may benefit from the services the organization has to offer, to provide information about available services, and to develop an initial relationship with potential individuals who would benefit from services (Elliot et al., 2005, p. 471)
Personal and Professional Values and Ideology

My personal and professional values were upheld to the highest importance during my practicum placement. As a social worker, I was accountable and ensured that my clients received efficient, quality supports. I am a registered member of the Saskatchewan Association of Social Workers (SASW). I am also bound to adhere to the Canadian Association of Social Workers (CASW), Code of Ethics (2005a) and the Canadian Association of Social Workers Guidelines for Ethical Practice (2005b), the Social Work Act (2015) and the SASW Guidelines for Practice (2017). As a social worker, I strongly believe that all individuals deserve the right to be respected and I am passionate about providing services to clients from a strength-based approach and remaining true to the professional Code of Ethics at all times.

Social workers in Canada have six core values and principles, which include, Respect for Inherent Dignity and Worth of Persons, Pursuit of Social Justice, Service to Humanity, Integrity of Professional Practice, Confidentiality in Professional Practice and Competence in Professional Practice (CASW, 2005a; CASW 2005b). The guidelines for ethical practice need to be reviewed and reflected upon whenever there are any divergences that social workers are faced with (CASW, 2005b). Although, I did not encounter significant dilemmas during my placement, the core values and principles are prominent in ensuring social workers remain ethical and responsible to the clients in which they serve and maintain the interests of their clients as their top priority. The Guidelines (2005b) also outline that social workers need to promote self-determination and autonomy of clients, encouraging them to make informed decisions on their own behalf. This point is crucial when being in a clinician role because clients tend to look to their counsellor for guidance and direction. As clinicians, we must always remember that clients
know themselves best and must make their own decisions we are simply a helpful, caring guide along the way.

I encountered dual relationships with a client during my placement. I had a couple of sessions with an individual and later had contact with her at my place of employment as she was also working at the hospital. Our CASW Guidelines of Ethical Practice (2005b) outline that dual or multiple relationships can occur simultaneously or consecutively. Although having contact with clients in different life situations is not inherently harmful, the nature of the contacts must be evaluated (p. 12). After a discussion with the client and my Professional Associate it was decided that I was not in a position of power or authority and that contact would not negatively affect the decisions or actions of the client. The client informed me that she was comfortable seeing me in our working environment and in counselling sessions and neither role imposed any type of conflict or risk to working together; therefore there was no conflict of interest.

Throughout the years, as a social worker, I have developed my personal and professional values based on my experiences in working with children, families and individuals in crisis. Based on my professional experiences, it has become my personal and professional value that I have the duty to advocate for change in the best interest of the clients I serve and for the overall benefit to society, regardless of the role I am in at that moment of time. Regardless of my place of employment, I believe, as social workers, we have a social responsibility to assist with protecting vulnerable members of society from harm. Supporting women who are survivors of sexual abuse and being a team member at the Regina Sexual Assault Centre, I strived to identify and advocate for the prevention and elimination of domination, or exploitation of, and discrimination against, any person, group, or class based on age, abilities, ethnic background, gender, language, marital status, national ancestry, political affiliation, race, religion, sexual
orientation or socio-economic status, which is consistent with the Guidelines for Ethical Practice (2005b, p. 24). I became passionate about political action when witnessing the endless devotion the counsellors at RSAC have for survivors. Hearing every woman’s struggles and barriers to services, has driven me to want to strive for changes in policy and legislation to improve the social conditions in order to promote social justice.

**Three Stages of Trauma Recovery**

Throughout the first couple of weeks at my practicum placement, I needed to become knowledgeable on Judith Herman’s Three Stages of Trauma Recovery as this was the main model followed by clinicians at RSAC. In 1992, Judith Herman published *Trauma and Recovery* which outlined new concepts for understanding, defining, and treating posttraumatic stress disorder (Zaleski et al., 2016, p. 377). Herman worked with individuals who suffered from trauma, specifically, survivors of sexual assault. If traumatic memory is worked with directly, it can contribute to individuals re-living their traumas and create further destabilization (Herman, 1997). Rather, the focus of recovery for survivors of sexual assault should be helping to create safety and stability, while developing internal and external resources. The helping relationship is of critical importance in helping the client address the trauma, regulate their mind and body reactions and can create conditions needed for optimal health and wellbeing (Fisher, 2019). Underlying the first stage of Herman’s model is the fact that central to the experience of interpersonal trauma is helplessness, meaningless and disconnection from oneself and others. The recovery process, as it unfolds over the three stages is based on the empowerment of the victim and the creation of new connections and new meanings (Herman, 1997). Herman viewed the primary role of the therapist as an ally and witness, “the therapist and client must engage in a
dance of developing trust and rapport, while working toward skill building” (Zaleski et al, 2016, p. 384).

The first stage of trauma recovery is Safety and Stabilization, Overcoming Dysregulation. During this stage, the client must recognize common symptoms and understand the meaning of overwhelming body sensations, distorted cognitive schemas and intrusive emotions (Herman 1997). By establishing bodily safety, a safe environment, and emotional stability, safety and stabilization will then be achieved. The goal at this stage is to safely remember the trauma that occurred, however by not continuing to relive the incidents (Herman & Harvey, 1997). Herman (1997) believed that good trauma treatment required a much more client centered approach, delaying the focus on traumatic memories until survivors felt safe in their daily lives and had sufficient affect regulation to tolerate the stress of remembering the dark episodes in their histories. As a political feminist, Herman argued that victims needed to feel empowered not only in relationship to their peers and partners, but also to their own memories (Fisher, 2014). Stabilization was not just a dress rehearsal for the “important stuff.” Instead, stabilization gives clients back their lives, offers them a meaningful present as an alternative to reliving the past, and was invaluable in clients learning to tolerate their often volatile emotions (Fisher, 2014). Due to the short time frame, I had during my practicum placement, many of my clients were still working through Stage 1 when I finished my practicum. Several of my clients were still experiencing suicidal ideations, lacked a secure and safe living situation, continued to maintain abusive relationships, and did not have adequate supports or were not able to calm their body or self soothe when they became triggered.

During Stage One, I had a client experiencing hopelessness and helplessness, in addition to severe suicidal ideations. I found myself wondering what I could offer someone who was
experiencing significant trauma symptoms from a recent sexual assault. When survivors are engaged and have an empathetic counsellor, the possibility of restored attachment begins to take flight. By finding a connection with others, such as a therapist, clients can find their own pathways to recovery (Herman, 2008, p. 298). Survivors of sexual assaults often experience corruption of sense of self, sexuality and any capacity for intimacy (Herman, 2008, p. 299). Survivors may disengage from being intimate with partners out of the fear of being re-victimized, or of triggering traumatization.

Herman’s (1997) second stage is Coming to Terms with Traumatic Memories. During this stage the primary focus is to overcome the fear of specific traumatic memories so survivors can gain an appreciation for the person who they have become as a result of their past traumas. The main goal of this stage is to come to terms with their traumatic past and experience. By using mind-body therapies, such as the somatic experiencing and eye movement desensitization and reprocessing therapy, individuals are then able to integrate their memories (Fisher, 2019). Clinicians must be mindful during this stage, so clients do not begin to experience avoidance or become significantly overwhelmed by flashbacks or vivid memories. During my practicum, I had one client enter and remain in stage two prior to my leaving. It was very important for me to pace and continuously ground the client, so they did not simply become “stuck”. As a new clinician, I recall being nervous having clients enter this stage because I was concerned if they were prepared. By helping clients work through phase two, I was taught the importance of trusting where your client is at, and the importance of holding the space during sessions by ensuring the client feels safe enough to be themselves.

Herman’s (1997) third and final stage is Integration and Moving On. During this stage, survivors work on decreasing shame and alienation, developing a great capacity for healthy
attachments, and making meaningful personal and professional goals (Fisher, 2019). The focus shifts to overcoming fears of normal life, making healthy changes and having challenges with intimacy. As survivors identify feeling healthy and healed in the present moment, the traumatic experience they encountered feels distant. The trauma has become an integrated understanding of oneself and is no longer the focus in their everyday lives. I had one client who was confident that her file could be closed upon me leaving Regina Sexual Assault Centre. Through conversations with my Professional Associate, I learned that this process is not always linear, and clients may need to reenter therapy down the road due to specific life stressors or situations arising that may trigger past memories. This moment again proved to me that clients know themselves best and that their healing journey does not necessarily have to either be open or completed. An important note, as Herman (1997) states, recovery is not static, and people can achieve all the goals in Stage Three until a new event triggers the need for renewed processing of traumatic memories and feelings (p. 387).

It is important to note that not all clients will go through all three stages of Herman’s recovery model and furthermore, it may not be necessary to go through all the stages. Some clients may not suffer from many of the problems experienced in Stage One and enter treatment easily, ready to begin work in stage two. Through my experience, I had one client who was managing very well in her life, had incorporated sufficient grounding skills throughout the years and entered therapy simply to make meaning of her experience and fully understand ways in which she has been impacted. “The primary locus of control of the recovery process rests with the survivor. Therapists assist with the recovery process, and act as a witness, ally and expert educator” (Herman, 1997, p. 382). By sharing information about trauma recovery and psychoeducation around trauma, the victim is provided with a cognitive structure for their
empowerment and healing (Herman, 1997). By providing information about trauma, the experience is normalized, which in turn helps give meaning to their collective experience and assists with advancing the therapeutic process.

**Feminist Theory**

Howard and Arbaugh (2019) explain feminist theory recognizes multiple forms of oppression, to better respond to the intersectional overlapping role of multiple social identities, and to argue against generic approaches that are not designed with marginalized people in mind (p. 704). Feminist theory is driven by feminist philosophy and a commitment to social justice values. At its very core, feminist theory assumes that society is racist, sexist, classist, colonizing, ableist, and violent and that society is currently structured in a way that contributes to individuals’ mental health struggles (Howard & Arbaugh, 2019, p. 705). Feminist theory underscores systemic oppression and aims to empower clients through “affirming diverse identities and attending to social inequalities and stigmatization” (Howard & Arbaugh, 2019, p. 704). By feminist theorists viewing reactions to oppression and trauma as normative, versus pathological, this assists with deconstructing all systems of privilege and oppression in society (p.706). Brown (2016) suggests feminist therapists adhere to the following core concepts of feminist theory: the person is political, egalitarian relationships, honour the clients lived experiences and perspectives, and recognize all forms of oppression. Feminist perspectives about violence against women conceptualize it as a continuous pattern of behaviours designed to remove a woman’s right to autonomy and self-respect (Howard & Arbaugh, 2019, p. 706).
Chapter 3: Counselling Theory and Techniques

This chapter provides a review of counselling theories and techniques that I utilized and witnessed during my practicum. These counselling approaches were cognitive behavioural therapy, trauma focused cognitive behavioural therapy, dialectical behavioural therapy, sensorimotor psychotherapy, somatic experiencing and EMDR. Behavioural therapy models are approaches that I originally identified in my practicum proposal. However, within the first few weeks at my placement, I quickly noted there were more significant beneficial therapies that I needed to learn. Completing a literature review on these approaches at the beginning of my placement helped me gain an understanding of their theoretical foundations, how to apply them, and the benefits of each approach. This chapter also discusses techniques on assessing a client’s window of tolerance, providing containment, the importance of holding the environment and recognizing dissociation, which will be explained later in this report.

Cognitive Behavioural Therapy

Cognitive behavioural strategies challenge core beliefs and assist survivors in recognizing and challenging distortions in their thought processes. Cognitive behavioural approaches also assist with normalizing and managing experiences, feelings and reactions (Knight, 2015, p. 29). By using this technique, clients are able to see the connection between their present difficulties and past traumas. Therefore, emotional distress is caused by errors in thinking patterns that can be recognized and corrected (Howard & Arbaugh, 2019). Cognitive strategies include the use of daily logs to chart effective stages and adaptive responses, defining manageable homework tasks, and developing of concrete safety plans.

Cognitive behavioural therapy (CBT) is an evidence-based therapy. It does not always incorporate a full exploration of the dynamics related to complex trauma. I believe that due to
this limitation, many survivors of sexual assault are not able to recover. In addition, professionals who work in community resources also lack understanding of trauma treatment. I can attest to this, because I was previously in such a role. While working as a mental health therapist, CBT was the main theoretical background we used and therefore at the time, I do not feel I was providing appropriate therapeutic intervention. I noticed a cognitive behavioural approach tends to work well in the beginning, while developing rapport as clients feel safe with you and they trust you enough to move forward into more emotionally charged trauma work. As Sanderson (2013) explains, many of the skills used to restore control over trauma reactions come from the cognitive behavioural therapies and are combined with more humanistic principles in trauma treatment.

Cognitive behavioural therapists believe that a person’s assumptions, beliefs, and interpretations of events directly affect both their emotions and behaviours. Techniques used in CBT include “reframing thoughts to be more accurate, assuming an objective perspective and analyzing thoughts before accepting them as facts, tracking symptoms and thoughts, engaging in behavioural experiments to test assumptions, role play and assertiveness training (Howard & Arbaugh, 2019, p. 714). CBT tends to be more time limited than other modalities, and it focuses more on the present rather than the past and looks for changes in specific, measurable goals. Clinicians assist the client in developing goals, and sessions include working towards those goals in an organized way. Far too often, when clinicians use CBT, they focus on the presenting problem too precisely and therefore can miss underlying issues, or past traumas. Clinicians must listen to subtle signs of power and abuse in their stories, specifically when working from a feminist approach and make it a point of understanding a client’s lived experiences.
Trauma Focused Cognitive Behavioural Therapy

Kira, Ashby, Omidy and Lewandowski (2015) state the use of trauma-focused CBT includes helping clients differentiate between real danger and generalized trauma reminders and between realistic and unrealistic solutions. A part of this involves counsellors conducting routine and continuous safety assessments (often noted to be suicide risk assessments), providing safety plans and having the client review safe behaviours during each session. At times, immediate intervention may be required to alleviate current or emerging dangers. At the Regina Sexual Assault Centre this was often done during sessions with clients who portrayed significant trauma symptoms. For example, I had one client who required frequent phone check-ins, suicide assessments and ongoing safety planning. I often had to reach out to her external resources in the community to assist with safety intervention. Behavioural skills were frequently addressed by assisting her in developing skills for problem solving, stress management techniques, and personal emotional regulation techniques. Psychoeducation plays an important role in cognitive reprocessing, by assisting with interventions that increase the clients’ self-awareness, self-reflection and reprocessing of events. By learning these skills, clients can increase and gain effective coping skills.

Herman and Harvey’s (1997) research suggests that the delayed recall of childhood trauma is often a process that unfolds over time rather than in single event and that it occurs most commonly in the context of a life crisis or developmental milestone. Events act as a reminder of the trauma a client has experienced and serve as a prompt to new recall of events that occurred (Herman & Harvey, 1997, p. 567). My practicum experiences showed me that life changes can indeed trigger hidden memories of trauma. I noted several clients having this exact process unfold as a divorce, a severely sick child or another sexual assault and older trauma memories.
came to the surface. Clients often wished to gain control over their lives, specifically by reliving of traumatic memories and ongoing recollections. Over time, a couple of my clients were able to narrate their own stories of their traumatic experiences. When a client can change the understanding of their past traumas, they become more open-minded, and can tolerate uncertainty and difficulty in their lives (Herman & Harvey, 1997, p. 569). When clients successfully gain understanding of the impact of the traumatic event, then exploration of the abuse can then safely be carried out (Herman & Harvey, 1997, p. 569).

**Dialectical Behavioural Therapy**

Dialectical behaviour therapy (DBT) was initially developed for the treatment of chronically suicidal individuals who met the criteria for borderline personality disorder (Keane et al., 1994). There are two potential applications of DBT to individuals with histories of trauma. One main use of DBT is to achieve stabilization prior to initiating exposure-based interventions. A second potential application of DBT is with the treatment of specific trauma-related problems. DBT is organized into treatment stages; the first stage aims to achieve behavioural control, safety, and connection to the therapist. This aim of DBT is consistent with the initial goals of other stage-oriented treatments for trauma and PTSD (Fisher, 2014). Perhaps more than other treatments, DBT clearly specifies the manner in which stabilization can be achieved. In Stage II, DBT aims to treat trauma-related problems in individuals with borderline personality disorder or histories of severe emotion dysregulation (Keane et al., 1994).

Keane, Fisher, Krinsley and Niles (1994) further indicate DBT departs from traditional behaviour therapy in part, by its incorporation of the theory of dialectics. In DBT, dialectical theory has implications for both a worldview on the nature of reality and the process of change in psychotherapy. From a dialectical perspective, reality is viewed as interrelated and connected
(similar to a systems perspectives), comprised of opposing forces and always changing, rather than static (Keane et al., 1994, p. 127).

A dialectical view also holds assumptions about the nature of change in that: change is viewed as a continuous process that results from the synthesis of opposing views or events. This notion extends the assumption that tension is natural, to the assumption that tension is actually necessary to bring about change (Keane et al., 1994). Therefore, in DBT, the goal is to use tension as an opportunity for teaching dialectical thinking, for finding synthesis, and ultimately for change. The most fundamental dialectical tension in DBT is between acceptance and change and between accepting the client as he or she is versus striving for different behaviour. Ultimate change is achieved by pushing for both tensions in therapy. To be more concrete, in DBT the different treatment strategies are categorized as change-oriented or acceptance-oriented, and effective interventions maximize the balance between both categories of strategies (Keane et al., 1994).

**Sensorimotor Psychotherapy**

Sensorimotor psychotherapy can be instrumental in treating the autonomic and affective dysregulation that underlies both intrusive and numbing responses of traumatic events. Sensorimotor psychotherapy was developed in the 1980s by Pat Ogden, Ph.D. as a body-centered talking therapy, and was designed to specifically address the bodily and autonomic symptoms of traumatic stress disorders and the cognitive-emotional aspects (Ogden & Fisher, 2015). Because it does not require the use of hands-on interventions, it is a somatic approach easily integrated into all traditional inpatient and outpatient talk therapies for trauma-related disorders. Sensorimotor psychotherapy incorporates treatment techniques derived from psychodynamic psychotherapy, gestalt therapy, cognitive-behaviourual therapies, and the Hakomi method of body
psychotherapy (Ogden & Fisher, 2015). Its theoretical principles are based upon a number of well-established theoretical models and the neuroscience research findings on the effects of trauma (Fisher, 2019, p 8).

In addition, sensorimotor psychotherapy incorporates techniques similar to those used in focusing, in which clients are asked to observe moment-by-moment the physical and emotional feelings of their experience rather than simply talk about it. In sensorimotor psychotherapy, the practice of asking the client to focus on the minute details of cognitions, emotions, internal body sensations, movements, and sensory perceptions he or she is experiencing is defined as “directed mindfulness” (Fisher, 2019, p 9).

Therefore, a therapist practicing sensorimotor psychotherapy focuses on increasing the client’s emotional, cognitive or physical reactions when they are reminded of the traumatic experience. Rather than the focus of treatment being on the event itself, the client is asked to mindfully notice their thoughts, feelings and body sensations or movements that occur when thinking or talking about the event. This emphasis on mindful noticing of thoughts and feelings often results in a person automatically self-regulating themselves. Narrative re-telling of distressing experiences or understanding over-learned interpretations of the traumatic experience is applied when using this approach (Fisher, 2019, p. 13) In a mindful state that encourages observation rather than reactivity, traumatized individuals learn to become more curious rather than fearful as they experience their emerging thoughts, emotions, sense perceptions, internal body sensations and movements.

Under the guidance of the therapist, clients are asked to pause periodically as they speak about distressing or traumatic experiences, to observe their thoughts, feelings and intuitive responses that arise moment-to-moment and to use techniques to self-regulate their emotions if
necessary (Fisher, 2019, p.15). Mindful observation requires practice but also education as well. The therapist may need to teach clients how to mindfully observe trauma-related emotions and sensations, how to understand the role of autonomic activation in what they are experiencing, and how to regulate their bodies’ defensive responses of fight-flight-freeze (Levine, Blakeslee, & Sylvae, 2018). By having a cognitive understanding of how their symptoms function to preserve their physical and psychological integrity when they are automatically aroused is usually helpful to clients, which results in helping the client to comply with treatment, lessen their self-judgment and self-blame, and increases their curiosity (Fisher, 2019; Van Der Kolk, 2014).

Van Der Kolk (2014) states the message that trauma responses live in the body and brain and becomes a source of tremendous discomfort is because the field has not yet recognized body-based treatments as reputable when his initial research was released. Van Der Kolk’s (2014) findings laid the groundwork for an alliance between traumatologists and neurobiologists as opposed to only using talk therapy (Fisher, 2014). Van der Kolk has been instrumental in bringing greater visibility and credibility for use of non-talk treatments, including eye movement desensitization and reprocessing (EMDR), sensorimotor psychotherapy, somatic experiencing, internal family systems, yoga therapy, and neurofeedback. Van der Kolk’s work has brought heightened attention to therapies showing how they have a neurobiological impact. (Fisher, 2014).

**Somatic Experiencing**

The somatic experience in a non-psychoanalytic, bio-psychological model originally developed by Peter Levine (1997), for understanding and treating posttraumatic stress disorder. Somatic experiencing offers a hopeful perspective on trauma because it views people as having an instinctual capacity to heal from their traumatic experiences. Somatic experiencing is a short-
term naturalistic approach used to reduce and resolve post-traumatic stress reactions (Levine, 1997). By focusing awareness on bodily sensations, individuals are able to access restorative physiological patterns.

As Levit (2018) notes, somatic experiencing provides approaches that are especially helpful in treating all forms of dysregulation, such as patients who are prone to states of intense over activation (overwhelming panic, anxiety, terror, agitation, rage, etc.) and/or under activation (numbness, freeze, emptiness, etc.). As I very quickly witnessed during my practicum, the overwhelmed states entail dissociation; involving dysregulations in the body and at the lower level of the so-called reptilian and mammalian portions of the brain, where the survival orientated fight/flight/ freeze responses are mediated (Levit, 2018, p. 588). As explained by Levine, et al. (2018), these dysregulations also disrupt hippocampal and cortical functioning at the higher level of the brain, impairing both the encoding of events in temporal sequence and the most sophisticated capacities of symbolic, reflective and integrative mental functions. These functions are needed for the client to reprocess traumatic experiences and develop new revised or prolonged meanings of their experiences.

Throughout my placement, somatic experiencing (SE) brought upon new ways of listening, looking and responding to clients. I was able to practice a specific focus of SE; that of primary attention on body sensations, urges, emotions and motions and images (Levit 2018, p. 595). When a client was experiencing dissociation, SE allows the client to ease external positioning toward the therapist. For example, if a client was losing her words, moving rapidly into autonomic over activation, I would suggest the client focus on the present, including me sitting in front of her. Once the client was able to orientate herself towards me, the high activation was able to subside. Another example includes a client discussing her attempts at
leaving an abusive partner, her emotions were starting to rise, and she began to pick at her nail bed extensively. I asked her if she noticed the movement in her hands. She was not aware what she had been doing. The client was asked to bring awareness to the feelings of movement in her hands, to see what would come next. The client reported feeling tense in her shoulders and turning her stomach. Through sensing techniques, the client was able to become grounded and moved forward in telling me about the worries she had for her safety, while remaining in focus and knowing she was safe in the room with me.

Of importance to note, as mentioned by Levit (2018), somatic experience is not about dampening intense emotions, rather it is about regulation of an overwhelmed nervous system. The resourcing of somatic experience is aimed at expanding the client’s capacity to access and experience greater intensities of emotion (Levit, 2018, p. 591). A client, who was sexually assaulted as a little girl, was able to trace back feelings of disappointment due to being let down by her parents as they forced her to keep being sexually assaulted by a family member, a secret. The client was able to acknowledge her own unconscious recurrence of those times when she continuously felt her role was to keep the peace between all of her family members, unbeknownst to her she was carrying the role she was forced endure as a child. This specific client slowly prepared to revisit her own trauma, at her own empowered pace. While feeling grounded in one particular session, this client was able to speak to herself as a child, going back and forth from a child and adult/caregiver role. Although the client shed many tears, she was able to consolidate her past experiences, by retrieving positive attachments from her past, following with feelings of enablement and safety. By revisiting the trauma in a regulated state, the client can find new meanings in memory and allow for closure (Levit, 2018, p. 594).
Of importance to note as discussed by Levine, Blakeslee and Sylva (2018) is the idea that using somatic experiencing may lead to a more positive transference. A client’s anger often comes outward towards the practitioner as negative transference. A clinician skilled in somatic experiencing can often contain the negativity, allowing clients to feel the power and intensity of their own emotions, acknowledge the emotions and explore where the feelings come from (Levine et al, 2018, p. 626). Throughout my practicum, I was able to witness the effects of integration and practices from readings and self-learning on somatic experience.

**Eye Movement and Desensitization Reprocessing (EMDR)**

EMDR requires specialized training and an understanding of the neurophysiological changes in the brain as a result of specific childhood trauma (Knight, 2015, p. 29). This technique should not be used without appropriate training and thorough advanced knowledge and understanding. Goodyear-Brown (2001) explains EMDR is a comprehensive and integrative eight-phase psychotherapy treatment approach that is guided by the adaptive information processing model. According to this model, a wide range of pathology is caused by unprocessed memories of trauma and other disturbing events (Goodyear-Brown, 2001, p. 230). The goal of EMDR is to assist the client in reprocessing relevant memories in order to both alleviate symptoms and foster personal growth. EMDR therapy was described as more efficient, using fewer sessions and EMDR required no homework as is required in the CBT treatment (Goodyear-Brown, 2001). EMDR reduces psychological distress. When using EMDR, clinicians guide the client to access experiences that have been encoded and retained, retrieve the encoded information, and through the innate information processing system reprocess the information to more adaptive resolution (Goodyear-Brown, 2001, p. 233). With EMDR there is no need to
create a coherent narrative or to gather facts about the disturbing event. Instead the focus is on the symptoms the client presents and describes.

During my practicum I had the privilege, with client consent to observe an EMDR session by my Professional Associate. The session left me yearning for more knowledge, information and expertise on the techniques I saw being used. I was amazed by the ability she had to assess the ways in which the client was showing the after effects of the trauma exposure. My Professional Associate listened for potential targets to reprocess with EMDR and was always listening for symptoms while continuously observing the client’s needs. Support and guidance were provided during the process as they dealt with her feelings and questions. I was shocked by the lack of dialogue that took place during this session. I left the session eager to learn the process of stabilizing and reprocessing current symptoms and triggers, from an EMDR lens. EMDR provides the opportunity to document a client’s history, create a treatment plan and develop coping skills without contaminating recall of their traumatic event. Recalling my practicum experience, I wish I could have been trained in EMDR as I believe my clients would have greatly benefited from this counselling technique. During the termination phase of my practicum, I was able to transfer some of my clients to my Professional Associate, for the purpose of EMDR therapy.

**Window of Tolerance**

Affect tolerance develops in the context of attachment relationships in early childhood as caregivers respond to the infant’s distress with attuned “repair” efforts (feeding, rocking, changing of diapers, soothing or stimulation) until the child is relieved (Ogden, Pain, & Fisher, 2006). With repeated regulation of the child’s immature nervous system, children gradually develop a “Window of Tolerance”, or an increased capacity for both positive and negative
stimuli and more ability to recover easily from states of distress (Ogden et al., 2006). In
sensorimotor psychotherapy, clients are taught to identify signs of autonomic dysregulation and
to expand their windows of tolerance by practicing habits of self-regulation. The
psychoeducational language combats shame and self-blame and helps the individual focus on
achieving more control over the trauma related feelings such as being overwhelmed or numbing
(Fisher, 2019, p. 23). During my placement, I noted a client was able to tolerate an increase in
stress, while remaining within their window of tolerance the client was able to increase a sense
of power and control, particularly feeling safe from future dangers and having deeper trust in
those closest to her.

In clients without clear memories of traumatic events (such as in drug-induced date rape
or a young child), sensorimotor psychotherapy provides a method for treating the trauma without
the necessity for remembering the details of events (Van Der Kolk, 2014). Because of its
emphasis on autonomic self-regulation, sensorimotor therapy avoids many of the pitfalls
associated with other trauma treatments such as high dropout rates, potential flooding, and
exacerbation of symptoms (Fisher, 2019, p. 24). Historically, psychotherapeutic treatments for
trauma and attachment failure have focused on the task of creating a narrative in order to access
and express the affects connected to it (Herman, 1997). In recent years, treatment focus has
shifted to cognitive-behavioural treatments, psychopharmacological symptom management, and
other present-centered and trauma-focused techniques. In sensorimotor psychotherapy, exposure
to the details of the event is used primarily to access the unresolved somatic and affective
components of the memory.

As a client relates a traumatic experience, the therapist pays equal attention to the
narrative and to the body responses until signs of unresolved emotional, muscular, postural,
visceral or autonomic activity are observed. Therapeutic breaks from the trauma-related reactions and re-focusing the patient’s attention to the somatic responses facilitates these reactions as being recognized simply as sensations and emotions rather than experienced as signals of danger. With the client’s growing ability to maintain dual awareness, reactivity diminishes, and arousal gradually comes under greater control. Re-organization of the experience results not only in improved affect regulation but also improvements in mood, energy, interest, and present-day reality-testing, along with the lessening of impulsivity. The client now has a narrative that places the events in the past and a body that experience these events as ‘over.’ The body and thus the client now have the “know how” and the capacity to appropriately respond to environmental stimuli as either stressful or pleasurable but not dangerous and threatening. (Fisher, 2019, p. 26).

**Dissociation**

Dissociation often includes feeling strongly detached from your body, emotional numbness, or having significant difficulty remembering things (Boon et al., 2011). I experienced several clients who suffered from flashbacks and painful memories that were so intense they lost periods of time. Heller and LaPierre (2012) acknowledge the disconnection from the body itself, emotions and other people is traditionally called dissociation. Dissociation keeps threat from overwhelming consciousness which allows a traumatized individual to continue to function. Adults with early childhood trauma have turned away from their body and retreated into their mind. When individuals are dissociated, they have little or no awareness that they have become dissociated. They become aware of dissociation only as they come out of it (Heller & LaPierre, 2012, p. 146).

Boon, Steele and Van Der Hart (2011) explain dissociation typically develops when an experience is too threatening or overwhelming at the time for a person to be able to integrate it,
especially when there is limited emotional support available (p. 9). They further describe dissociation being a state that allows a person to try to go on with “normal” life by avoiding becoming overwhelmed by extremely stressful experiences that are occurring in the present or have occurred in the past. Undenounced to survivors, dissociation unfortunately also leaves one or more parts of a person stuck in their unresolved experiences and another part forever trying to avoid the unintegrated experiences (Boon et al., 2011, p. 10). There are social, biological and environmental factors that tend to make people more vulnerable to experiencing dissociation. Specific skills are needed to overcome dissociation and resolve traumatic experiences.

The divided senses of self and response patterns are known as dissociated parts of the personality (Boon et al., 2011, p. 8). The idea is that there are not enough links or connections between one sense of self and the other, or between one set of responses and another. For example, in my practicum, I noticed that an individual experiencing dissociation may believe some of their experiences are not theirs. For example, a client who experienced sexual assault as a child strongly believed she was not that little girl who was sexually abused by her uncle. She identified the little girl was helpless but could not see as her own helplessness. The core of dissociation is the lack of realization that the experience an individual is having is their own (Boon et al., 2011). Dissociation takes many forms, each having somewhat different responses, feelings, thoughts, perceptions, physical sensations and behaviours. As described by Boon et al. (2011), the inner world of these individuals involves interactions among various parts of their personality, even if they are not consciously aware of the interactions (p. 25). It is important to note, the dissociated experiences are part of one’s personality even though they are not experienced as such.
During my placement I noted the central problem for individuals experiencing dissociation, was that parts of the personality often avoid each other because of painful memories and often these experiences are in conflict with each other. Boon et al. (2011) states, parts often feel fearful, ashamed, or repulsed by other parts in that the parts that function well in everyday life want little to do with parts that are fixed in trauma. The parts stuck often feel abandoned and neglected by the part of the personality that is moving on. These ongoing inner conflicts are often frightening and painful, however in order to heal, clients must accept all aspects of themselves. As clinicians, we can assist with acknowledgement and acceptance for positive changes to occur within our clients. Educating myself regarding dissociation took some time, as I initially struggled to understand that an individual is still one person; however, they may not always feel that way. As someone who wants to better assist future clients, on-going education and learning of dissociation is vital.

**Holding the Environment**

Applegate (1997) describes holding the environment as the frame within which the therapeutic process unfolds. The clinician adapts to meet a client’s needs in the same way that a caregiver would adapt to meet an infant’s needs, while holding a non-judgmental stance (Alessi & Kahn, 2019, p. 31). Prolonged exposure to trauma can disrupt one’s ability to trust others, making it difficult to form close relationships. I had one client that specifically took almost all of our sessions to develop trust and rapport with me. I often found myself questioning the impact of my role. However, I realized near the end of our time together, that although we may not have made significant strides in terms of trauma recovery, our time allowed for something greater; for the realization that the client found the ability to trust someone. Through building trust, and
holding the environment, clients feel they can share their concerns without being judged or rejected (Alessi & Kahn, 2019, p. 32).

Alessi and Kahn (2019) review three main tasks social workers must endure to ensure the clients feel safe in a therapeutic environment. First, clinicians must be aware of the influence of traumatic events on the client’s current functioning, especially those that occurred in childhood. Second, clinicians must be aware of how a client’s race, ethnicity, sexual orientation, gender identity and socio-economic status have impacted their lives. Third, clinicians must understand their own identities and how these may differ from their clients (Alessi & Kahn, 2019).

**Containment**

By providing a holding environment for clients, clinicians are able to practice and offer containment. Providing clients with a sense of internal safety, where they can regulate their emotions allows for containment to be successful during sessions. Containment occurs when the clinician hears the clients’ unwanted feelings and then reconstructs and expresses them to the client in an accessible form (Alessi & Kahn, 2018). By remaining calm, clinicians can turn clients’ projections into something they can then easily manage. Of most importance, clinicians must manage countertransference before responding to a client experiencing anger, anxiety, etc. By helping clients process their emotions, clinicians present the emotions back to clients in ways that allow clients to develop new forms of thinking. Offering containment was extremely beneficial with clients who were continuing to blame themselves for being a survivor of sexual assault.

Assisting clients to work through feelings of self-blame by offering containment and psychoeducation, helps clients experience growth, healing and a new language to understand their sexual assault. Howard and Arbaugh (2019) state containment activities are intended to help
clients to control intrusive sensations, emotions, and images in the mind (p. 708). The most important skill I gained during my placement was to take advantage of the silence. Although this took me a fair amount of time to accept, I was able to attend to the client’s immediate emotional affect. By practicing mindful breathing and witnessing a client’s distress, I was able to gently move the client along and assist with narrating the clients internal dialogue, such as specific conflicts, etc. This is a key component when a client is lacking insight due to anxiety and feeling hopeless or powerless, and an area that I want to gain more knowledge in as a clinician.

Chapter Summary

Some clients may respond well to one form of treatment over another, as Herman (2008) suggests we do not yet know how to predict what the best match is for each client. During my placement I found this to be somewhat of “trial and error”. I had some clients respond well to the somatic experience, while others felt it was not their preference. We can recognize that treatment of trauma is a “complex, biological, psychological, and social project that unfolds in stages over time and may involve different modalities to reach each stage of optimal recovery (Herman, 2009, p. 297). Clients may respond better to a specific approach at different stages in their trauma recovery process. I had one client who was in good health, with good social supports who suffered from a single traumatic incident, who did exceptionally well with a wide range of treatments in her therapy. Regardless of the theory or technique being used, practitioners must always work with the client, in partnership to determine what strategies would work best and the reason for it (Knight, 2015).
Chapter 4: Achieving Practicum Goal and Objectives

Learning Objective One

My first learning objective was to critically analyze and gain understanding of the “Three Stages of Trauma Recovery” model utilized by my Professional Associate and other counsellors at Regina Sexual Assault Centre. I developed a concrete understanding of the trauma recovery model and was able to apply the model in my counselling sessions with clients. I learned that the model most often unfolds in a non-linear way. I was able to take a client centered approach throughout all of my counselling sessions and as a result, meet the needs of my clients. By gaining a beneficial foundation and understanding the importance of the model, I was able to always end sessions with safety, regardless of where my clients were at. By using the skills of grounding and containment, tracking for levels of distress and assessing for signs of dissociation, I was able to ensure the needs of my clients were being met.

Learning Objective Two

My second learning objective was to equip myself for effective practice by becoming familiar with the roles and duties of counsellors at Regina Sexual Assault Centre. I was able to gain an understanding of their roles as community stake holders by learning about the goals, objectives, and values utilized at the Regina Sexual Assault Centre. I accomplished this learning by reviewing manuals, having open discussions with the staff, and being an active participant within the organization. I immersed myself in the organization by asking questions about the history and day-to-day operations in the agency. Because I carried a caseload and facilitated individual counselling sessions; I demonstrated understanding of the clinical component of services offered at RSAC. I also carried out other administrative duties at the front desk, provided crisis support over the phone and in person to clients. I conducted intakes and
facilitated a psychoeducational group on trauma for survivors of sexual abuse. As the months quickly went by, I found myself becoming more actively engaged in staff meetings and group supervision, offering any knowledge I had based on my work experience and new learnings through my practicum.

**Learning Objective Three**

My third learning objective was to obtain an advanced level of understanding about trauma and the recovery process as well as to acquire knowledge of the current research and best practice models for counselling individuals who have been victims of sexual abuse. By reviewing policies, reading literature on trauma recovery and through discussions with my Professional Associate this objective was achieved. I gained insight and knowledge of theories on trauma recovery, including models for best practice. I have learned additional skills and interventions, by employing a non-pathologizing framework in understanding trauma responses and behaviours. I read literature on trauma recovery, dissociation, somatic experiencing and eye movement desensitization and reprocessing therapy to meet this objective. I was able to integrate my learning in sessions with my clients. I observed an eye movement desensitization and reprocessing therapy session to better understand this model and its benefits.

Throughout my learning, as discussed by, O’Callaghan, Shepp, Ullman and Kirkner (2019), I found that clinicians working with survivors should consider how clients navigate their sexual identity and sexuality in conjunction with their sexual experiences prior to being assaulted. I noted very quickly throughout my counselling sessions, that I needed to be comfortable with all discussions related to sexuality. In the beginning, I was worried that I might come across as being uncomfortable, however I noticed once I became more relaxed, so did my clients. I learned it was important to notice and understand the fluidity of survivor’s choices
around sex and sexual partners. The most crucial piece of my learning, revolved around survivors experiencing flashbacks in subsequent sexual encounters, following their sexual assault. Many clients I worked with suffered from flashbacks and I was able to assist clients with processing potential flashbacks in the future, how to have positive consensual experiences and how to communicate their needs to their sexual partners. I quickly noted the importance of present and future sexual experiences and the role it plays throughout counselling.

James and Gilliand (2005) discuss the importance of psychoeducation for clients on trauma and sexual abuse. Psychoeducation is important because it can help diminish clients’ fears that they are different and what they experienced as a trauma symptom is different or wrong (James & Gilliand, 2005, p. 191). Psychoeducation also allows the clients to recognize that they can get better through treatment. I found providing psychoeducation around trauma and sexual assault to be of great benefit and eye opening for many clients. Clients often were able to see why specific things in their lives were happening or be able to better understand specific patterns that have been evident in their lives for some time. One client in particular, had several tears after she was educated about trauma because it provided her with reassurance and relief that she was not “crazy”, as she believed. For many years she thought she was responsible for what she was experiencing and eventually gained a deeper understanding regarding trauma reactions and knew what she was experiencing was a trauma symptom due to her traumatic history. I noted that psychoeducation provided many clients with relief and hope that through treatment or their healing journey they could get through their pain and experiences.

**Learning Objective Four**

My fourth learning objective was to gain exposure about various styles of engaging and building therapeutic relationships with the client groups served at Regina Sexual Assault Centre.
The main feminist thought I learned during my placement was that knowledge is power. During Intakes and the initial sessions, I discovered the importance of psychoeducation when it came to trauma and trauma symptoms. Herman (1992) explains if a therapist believes a patient is suffering from a traumatic syndrome, she should share this information on trauma symptoms with the patient (p. 157). Throughout several of my sessions, I witnessed clients expressing relief and develop the ability to have self-compassion when they began to fully understand their experiences were a normal symptom of trauma. When I witnessed clients discovering that they were not alone and that others have had the same experience, it laid the groundwork for a therapeutic alliance (Suleiman, 2008, p. 277). Herman believed that therapists must become educators by, providing information that made sense of the client’s symptoms and helping clients understand their intense reactions were survival adaptations to a dangerous and coercive childhood environment (Fisher, 2014).

By utilizing active listening skills and remaining empathetic in sessions for the purpose of developing a therapeutic alliance, I achieved the objective of learning various styles of engaging and building therapeutic relationships. Of the utmost importance, I witnessed clients were able to have trust within our relationship, and the groundwork for stage one was officially set. I noticed when I put work into developing a positive therapeutic alliance it can lead to significant client progress.

Meeting clients for the first time, I liked to give the analogy of trying on a pair of shoes in relation to finding the right counsellor. I explained they could be a size 9, and try on 5 pairs of shoes, but only a few may fit properly. Each client must feel their counsellor is empathetic, kind and a good listener. The reality is that not all counsellors are a good fit for clients’ needs and preferences. I encouraged open dialogue with clients and checked in with them often in regard to
their experience in sessions and to get feedback, which was also a crucial learning aspect in my practicum. I could complete all the literature reviews possible; however, it was the client’s experiences in sessions that provided me with the most beneficial learning.

Learning Objective Five

My fifth learning objective was to become competent and gain advanced graduate level skills in treatment planning by learning administrative counselling skills completed at Regina Sexual Assault Centre. This included understanding the intake process, taking clinical notes, and providing assessments and interventions. By reviewing policies around the intake process, clinical documentation, assessment tools and trauma informed interventions, this goal was successfully met. I completed intake assessments for each client on my caseload, after the end of the intake. These assessments most often took a couple of sessions to complete, and further information was also gathered throughout our sessions. The initial assessments included a thorough clinical summary of the client’s presenting problem, current situation or life stressors, pertinent background information, and agreed upon treatment plan. Case notes were completed following each session by using the SOAP notes process. SOAP is an acronym for Subjective, Objective, Assessment and Plan. The notes were to be brief and focused. I struggled with these notes as I have always included as much detail as possible, specifically during my years working in child protection. Even near the end of my practicum, I was still having difficulty making notes short and to the point. My Professional Associate kindly reminded me that we could be asked to testify in court and case notes should be completed with less detail, leaving little room for interpretation by defense attorneys.
Learning Objective Six

My sixth learning objective was to deepen my knowledge of cognitive behavioural therapy (CBT) and dialectic behavioural therapy (DBT), as well as gain knowledge of eye movement desensitization and reprocessing therapy (EMDR) through discussions with my Professional Associate and observing counselling sessions. I reviewed literature thoroughly at the beginning of my placement and throughout when I required further clarification or needed ideas in moving forward with a client. I also watched several videos online by Peter Levine regarding the healing of trauma and counselling sessions he had with clients. His approach left me in awe by his ability to use somatic experiencing. By moving beyond trauma and engaging the bodily process that should occur, rather than reliving what happened. By doing so, I was able to provide an integrated approach throughout my work with trauma. I am highly interested in developing my knowledge and skills in EMDR and somatic experiencing. After my MSW I want to receive formal training in both mentioned modalities to expand my knowledge base and better be able to assist clients with a trauma history.

Learning Objective Seven

My seventh learning objective was to become skilled at recognizing dissociation and the process of assisting clients by identifying and understanding that catalysts. Knowing how to intervene and re-ground the client and to assist with restoring a sense of safety during sessions and within the therapeutic relationship was key in meeting this objective. I implemented clinical approaches, such as CBT, DBT, and EMDR. Through sessions with clients, I gained experience in tracking dissociation and gained an understanding of dissociative symptoms. This objective was also achieved by reading books and continuously consulting with colleagues. During most sessions, I facilitated containment and provided grounding exercises for clients. This assisted
with increasing client’s safety and their awareness in the present moment. The key I found to using tools to assist with dissociation was practicing them myself so I could fully explain the process and exercises to my clients. Providing education around recognizing dissociative symptoms was important. A couple clients often found the exercise to be “silly” or “odd”, however with further explanation and practice of each tool, clients became more open to new ideas. By assisting clients to learn how to be present using their five senses and finding their own anchors in the here and now, the interference of their dissociative parts brought about changes in their self-awareness.

In order to successfully restore a sense of safety, I provided empathy and nonjudgmental warmth. By maintaining a deep respect for the client, being sensitive to their autonomy, and by maintaining a relational connection with my eyes, voice, words, laughter, and occasionally, touch, the objective of recognizing dissociation was achieved. Herman (2008) argues that by maintaining relational connections, clients overcome their dissociative reactions by continuing to build their own conceptual framework (p. 296). By continuously reading books, educating myself and consulting with colleagues and practicing grounding and containment exercises this objective was achieved.

**Learning Objective Eight**

My eighth learning objective was to write journal reflections and insights daily throughout the practicum experience as a means of developing advanced graduate level intrinsic practice and proficient use of self to grow and better meet the needs of clients. The ability to take time to journal daily during my placement was of great benefit; it allowed for my reflection and growth. Journaling assisted with reminders of topics or questions to take to supervision. I often found myself journaling and being reflective of past and current work experiences, in relation to
the practicum setting and the influences my experiences were having on current and future clinical skills. Reflecting on my practicum and thoroughly reading my journal to prepare for this report, I noticed a clear distinction in understanding how the medical model differs from trauma-informed therapy. Continuing to work in the Emergency Department after my placement, I found myself wishing I had more time to discuss past traumas with clients, more so, at times I felt defeated knowing I could not provide patients with the support I knew they fully required. I struggled knowing the counselling options available throughout our community had significant wait times, regardless of where support is sought. Journaling was an effective tool to review progress that I made as a clinician and something I plan to continue to do continue to use as a means of growth.

Learning Objective Nine

My ninth learning objective was to facilitate a final presentation at the end of the practicum placement and complete a practicum report in a timely manner that will include literature and theory of clinical practices related to assisting clients who are victims of sexual abuse. Throughout my placement I gained knowledge and understanding of theory and best practices, as it relates to working with survivors of sexual abuse and interpersonal violence, which has prepared me to be able to complete this report and subsequently do my presentation. My presentation will be completed in a timely manner after the completion of this report. Completing the practicum report has taken a few months longer than I initially anticipated. I found myself taking a significant amount of time reviewing literature and theory and the history behind both, and lost attention to how it pertained to my practicum placement. However, taking a break from research allowed me to focus on the goal of this report, which is to display my
credibility in counselling sessions in a clinical setting, working with individuals who have been victims of sexual assault from a trauma recovery approach.

**Learning Objective Ten**

My tenth and final learning objective was to prepare myself for clinical practice by carrying a caseload of between 10-15 clients under the clinical supervision of my Professional Associate. Hour-long meetings were to occur on a weekly basis to discuss areas of strength and progress, application of clinical approaches, treatment planning goals, and areas in need of growth. During my placement I carried a caseload of fifteen clients, most of whom I met with on a weekly or bi-weekly basis. Sessions were facilitated for 60 minutes. However, I had one client who resided a few hours out of Regina and in this situation my sessions were once a month for 1.5 hours and weekly phone sessions were 30 minutes. I was an active participant in clinical supervision with my Professional Associate. I frequently asked questions, reviewed progress, identified ongoing area of learning and areas I was struggling with. Supervision most often occurred on a bi-weekly basis due to caseload demands. Open communication was consistent and unscheduled discussions regarding my caseload or clinical application of therapies were often held with my Professional Associate.

**Chapter Summary**

Completing my practicum placement at the Regina Sexual Assault Centre and successfully meeting the ten learning objectives has provided me with critical thinking and reasoning skills. I have also developed the ability to address specific issues in regard to trauma recovery and the healing process. I can say with full confidence that I am able to move theory into practice and practice into theory, while following social work value and ethics. I was able to use the required skills for trauma recovery while appropriately integrating my own personal style
to meet my clients’ needs. My competency around trauma and knowledge of clinical skills with trauma recovery grew each month throughout my placement. Going into my placement, I felt I was not competent to assist survivors of sexual abuse; however I quickly realized these were some of the same group of clients I worked with in the past, simply in a different capacity, which was a privilege to partake in. Through self-awareness and letting go of expectations I had of myself I was able to place trust in the counselling process and the resilience of my clients.
Chapter 5: Themes

Guilt and Shame

Surprisingly to me, several of my clients experienced guilt and shame as a result of their sexual assaults. I never imagined shame could become so immensely powerful, contagious and emotionally toxic. Herman (2008) describes shame as a state of unbearable self-consciousness and an emotion that becomes a universal human reaction to rejection, humiliation or defeat. She goes on to explain that although shame is experienced powerfully in the body, it is relieved by the affirmation of restored relational connecting (Herman, 2008, p. 299). Both individual and group therapies can have an impact in overcoming feelings of shame by providing a sense of belonging and connection in human relationships.

Peter-Hagene and Ullman (2018) addresses how society blames sexual assault victims when they engage in risky behaviours such as drinking. Being blamed by society can become internalized which has detrimental effects on recovery. They further explain, women who were drinking before the assault tended to blame themselves more, because they believe their drinking enabled the assault (Peter-Hagene & Ullman, 2018, p. 84). Society in general tends to blame victims for behaviours that are not seen as “normal” which facilitates sexual victimization. For example, one of my clients was a victim of sexual assault and invited someone she did not know over to her house. This invitation led to the assault. The client’s family felt she was to blame for what happened to her, even though the client suffered from a physical and cognitive impairment. We continue to see survivors who are to be blamed for being sexually assaulted.

Sanderson (2013) discusses that clinicians need to be mindful at all times to acknowledge and articulate the survivor’s experience of shame from an empathetic and compassionate position (p. 212). By using the tool of mirroring in a non-shaming way, I offered understanding,
encouragement and warmth. Clinicians are able to assist by re-framing the survivor’s experience of shame while being genuine, caring and sensitive to a client’s experiences. I completed several activities surrounding shame with clients. As clients were able to talk about their shame, it was important they had an understanding that the “shame of their abuse is not their shame, but the abuser’s shame that they have taken on” (Sanderson, 2013, p. 214). I had one client in particular that was able to place the blame on the offender and speak about the shame while being open to self-compassion and self-forgiveness.

Survival

Judith Herman (2008) suggests, “it is important to understand that trauma is not only a drama of a past event, but also, even primarily, a drama of survival” (p. 280). All of the women I met had undeniable strength and courage. During my placement I noticed individuals often were unable to move beyond indelible images of their sexual assaults, guilt about the event and shame due to societal views. Individuals also encountered a lack of trust in the world, in society as whole, in their communities and in people they have come to know and love at the same time they were struggling to find meaning in their lives. The theme of survival is immanent in gaining knowledge and power to overcome symptoms of trauma. The profound term of changing the ideology of being a victim to survivor was proof that women could use the term as a source of their creativity and build on it.

The theme of survival was evident in each session, as I saw women grow, heal and exert their way through their journey, surviving each step along the way. When survivors are empowered, they are better able to manage their current lives and understand current challenges in light of past victimization (Knight, 2015, p. 37). The most empowering tool for survivors is being able to express their experiences and feelings into words. I had the ability to witness this in
a few sessions, where survivors wrote letters to their abuser or spoke to childhood pictures. Being mindful and encouraging during this process is beneficial to clients because it offers them the opportunity to make sense of their own story and prove their own resilience.

A book that I heavily relied on for developing skills was *Counselling Skills for Working with Trauma: Healing From Child Sexual Abuse, Sexual Violence and Domestic Abuse* by Sanderson (2013). She acknowledges that survivors are rarely passive victims and have developed strategies to manage the abuse (p. 14). To dispel the negative connotation associated with the term “victim”, the term “survivor” was used throughout the literature, as is used at Regina Sexual Assault Centre. It was not until I had these conversations with clients, telling them they were survivors that I noticed the impact a single term could have on an individual. The power of being told one is a survivor holds significant impact, even in terms of recovery. During termination, one client expressed how empowering those conversations were and how being told she was survivor assisted with the realization that being the victim was not part of her identity.

**Advocacy**

As clinicians, we must take a critical lens when assessing the needs of sexual assault survivors. Throughout my placement, I saw the importance of advocating for our clients, both in our professional and personal life. Clinicians must strongly advocate for heightened awareness and improved responsiveness among all providers and policy makers regarding victims of sexual assault. It is our duty as registered social workers to advocate for services that are effectively and ethically meeting the diverse needs of survivors. Our responsibility in advocacy is to assist with preventing re-victimization and re-traumatization by the very systems that are designed to help victims, such as our justice system. RSAC counsellors consistently do community diligence in ensuring a trauma informed approach is implemented at an individual, organization and systemic
level. I had the opportunity to take part in an event held by RSAC, titled, Take Back the Night, which raised awareness and provided a voice to those who experienced sexual assault. The executive director and counsellors meet with lawyers, police officers, social service staff and treatment centers, etc. to raise awareness and provide public education in a multifaceted manner.

Torres (2019) suggests, policies must support survivors’ awareness of the structural inequalities that are amplified in intimate partner violence (p. 4). She also explains that structural inequalities, gender norms, state responses to sexual violence and localized understandings of intimate partnerships radically shape how sexual violence in intimacy is experienced (Torres, 2019, p. 6). Of most importance for social work is sexual violence must be acknowledged as a societal problem and advocacy must be at the forefront of our work for this very reason.

**Boundaries**

Due to the nature of sexual abuse disclosures, practitioners can overextend themselves or move the relationship into a realm that is more personal in nature (Knight, 2015, p. 27). Setting boundaries are crucial when maintaining a therapeutic relationship because clients often have difficulty with trust in the therapeutic relationship and for many clients the therapist is the only person they have spoken to about the sexual assault. By establishing professional boundaries, practitioners enhance survivor’s self-capacities. At times, survivors may have a sense of urgency which can lead practitioners to engage in activities that are not consistent with the agency or professional responsibilities, such as maintaining the time of the session. Thus, clients benefit from a consistent and predictable relationship with their clinician. Knight (2015) notes, when working with survivors, the clinician may need to have flexible boundaries to be more available in times of crisis, without losing sight of the professional responsibilities. For example, I needed to be flexible with boundaries and fit a client in when she called in a moment of crisis. I was able
to see her later in the afternoon, assist her with safety planning for her partner, and referred her to an agency where she could seek assistance.

There are times when physical contact may be requested, such as a pat on the shoulder, or a hug to convey empathy. However, practitioners must always ensure that clients remain in control of their bodies and be mindful of their clients’ boundaries. It is critical that the client consent to physical contact and understand the nature of the contract is to provide support and comfort. It is critical that counsellors are sensitive to clients becoming re-victimized by being aware of the client’s sexual assault history (Knight, 2015, p. 37). Clients must always be asked by the practitioner if touch is allowed, prior to it occurring. During my last sessions with clients, most of them asked if they were allowed to give me a hug, which I agreed to. This was done out of mutual respect for one another and was direct reflection of the impact of the emotional intensity of the therapeutic relationships I established with them.

The theme of boundary difficulties was common for many clients. As Sanderson (2013) notes, the nature and dynamics of complex trauma often prevents survivors from setting and managing healthy boundaries (p. 222). Trauma can create distorted views of boundaries because abusers use boundaries to manipulate or control others, leaving the survivor “afraid to set boundaries for fear of the consequences, or they set very rigid boundaries as an attempt to control others” (Sanderson, 2013, p. 223). All of my clients required assistance in learning how to set appropriate personal boundaries after they learned how to identify and express their needs. Psychoeducation was also provided around common difficulties with boundaries and the purpose and function of healthy boundaries. Exercises were done with most clients to help them learn how to set healthy boundaries and develop assertiveness. Setting boundaries was difficult for clients who were struggling with maintaining safety in their lives. For example, one client
remained in an abusive relationship while she was in counselling and any display of her needs was not accepted by her partner. This situation was very difficult because the client wanted to learn all she could in sessions, yet it was important to balance her need to learn how to set boundaries with her safety. After many clients had gained insight and were better able to manage boundaries, they were able to move on to managing relationships and sexuality in their lives.
Chapter 6: Challenges

Nonprofit flexibility

To most people, the flexibility of working in a non-profit agency would be a positive aspect; however, initially this was a slight challenge for me. I entered several of my initial assessments with goals and tasks to accomplish prior to the end of each session. I quickly learned this was not how this organization operated because there was no time frame on the amount of sessions clients could have. I anticipated following a treatment plan and proving how we were one step closer to termination after every session. I did not realize how my past work history, in child protection, mental health and the emergency department shaped me as a professional who could not sit still and constantly worked under pressure to meet the needs of each organization, rather than the needs of the client. I am not saying, RSAC did not have expectations, but there was no pressure to provide quick fix therapy or the illusion that the client was getting better.

Being in an environment where staff were valued for their skills and each counsellor had a cap on the number of individuals they could see was initially a shock; I truthfully did not know such workplaces existed. Spending time at RSAC forced me to slow down my thought process and movement of my body. By doing so, I was truthfully able to be in the moment with each of my clients, and I did not have to worry about several other tasks that I needed to do, while in sessions with them. Within a month I was able to sit comfortably in stillness and the experience was beneficial in showing me what providing client centered counselling had to offer employees.

Confidence

Initially, I struggled with confidence as a sexual assault counsellor. Although I had worked in the role of one-on-one counselling before and assisted patients and children who had been sexually assaulted, I did not feel that I had enough of knowledge to be truly beneficial as a
counsellor to clients. By reading several books, my confidence grew, and I began to recall information that I had already knew or had used in my social work career thus far. Through conversations with my Professional Associate, I received encouragement and reminders that I did have a good knowledge base and a lot to offer clients. On occasion, I found myself attempting to explain my work and counselling experience to clients, thinking they would feel more secure speaking with me. However, this was not necessary because I did not have any clients who questioned my ability to assist them. I did encounter a few clients from the waitlist who over the phone stated they were not willing to meet with a student, simply because they knew I would not be there long term. “Clinicians in these settings often feel ill-equipped to be helpful to survivors, mistakenly assuming they lack the required knowledge and expertise” (Knight, 2015, p. 25).

Although I struggled with feeling unequipped throughout my entire practicum, it was in my final sessions with clients that I saw the impact of the guidance I had provided clients. Understanding it was not me doing the work, I simply walked along side my clients on their journey. This realization assisted me with gaining more confidence. I often questioned if I was competent enough in my role, to be an effective support to clients. Eventually near the end of my placement I received client feedback, which allowed for me to further believe in myself as a clinician and the impact of my role. One client relayed that she was able to disclose past abuses and work through issues so much more effectively with me in our limited time compared to her past ten years of counselling. Although this did provide me with some confidence, it further showed me the importance of the therapeutic relationship and always remembering that the client is the expert of their lives, not us as clinicians. I had a few clients who were visibly upset during our last sessions, not because they were scared of me no longer being there, but because they
were thankful for our time together. I told clients that they had completed the work all on their own; I was simply a guide along the way. Through these conversations with clients and journaling my experience and my irrational thoughts, I now feel more confident in being able to assist individuals through the three stages of trauma recovery. More importantly, gaining confidence led to me believing in the counselling process itself.

**Time frame**

Because I completed my practicum placement on a full-time basis it created difficulties and limitations in the counselling process. The Regina Sexual Assault Centre does not have a limit on the number of sessions clients can receive because there is no time frame on trauma recovery. Many of my clients remained in Stage One of Trauma Recovery, therefore by working every day, I was able to finish my practicum sooner, but it did not allow for me to see clients through, to the end of treatment. Trauma counselling can be long term. I began my practicum with the idea that I would be completing treatment plans; this was not the case. Initially I felt disappointed that I would be leaving clients, who did not complete their “healing journey” or were still at the beginning stage. However, through discussions with my Professional Associate I came to understand that success was not measured by the closing of a file, but rather by smaller tasks, such as clients simply attending for sessions, clients being able to successfully use grounding skills or no longer be triggered. At the end of my placement I suggested, should Regina Sexual Assault Centre have another Master of Social Work student, a part time placement would provide a longer extension of services. The opportunity to assist clients for a longer period of time would allow clients to enter other phases of the trauma counselling model. Around the time of my leaving, I noticed many clients were finally able to feel secure enough with our relationship to open up to me. Lack of time also left me to address my fear that I was
leaving clients too quickly. This process taught me what the role of a counsellor truly is in the lives of clients, which is a guide, and left me with a newly found respect and admiration for the role I had encompassed. Resnick (2001), states there is a limit to how much can be accomplished within the framework of short-term intervention; true integration of change needs time and opportunity to experiment, especially in cases with complicated family history (p. 62).

**Trauma Recovery Model**

I encountered two clients who wanted to move through the stages of trauma recovery quickly, prior to establishing basic safety. These clients did not have the capacity to keep themselves safe at all times. They did not have positive coping strategies and their only secure attachment at the time was me as their counsellor. Herman (1993) insists, “Basic safety must be established before we recommend exploratory work” (p. 387). I found myself trying to take a step back, when clients were pushing to recall their traumatic memories. I was able to discuss this concern with my Professional Associate, and through this process was able to acknowledge both of these individuals had characteristics similar to those of borderline personality disorder, where the root cause is often traumatic experiences. With one client, I was able to have open discussions about always making safety the main priority, in addition to allowing her to work through her feelings and emotions using the somatic experiencing, which she requested.

My other client chose to no longer continue with counselling because she felt talk therapy was not something she required at the moment. The use of the three stages of trauma recovery model that is used at the Regina Sexual Assault Centre proved important to me in maintaining the ability to integrate information with the practice experience and be knowledgeable about this framework. A challenge with the model is the impact the survivors’ stories have on clinicians. Disclosures can be extremely hard to hear and the emotional reactions to their narratives can be
difficult to witness (Knight, 2015, p. 33). I learnt that countertransference can be a common reaction among clinicians who work with survivors of sexual assault. At times, practitioners can display rescuing behaviours or over identification (Knight, 2015, p. 33).
Chapter 7: Conclusion

Future Social Work Practice

I strongly believed a personal goal was to develop my own practice model and find a rhythm that works best for me as a clinician. However, through my practicum experience, I know this is not best practice for clients. Rather, we must work from an approach and counselling theory [ies] that best meets the needs of our client. Our responsibility as clinicians is to consistently be trauma informed, regardless of our place of employment or area of practice and to continuously educate ourselves on new and emerging theories that benefit our clientele.

Those in the field of social work must acknowledge sexual assault affects people in all domains. Azzopardi (2016) suggests, social workers must advocate for trauma informed child welfare and criminal justice system responses to sexual violence, and commit to collaborative community partnerships to provide education, prevention, and intervention together (p. 215). I am proud to have been a part of a community that raises awareness and motivates significant changes, thanks to the dedicated staff members of RSAC.

As Duma, Mekwa and Denny (2007) discuss the challenges posed by recovery from sexual assault trauma as a reality that confronts the survivors of sexual assault, their families and the larger community of service providers (p. 4). Viewing sexual assault as a phenomenon allows for continued research on systemic issues survivors continue to encounter and on the higher importance held for survivors to partake in their own journey to recovery and healing. Of most importance, clinicians must always remember that recovery is a personal journey, held by the individual. The journey of recovery will not lead to the same person that one was before the event of the sexual assault, but to a new self (Duma et al., 2007, p. 9). “Awareness and understanding of this is evidenced by the women’s acknowledgement of what they had lost
during the events of sexual assault, the grieving process that they underwent for the aspects they had lost” (Duma et al., 2007, p. 9). For recovery to occur, one has to have a goal, or as Duma et al. (2007) explains a direction, an inspiration, faith or hope (p. 10). Recovery is “a deep personal, unique, process of changing one’s attitudes, values, feelings, goals, skills and or roles” (Duma et al., 2007, p. 11).

Tutty and Goard (2002) describes how we must remain open to hearing the voices of survivors to ensure the system’s responses address the needs of all the individuals affected by sexual violence (p. 128). They further explain it is critical to engage and recognize the strengths women have, which is crucial to the social work profession because we always must work from a strength-based approach in all services we are providing. Clinicians must acknowledge the gaps in services and difficulties finding support. Clients’ complex realities must be understood and accommodated; support for them should not be rejected.

**Final Comments**

As demonstrated in this paper and discussed by Zaleski, Johnson and Klein (2016), no single treatment plan will help all trauma survivors recover the same way. Herman’s (1997) work explains trauma occurs in relationships and healing must also occur in relationships. Processing the trauma can only occur once basic safety and self-regulatory capacities have been attained. She also notes, therapists must act as bridge, helping the client regain safety in the world, testing each new social situation, with the anchor of safety in place (Herman, 1997, p. 392). Reengagement with the outer world is viewed as the final step to trauma recovery treatment.

During trauma treatment, we aim to help our clients find the light, or at least to find their bodies, their resources, and their resilience (Fisher, 2014). We can cultivate an attitude of
humility, curiosity, and wonder at human resiliency, acknowledging that we are still far from understanding the active principles in recovery from psychological trauma (Herman, 2008). Mishna, Van Wert and Asakura (2013) remind us that practitioners must work from a theoretical framework that stresses the centrality of the therapeutic relationships in clinical practice (p. 292). They conclude social work practice should be informed by evidence; practitioners should be confident that there is some evidence that specific practice approaches they are using are in fact helpful and not harmful to clients (Van Wert & Asakura, 2013).

Social work practitioners historically and ethically have always served societies most vulnerable and oppressed populations (Canadian Association of Social Workers, 2005a). Due to clients often experiencing intersecting oppressions, and receiving support from multiple service providers, it is crucial that social workers use a variety of treatment models. Howard and Arbaugh (2018) research shows that mental health professionals do not routinely assess for violence in the home, and even when violence is disclosed professionals, are often unprepared to address it in therapy. Of most importance, when social workers fail to recognize the impact of abuse, survivors may be misdiagnosed or re-victimized by the treatment provided (Howard & Arbaugh, 2018, p. 704). When the impact of abuse is not recognized it can cause emotional harm and can delay individuals from seeking further help. It is crucial that social workers receive appropriate training to assist survivors of sexual assault.

To say in the year 2020, sexual assault and violence against women is still an issue in society is a cultural devastation. Survivors deserve to be heard and believed and they deserve to know that healing is possible and most importantly, from a clinician’s viewpoint, they are not alone. Resilience is a capacity that survivors of sexual assault will always hold. Our duty as social workers, regardless of our area of work or expertise is to be trauma informed, assist
survivors in their healing journey and to constantly educate ourselves and grow as clinicians. As Herman (1993) says, to be effective, interventions must be tailored to the individual’s unique ecology, responding to the personal, sociocultural, environmental and interpersonal exigencies of an individual’s life (p. 379). This perspective offered by Herman (1997), provides an overall framework for understanding recovery from sexual trauma, which RSAC counsellors work diligently to implement into their practice, from a client centered and collaborative approach. This was an experience in which I ever so gratefully was able to personally and professionally learn and grow from.
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